H Gregorian

Homefield Court

Inspection report

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Ratings

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

Overall summary

Our inspection of Homefield Court took place on 10 December 2015 and was unannounced.

Homefield Court is a care home situated in Brent which is registered to provide care for to up to 24 older people. At the time of our inspection there were 23 people living at the home, the majority of whom were living with dementia or mental health needs. We last inspected Homefield Court on 4 July 2014 when we found that the service met the regulations that we assessed.

There was a registered manager in post. 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.

People who lived at the home told us that they felt safe, and this was confirmed by the family members and friends that we spoke with.

People were protected from the risk of abuse. Staff members had received training in safeguarding, and were able to demonstrate their understanding of what this

Summary of findings

meant for the people they were supporting. They were also knowledgeable about their role in ensuring that people were safe and that concerns were reported appropriately.

Medicines at the home were well managed. People's medicines were stored, managed and given to them appropriately. Records of medicines were well maintained.

Staff at the home supported people in a caring and respectful way, and responded promptly to meet their needs and requests. There were enough staff members on duty to meet the physical and other needs of people living at the home. People who remained in their rooms for some or part of the day were regularly checked on.

Staff who worked at the home received regular relevant training and were knowledgeable about their roles and responsibilities. However, the staffing records that we viewed did not always provide evidence that appropriate checks had taken place as part of the recruitment process to ensure that staff were suitable for the work that they would be undertaking. Some staff members had not received regular supervision from a manager, although the staff members that we spoke with told us that they felt well supported.

The home was meeting the requirements of The Mental Capacity Act 2005 (MCA). Information about people's capacity to make decisions was contained in people's care plans. Applications for Deprivation of Liberty Safeguards (DoLS) had been made to the relevant local authority. The majority of staff had received training undertaken training in MCA and DoLS, and those we spoke with were able to describe their roles and responsibilities in relation to supporting people who lacked capacity to make decisions.

People's nutritional needs were well met. Meals were nutritionally balanced and met individual health and cultural requirements as outlined in people's care plans. Alternatives were offered where required, and drinks and snacks were offered to people throughout the day. People told us that they enjoyed the food.

The home environment was suitable for the needs of the people who lived there. We saw that a number of improvements had been made, including the redecoration of people's bedrooms and a communal lounge and the provision of a shelter in the garden for people who wished to smoke. However, we had concerns about the cleanliness and condition of some of the flooring and a bathroom and toilet that had not yet been refurbished as these could compromise infection control measures within the home.

Care plans and risk assessments were person centred and provided guidance for staff. We saw that these had been regularly updated and reflected any changes in people's needs.

The home provided a range of individual and group activities for people to participate in throughout the week. Staff members engaged people supportively in participation in activities.

People and their family members that we spoke with knew what to do if they had a complaint.

Care documentation showed that people's health needs were regularly reviewed. The home liaised with health professionals to ensure that people received the support that they needed.

There were systems in place to review and monitor the quality of the service, and we saw that action plans had been put in place and addressed where there were concerns. Policies and procedures were up to date and reflected regulatory requirements and good practice.

People who used the service, their relatives and staff members spoke positively about the management of the home.

We found three breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Aspects of the service were not safe. Some staff files did not include evidence that appropriate recruitment checks had been carried out.

Improvements had been made to the building, but some areas still required redecoration and refurbishment to ensure that people were not at risk.

Staff we spoke with understood the principles of safeguarding, how to recognise the signs of abuse, and what to do if they had any concerns.

Risk assessments were in place and included guidance for staff around how to manage identified risks. These were updated regularly as people's needs changed.

Medicines were well managed and recorded, as were people's finances.

Is the service effective?

Requires improvement

Aspects of the service were not effective. Staff members had not always received regular supervision by a manager to ensure that they were effective in their role.

The home was meeting the requirements of The Mental Capacity Act 2005.Applications had been made for Deprivation of Liberty Safeguards authorisations to ensure that people were not unduly restricted in their best interests.

People told us that they enjoyed the food provided at the home and we saw that people were offered choices that met their individual preferences.

Is the service caring?

Good

The service was caring. People who used the service and their family members told us that they were satisfied with the care provided by staff. We observed that staff members respected people's privacy and dignity.

Staff members spoke positively about the people whom they supported, and we observed that interactions between staff members and people who used the service were caring and respectful.

People had been supported to identify their wishes regarding care at the end of life.

Is the service responsive?

Good

The service was responsive. Care plans were up to date and person centred and included guidance for staff to support them in meeting people's needs.

People were able to participate in a wide range of individual and group activities.

