Care Quality Commission

Eastern Healthcare Ltd

Brundall Care Home

Inspection report

4 Blofield Road
Brundall
Norwich
Norfolk
NR13 5NN
Tel: 01603 714703

Date of inspection visit: 5 January 2016
Date of publication: 14/03/2016

Ratings

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

Overall summary

This inspection took place on 5 January 2016 and was unannounced. It was carried out to establish whether improvements had been made since our last inspection.

Brundall Care Home provides accommodation and support to a maximum of 40 people, some of whom also require nursing care. At the time of our inspection there were 27 people living in the home.

The manager had been in post since July 2015 but had not yet submitted an application to become registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with CQC 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 and associated Regulations about how the service is run.

When we inspected this service on 9 and 13 July 2105, we found that it was not meeting several requirements of the Health and Social 2008 (Regulated Activities) Regulations 2014. The provider was in breach of the regulations for

Summary of findings

person-centred care, dignity and respect, the need for consent, safe care and treatment, meeting nutritional and hydration needs, premises and equipment, good governance, staffing and safeguarding service users from abuse and improper treatment.

As a result of our inspection in July 2015, the service had been placed in special measures. The provider sent us an action plan in October 2015, which told us what changes and improvements were being made or were planned. The provider had also enlisted the services of a consultant, to help make the necessary improvements to the service.

This inspection in January 2016 found that some improvements had been made in respect of access to healthcare professionals and the cleanliness of the environment. However, we found that the provider was still in breach of the regulations for staffing, person-centred care, dignity and respect, the need for consent, safe care and treatment, meeting nutritional and hydration needs and good governance.

Not all staff could demonstrate their understanding of keeping people safe and some staff needed to complete their training in safeguarding. Risks to people were still not always being assessed and actions did not always protect people or promote their freedom.

Although the physical numbers of staff on shift had increased per ratio of people using the service, there were still not consistently enough staff supporting people that had been appropriately trained or were sufficiently experienced and competent. Despite the use of agency staff to boost staffing levels, some permanent staff had not completed their inductions or training and some had a poor command of English and were unable to hold discussions with us regarding their roles.

Although there had been an increase in the training opportunities provided for staff, some staff still did not demonstrate that the training had been effective. There was a lack of understanding of some basic principles and some staff lacked awareness and understanding of people living with dementia. Most staff had received formal supervision sessions and competency assessments had been completed for all nurses.

Appropriate recruitment procedures were being followed to make sure that new staff were safe to work with people who lived in the home.

Procedures for the safe management and administration of medicines were not being followed and there were a number of gaps in people's medicine administration records.

The environment was clean and hygienic and had greatly improved since our last inspection. The service also had its own dedicated housekeeping and domestic team.

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 the 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 service did not ensure that consent to care and treatment was always sought in line with legislation and guidance and it was not always following the principles of the MCA when making decisions on behalf of people lacking capacity.

Due to a lack of guidance for staff and inadequate record keeping, we were not confident that people were consistently supported to eat and drink sufficient amounts for their individual needs. However, improvements had been made for people to make choices at mealtimes and staff helped people to choose what they would like to eat.

Appropriate referrals to healthcare professionals were being made in a more timely way. Input, advice and guidance was also sought from relevant professionals on a more regular basis and acted upon.

People were receiving their care in a more respectful and dignified manner, due to the increase in staffing levels. However, staff still did not always respect people's privacy and dignity. People's choices were not always given consideration and people weren't consistently encouraged to enhance or maintain their independence.

Decisions were being made on a group basis for people on a number of occasions and staff still lacked specific guidance for providing person centred care and recognising people as individuals. Meaningful activities

Summary of findings

and positive interactions were limited but the new Activities Coordinator was currently developing their role and an activities programme had been compiled for January 2016.

People were able to voice their concerns or make a complaint if needed. Formal complaints were being recorded appropriately, with information to show what action had been taken. However, we noted that some informal complaints had not been recorded.

A number of audits had been completed since our last inspection and director's audits had been carried out on a regular basis. However, not all of these audits were proving to be effective, as gaps in records, errors or omissions had not been picked up.

Communication had improved throughout the service. The manager was 'hands on' and approachable and operated an open door policy. Staff meetings and 'Resident and Relatives' meetings were being held more often.

The overall rating for this service is 'Inadequate' and the service remains in special measures.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

CQC is now considering the appropriate regulatory response to resolve the problems we found.