Summary of findings

The home had a complaints procedure and people knew how to complain. We saw that complaints had been managed effectively.

Is the service well-led?

Good

The service was well-led. There were systems in place to monitor the quality of the service and we saw that these were evaluated with improvements made where required.

The registered manager and deputy manager were approachable and available to people who used the service, staff members and visitors.

Staff members told us that they felt well supported by their managers. Family members of people who used the service felt that the home was well managed.

Homefield Court

Detailed findings

Background to this inspection

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

This inspection was unannounced and took place on 10 December 2015. The inspection team consisted of two inspectors, a pharmacy inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we also reviewed our records about the service, including previous inspection reports, statutory notifications and enquiries. We spoke with representatives from a local authority that places people at the service and reviewed a copy of their recent quality assurance audit of the home.

During our visit we spoke with seven people who lived at Homefield Court, three family members and two friends. We also spoke with the registered manager, the deputy manager, two care staff and the activities co-ordinator. We spent time observing care and support being delivered in the main communal areas, including interactions between care staff and people who used the service and activities that were taking place. We looked at records, which included six people's care records, six staff recruitment records, policies and procedures, medicines records, and records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

People told us that they felt safe. A family member told us, "When someone gets agitated they calm them down very well. They have worked wonders with them." A friend of a person who lived at the home said, "Staff work hard to keep them safe."

The six staff records we looked at did not provide us with sufficient evidence that robust recruitment and selection processes had always been carried out to ensure that staff were suitable for their role in supporting people who lived at the home. We saw that checks of criminal records were contained within staff files. However two of these showed that they had been provided through another organisation. There was no evidence that the provider had used a system for obtaining criminal record checks for these staff, such as the Disclosure and Barring Service's

update service Other documentation relating to employment was not always contained within the staff records. For example, one staff file did not include references, and another file's references did not match those given in their application form. One file that we looked at showed that a new staff member had signed their contract of employment and been provided with a start date before their references had been received.

This demonstrated a breach of Regulation 19 of The Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staff members were seen wearing disposable aprons and gloves when supporting people with their care. Soap and paper towels were accessible in most toilets and bathrooms. Staff members that we spoke with were aware of the importance of ensuring that they took action to prevent the risk and spread of infection within the home. However, we found that there was a strong smell of urine in a toilet and an upstairs corridor. We spoke with the registered manager about this. They told us that the smell in the corridor may have been generated by a steam clean of the carpet on the previous day. They also said that some people living in the rooms on that corridor were known to urinate on the floor. We were shown rooms where carpets had been replaced by vinyl flooring in response to this. The registered manager told us that the toilet where we had noticed the smell was due to be renovated, along with the bathroom next door, where we observed that the seal around the bath required replacement. We also noted that the carpet in the downstairs lounge was soiled, and that the flooring in the dining and lounge area required replacement. The registered manager told us that the carpet had been cleaned during the week prior to our inspection, and that the dining and lounge area was due to be redecorated, which would include new flooring. However, these unresolved issues could cause an infection control risk to people living at the home.

We saw that a cleaning schedule was in place, including for deep cleaning of carpets on a fortnightly basis. We also observed domestic staff cleaning floors and carpets in the communal areas. We saw that the provider had undertaken an infection control audit, but this was a year old, and did not reflect the current position at the home.

This demonstrated a breach of Regulation 12 of The Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments for people who used the service were personalised and had been completed for a selection of areas including people's behaviour, medicines, falls, pressure ulcers, infection control and moving and handling. We saw that these were up to date and had been reviewed on a regular basis. Risk management plans were generally detailed and included guidance for staff around how they should manage identified risks. Behavioural risk assessments included guidance for staff around providing positive approaches to supporting people. However, we noted that behavioural risk assessments did not always fully describe the actual behaviour. For example, two people's assessments referred to them being "verbally abusive" but did not provide further detail of how or when this behaviour manifested itself. We discussed this with the registered manager, who told us that he would review people's care documents to ensure that these reflected people's actual behaviours where there was an identified risk.

There was an up to date policy on safeguarding of adults that included contact details for the local authority. Staff members that we spoke with demonstrated that they understood the principles of safeguarding, and were able to describe different types of abuse and provide examples of indicators that abuse might be taking place. They were aware of their responsibilities in immediately reporting and recording any concerns. Staff had received training in safeguarding, and a training matrix that we viewed showed

Is the service safe?

that all but three staff members had undertaken this training within the past year. The records maintained by the home showed that there had been no safeguarding concerns during the past year.