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?

Inadequate

The service was not safe.

Not all staff could demonstrate their understanding of keeping people safe and some people's movements were inappropriately restricted. Risks to people were still not always being assessed and actions did not always protect people.

Although the physical numbers of staff on shift had increased per ratio of people using the service, there were still not consistently enough staff supporting people that had been appropriately trained or were sufficiently experienced and competent.

Medicines were not always safely and appropriately administered to people.

The service was clean and hygienic.

Is the service effective?

Inadequate

The service was not effective.

Some staff members did not demonstrate that training received had been effective enough training to do the job required.

The manager had not acted on the recent updated guidance of the Deprivation of Liberty Safeguards and mental capacity assessments or best interests decisions had not been completed for people who could not make decisions for themselves.

There were gaps in some people's food and fluid charts and little guidance for staff to ensure people were provided with sufficient amounts to eat and drink.

Appropriate referrals were made to relevant healthcare professionals when any needs or concerns were identified.

Is the service caring?

Requires improvement

The service was not consistently caring.

Some staff demonstrated a lack of understanding about the need to engage with people in an appropriate way and staff did not always treat people with dignity and respect. Some people's right to privacy was not always upheld.

People could have visitors at any time and people's friends and family were welcomed into the home.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Not all care delivered was person centred and specific information about people's needs was not easy to locate quickly.

Summary of findings

People were not consistently supported to undertake meaningful activities or engage in social interaction.

People were able to voice their concerns or make a complaint if needed, although informal concerns were not recorded well, or in a way that ensured appropriate actions were taken.

Assessments were completed prior to admission and people and their relatives were involved in planning and reviewing their care needs.

Is the service well-led?

Inadequate

The service was not well led.

Audits to monitor the quality of the service provided were completed but not always effective. Some areas that required improvement had not been identified and appropriate action was not always taken to address issues.

Some of the previously required remedial action had been completed but a number of areas still needed improvement.

Communication had improved within the service. Staff meetings and 'Resident and Relatives' meetings were being held more often.

Brundall Care 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 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 carried out by four inspectors on 5 January 2016 and was unannounced.

Before our inspection we looked at information we held about the service including statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also reviewed the provider's action plan that had been sent to us in October 2015 and obtained feedback from the local authority's Quality Assurance team and a safeguarding manager from the local Clinical Commissioning Group.

During this inspection we met with most of the 27 people living in the home. However, many of these people were living with dementia and were not able to tell us in detail about their care. 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 spoke with six relatives, a volunteer and two visiting healthcare professionals. In addition, we spoke with the two directors of the company, the manager, the deputy manager and an external consultant. We also spoke with the nurse on duty and 10 members of staff, including care staff, seniors, agency staff, kitchen and domestic staff.

We looked at care records for eight people and a selection of medical and health related records.

We also looked at the records for four members of staff in respect of training, supervision, appraisals and recruitment and a selection of records that related to the management and day to day running of the service.

Inadequate

Is the service safe?

Our findings

Our previous inspection of July 2015 identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to safeguarding people from abuse. We identified concerns that people were not protected against the risks associated with a lack of understanding of all types of abuse.

During this January 2016 inspection we found that there was a continued breach of this regulation.

Four members of staff we spoke with told us they had not yet completed their safeguarding training, two of whom were new but two had worked in the home for nearly a year. None of these four staff could describe more than one type of abuse without further prompting, although the two longer serving members of staff said they knew some signs to look out for.

One member of staff did not appear to understand the inspector's questions about safeguarding due to their limited command of English. Our overall questioning needed to be shortened as a result of this and we were concerned with regard to how they would report any poor care or abuse if needed.

We saw that one person was sitting on a pressure mat in the lounge, which their relative and a member of staff told us was because they were at risk of falling. When this person stood up from their chair, an alarm sounded. During a 30 minute period, we observed this person attempt to get up from their chair four times and on each occasion they were requested to sit back down and physically guided back into their chair. During the afternoon, we observed the same person walking around the service, with close staff supervision. This meant that the person's movements were being unnecessarily restricted by not being able to get up and walk around as they wished.

Although a falls risk assessment for this person stated they were at a high risk of falls, records showed that their last fall had occurred five months before, in August 2015. There were no records to show that advice had been sought from other professionals about how to appropriately manage this person's risk of falls and there was no Deprivation of Liberty Safeguards authorisation in place for this restriction or close supervision.