One person told us that they received their medicines on time, and a friend of another person confirmed this. Medicines were stored, managed and recorded appropriately, and administered to people safely. Medicines were securely stored and the fridge and room storage temperatures were monitored to ensure that they were maintained at a safe level. Although nobody living at the home was prescribed controlled drugs at the time of our inspection, there were appropriate facilities for storing controlled drugs if required. .An up to date medicines policy which included procedures for the safe handling of medicines was available to staff. The home had amended its medicines policy recently to include documentation of medicines of unused or spoiled medicines returned to pharmacy. Medicines were supplied in blister packs. Prescribed soluble aspirin which was packed among other medicines in the blister. A senior worker described the process for administering soluble aspirins and we noted that there was potential for error as these looked like another medicine in the pack. We discussed this with the registered manager who told us that they would work with the local pharmacist to ensure that aspirins were dispensed in a way to enable staff to administer them safely to people.

There was evidence that staff members administering medicines had received appropriate training. We observed that staff who administered the lunch time medicines offered people medicines prescribed as 'when needed' such as analgesia appropriately. However, we did not see any documented evidence of any pain assessment tools used. We saw evidence in people's care plans that those on diabetic medicines were appropriately monitored. The registered manager showed us a record from the local GP showing that people's medicines had been reviewed during the past year. However, this information was not recorded in people's care files. We discussed the importance of doing so with the registered manager who told us that he would ensure that people's care plans would be updated to include information about their medicines reviews.

The home managed small amounts of cash for people. Most people's relatives managed their money and provided the home with cash to for personal expenditure, such as on clothing, toiletries and hairdressing. Records of financial transactions were recorded including cash income and expenditure. Receipts of expenditure were available. The registered manager carried out regular checks of the management of people's monies. We were satisfied that the arrangements in place to support people with their monies reduced the risk of any financial abuse.

Staffing rotas and our observations of care at the home showed that there were sufficient numbers of staff on duty to meet people's needs. In addition to the registered manager, deputy and care staff, there was an activities co-ordinator, cook and domestic workers. A family member and two friends told us that they thought that the staffing levels were good. We were told that, "there seems to be enough carers." The staff members that we spoke with told us that they considered that there were enough staff members of shift at any time to meet people's needs.

We saw that staff members responded promptly to ensure that people were provided with the assistance they needed. There were enough staff to support people to take part in activities and to be accompanied by staff when needing support to take walks within the home. The registered manager told us that the staffing levels were based upon the dependency needs of people and were flexible, for example, he and the deputy manager covered shifts when people needed to be accompanied by staff to appointments including hospital appointments.

Health and safety checks were up to date. A food hygiene safety check had been carried out by the local authority who had rated the service as very good. Fire action guidance was displayed and fire equipment had recently been serviced. Fire drills were carried regularly and included night staff, and emergency evacuation procedures were in place for individuals. Accident and incident records were well maintained and showed that appropriate actions to address concerns had been taken. We saw that the call bell system had been fully replaced during October 2015. Records of accidents and incidents were well recorded.

The provider maintained an out of hours emergency contact service and staff we spoke with were aware of this.

Requires improvement

Is the service effective?

Our findings

People that we spoke with and their family members and friends were generally positive about the support that they received from staff members. A friend of a person who lived at the home told us, "[their friend] is much better since she has been here. The staff seem well trained." However, one family member said, "The people are very nice but it lacks a lot in my view, e.g. cleanliness, it smells when you go in, the standard of his room, the way he's dressed. I feel totally sad about it."

Staff members told us that when they started work they had received an induction, and had completed training that was relevant to the care and support that they were providing to people who used the service. However training records maintained within the staff files that we viewed were limited. Although, the provider maintained a record of training that staff members had undertaken, this was not always supported by other evidence such as training certificates.

Staff members that we spoke with told us that they received the support that they needed to undertake their duties effectively. The home's supervision policy stated that 'all members of staff are to receive a minimum of six formal supervision sessions each year.' However, the records that we viewed showed that supervision by a manager had not always taken place on a regular basis. For example, we saw that there was no recorded supervision for on staff member between March 2014 and August 2015. There was no record that supervision had taken place for another staff member since November 2014.

The above evidence demonstrated a breach of Regulation 18 of The Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We also saw evidence that staff meetings took place on a regular basis. Separate meetings were held with night staff to ensure that they were able to participate in discussions. The minutes of recent staff meetings showed that there was a focus on the care needs of people who used the service. However, we saw that notes of these meetings were limited and did not always describe any actions agreed.

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 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 care records that we viewed showed that information about peoples' capacity to make decisions was recorded.

Care plans provided information for staff about how they should support people to make decisions. We saw copies of applications to the relevant local authority team in relation to Deprivation of Liberty Safeguard (DoLS) regarding restrictions in place for people who were under continuous supervision and unable to leave the home unaccompanied due to risk associated with lack of capacity to make decisions.

The staff members that we spoke with demonstrated that they were aware of the requirements of the MCA and understood their roles and responsibilities in relation to this. One staff member told us that, "I let people make their own decisions, and talk with them in simple and gentle way." The home's training record showed that 13 staff members had received training in MCA and DoLS during 2015.

Care documentation showed that people were involved in agreeing their care plans wherever possible. We saw that, where people were unable to, or did not wish to participate in this process, a record of this was made.

The home's physical environment was suitable for the needs of the people who lived there. We saw that a number of improvements had been made to the home during October 2015. This included redecoration of people's bedrooms, a downstairs lounge area, replacement of a stair lift, and refurbishment of some bathrooms. One person told us that they liked decoration of their bedroom, and a family member told us that their relative had moved from

Requires improvement

Is the service effective?

an upstairs room to a downstairs room and was happy with her new room. .We also saw that improvements had been made to the garden area including the provision of a shelter for people who wished to go outside to smoke.

People's individual dietary and nutritional needs were met. Information about people's dietary and food preferences was recorded in their care plans. We observed people eating breakfast and lunch and saw that choices were offered by staff. We saw that a care worker, who was supporting a person to eat, gave them the time that they needed and chatted to them throughout. People told us they enjoyed the meals provided by the home. We were told, "the food is good. There is a choice." A family member told us that their relative, "likes the food and he is fussy."

People were offered hot and cold drinks throughout the day and we saw that drinks and snacks were always available in the dining area. Where there were concerns about weight loss or poor food or fluid intake we saw that relevant professionals, such as a GP or dietician were consulted and guidance developed for staff within people's care plans

People's health care needs were met and monitored. Records showed that people regularly received health checks. They had access to a range of health professionals including; GPs, dieticians, opticians, chiropodists, psychiatrists, and dentists. They also attended hospital appointments.

Good

Is the service caring?

Our findings

People spoke of being happy with the care that they received. We were told, "they look after me well," and, "the staff are very nice and caring." A friend of a person who lived at the home said, "they appear to be very caring, very attentive and there's always someone there. The staff are very welcoming. I think their patience is amazing. He's always well looked after, properly dressed, his nails and hair are done, and he's clean and looks dapper." A family member told us "I think they're very kind to him and he's happy with them. I think they do their best. He's never reported anything bad. The girls are very nice. I think they're wonderful with them."

Staff interacted with people in a respectful manner. We heard them ask people how they were, and saw that they would stop and chat to people about their interests. People were supported to maintain the relationships that they wanted to have with friends, family and others important to them. We heard staff speaking with visitors in a friendly manner. They provided family members with an update about their relative's condition.

We saw that where people required personal support, this was provided in a timely and dignified manner. For example we observed a staff member supporting a person who had soiled themselves to go to their room and change. The person was crying, but we noted that the staff member spoke with them and reassured them in a discrete and gentle manner. Some people chose to spend time in their rooms. We saw that staff members checked on their welfare regularly and asked them about any needs or wishes in relation to care and support.

Staff members spoke positively about the people whom they supported. The activities co-ordinator told us, "I really enjoy working with the people here. I'm learning new things from them all the time."

The majority of family members and friends that we spoke expressed satisfaction with the information and contact that they received from the home. A family member told us that, "communication is very good." A friend of a person who lived at the home told us that, "they phone regularly."

People told us their privacy and dignity was respected. We saw staff members knock on bedroom doors and wait for the person to respond before they entered. People's care plans included information about preferences in relation to communication needs and preferences in relation to delivery of personal care. Care documentation also included assessment and guidance about promoting people's independence.

Care plans included information about people's health, cultural and spiritual needs. We also saw that they contained information in relation to people's sexuality and relationship needs. Staff that we spoke with showed that they recognised the need to support people's individuality. This demonstrated that the home respected and supported the individual wishes of people who lived at the home

Care plans recorded information about peoples' end of life preferences and needs. We were able to see that people had been asked about preferences, for example, in relation to where they wished to end their days and how they wished to be buried, including the church and music they would like played at their funeral. People with capacity had also been asked about resuscitation should they become too ill to consent to this. A friend of a person who lived at the home told us that they had been asked to support decision making regarding end of life care. We saw that five staff members had received training in dying, death and bereavement during 2015.

Good

Is the service responsive?

Our findings

One person who lived at the home told us, “I’m quite happy and most people are happy and I haven’t heard anyone complain. I’m very lucky here. I’ve settled in quickly.” A family member said, “I’m very pleased with the home, he’s extremely well looked after. He says he’s brilliantly looked after.”

Care plans were up to date and person centred, and contained guidance for staff in relation to meeting people’s identified needs. Care documents included information about people’s life histories, interests and hobbies and important relationships. Care plans included guidance to meet people’s particular medical needs, for example in relation to diabetes and mental health issues.

Records showed people’s care plans were reviewed at least six monthly, and more frequently if people's needs changed, for example if they lost weight or when their behaviour challenged the service. We could see that reviews of care plans and assessments reflected changes in people’s needs and living situations. For example, one person’s assessment showed that they had developed a friendship with another resident since the previous review six months before. We saw evidence that placement reviews also took place regularly with the involvement of social care professionals.

People were supported by staff including the activity co-ordinator to take part in activities, including a wide range of group activities, along with individual activities such as board games, walks and shopping trips. We saw an activity programme on the home’s notice board that showed that activities were planned throughout the week. During our inspection we observed three activities that were taking place: a seated exercise session, a fun quiz, and a musical session with a visiting singer. These were well attended, with good participation by people. The activities co-ordinator for the home told us, “I try to have something for everyone. The staff are very good at helping and the manager comes up with ideas.” We saw that the home had arranged outings and holidays for people, and we were shown photographs of these activities. A poster displayed at the home showed that an outing had been arranged to visit central London to see the Christmas lights.

Residents meetings took place every three months. We saw that topics discussed at the most recent meeting included menus, ideas for activities, outings and holidays, and what people wanted in their rooms. Most people that we spoke with and their family members and friends told us that information provided by the home was very good. Comments included, “communication is very good,” and they let me know what is going on.” However, one family member told us, “I’ve asked the manager to keep us informed about outings and trips and they’ve never done that.”

The service had a complaints procedure that was available in an easy to read format. Family members and friends that we spoke with confirmed that they were aware of the procedure and knew how they should make a complaint if necessary. One friend of a person who lived at the home told us, “when I made a complaint, it was dealt with within seconds.” We looked at the home’s complaint’s register and saw that complaints had been dealt with appropriately.

Good

Is the service well-led?

Our findings

People who lived at the home and their family members and friends told us that they were happy with the management of the home. One family member said, “The manager is easy to talk with. If I raise anything he deals with it. He’s very good.” A person who lived at the home told us, “I like him.”

The registered manager for the home was supported by a deputy manager. There was always a senior care worker on duty. We saw that the manager and deputy manager spent time in the communal areas, speaking with people and assisting with care activities where required. We observed that they communicated positively with both people who used the service, their visitors and the members of staff who were on shift. Staff members spoke positively about the management of the service. One staff member told us, “I feel very well supported.”

We reviewed the policies and procedures.in place at the home. These were up to date and reflected good practice guidance.

There were systems in place to monitor the quality of the service and we saw recorded evidence of these. A health and safety assessment had been completed and there was evidence that actions in relation to these had been put in place. Monthly audits were undertaken in respect of maintenance, accidents and incidents, complaints, people’s monies and medicines. The quality of care plans and care records was audited on a six monthly basis. The records of these contained action plans where required and recorded information about how actions had been addressed. A local authority had undertaken a quality assurance visit in October 2015. This had raised a number of concerns, and we were able to see that actions had already been taken to address most of these. The registered manager told that they planned to complete the outstanding actions within a few weeks. This demonstrated that the provider was active in ensuring that the quality of the service was improved. However, we spoke with registered manager about the importance of being proactive in ensuring that service failures, particularly in relation to the home’s environment, were addressed immediately. He told us that he had learnt a great deal from the quality monitoring process, and that he would take immediate action in the future.

Satisfaction surveys took place annually. A survey had taken place during October 2015. Feedback about care provided by the home was good, but some respondents had raised concerns about the quality of decoration and furnishings. We could see that actions had already been taken to address these concerns.

Daily ‘handover’ meetings took place at the beginning and end of each staff shift. These were designed to ensure that information was passed on to the incoming staff, and that discussions about how to address any concerns about people’s needs took place. The home’s communication book and diary showed that important information was recorded. Staff members were required to read these at the start of each working shift.

Records showed the home worked well with partners such as health and social care professionals to provide people with the service they required. Information regarding appointments, meeting and visits with such professionals was recorded in people’s care files.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not taken action to fully assess and control the risk of spread of infection.** Regulation 12(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff members were not always receiving regular periodic supervision to make sure that their competency is maintained.** Regulation 18(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Staff recruitment records did not always include evidence that appropriate checks had taken place.** Regulation 19(1(a)(2)