We saw another person sitting in the lounge with their walking stick beside their chair. On two occasions we observed this person getting up from their chair and starting to walk away. We saw that their care records stated that staff needed to ensure that this person had their stick when walking. However, on both occasions, we saw that staff guided the person back to their chair, asking them to sit down again. They did not offer the person their stick to enable their freedom of movement, which meant that their movements were also being unnecessarily restricted.

This meant the service could not demonstrate whether the action they were taking was an appropriate or safe response to the level of risk identified or whether people's freedom to move around when they wanted was being appropriately restricted.

These concerns constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Additional safeguarding training was being provided for staff, although some staff had since left the service, and we saw that any safeguarding concerns were being reported more appropriately. One agency member of staff told us that they had received training on safeguarding and knew how to report any safeguarding concerns they might have. They told us that they had also been provided with information about safeguarding people and could refer to it if needed.

Our previous inspection of July 2015 identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to safe care and treatment. We identified concerns that the service was not identifying, assessing and reducing risks to people. We also found concerns in relation to the management of medicines.

During this January 2016 inspection we found that there was a continued breach of this regulation.

We observed some moving and handling practices which were unsafe. For example, two members of staff were seen to reposition a person in their chair by handling the person in a way that had the potential to cause themselves and the person an injury, such as one hand under each arm and under the person's thigh. We also saw occasions when care

staff pulled people up into a standing position from their chairs by their hands. Senior staff and nurses were present on some occasions but did not intervene to mitigate the risk.

A new member of staff had not yet completed any training or their formal induction. However, we observed this person using moving and handling equipment on three occasions during this inspection. This meant that people being supported and the staff member could be at risk of injury, if the equipment was not used properly.

We met with one person who stayed in their room to eat. The member of staff who was assisting this person did not demonstrate clear understanding or good practice with regard to supporting someone safely with eating. This was because the person was not appropriately positioned for eating, as they had not had their upper body raised enough and they were partially on their side. This incorrect positioning put them at risk of choking or aspiration.

Risks to people were still not always being assessed and actions did not always protect people. For example, we observed potential risks to people's health, safety and welfare when we walked around the premises, as we saw several items in people's rooms that were easily accessible, such as denture cleaning tablets and medical creams. These could have posed a hazard if accidently ingested or used incorrectly, which was a particular risk to those people living with cognitive impairments.

We observed the nurse on duty administering people's morning medicines. We saw that the Medicines Administration Record (MAR) was dotted as the medicine was popped from a blister pack into a medicine pot and given to the correct person. The nurse told us that signatures were not placed on the chart until the medicine had been seen to be swallowed. During our observations we saw the nurse handle medicines directly on two occasions, once when a tablet started to roll off the table and once when placing tablets into a crushing device. This was unhygienic and did not follow the good practice guidelines for administering people's medicines.

The trolley was kept locked between each administration but, with the use of two trolleys, we saw that the process took a long time. The nurse told us that they had started the round a bit late that morning at 8.15am. We saw that the last person's medicine to be administered was a controlled pain relief, which was given at 11am. We noted that the previous dose had been given at 8pm the night before, which meant there had been a gap of 15 hours instead of the required 12 hours. This meant that the effectiveness of the person's medicine would have been reduced and their comfort and wellbeing compromised.

The nurse told us that three people were given their medicines crushed or with food. We observed two people who received their medicines mixed with food. One person understood this and they were happy to take them this way. However, two other people had been assessed as lacking the mental capacity to make decisions about taking their medicines in this way. There were no records showing that best interests decisions had been made by staff on these people's behalf, nor was there written guidance for staff to refer to about administering medicines in this way. Staff had also not consulted with a pharmacist to ensure people's medicines could be administered in food or were safe to be crushed.

We looked at a four week cycle of MAR charts and noted dots or gaps with no signatures on a number of these. For example, one person's lactulose and paracetamol suspension was sometimes recorded with an N or sometimes a gap. Another person's records showed N or ticks on some days in November 2015 but there were gaps on 12 and 17 November. A third person also had dots only for one of their medicines on 12 and 30 November. On some occasions the reason a person had not taken their medicine was recorded on the back of the MAR chart but this was not always the case. This meant the service could not demonstrate that people's medicines had been administered as the prescriber had intended.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Controlled medicines were administered by two staff and counted and signed for appropriately. We saw that the balance in the controlled medicines register corresponded with the amount of medicines counted.

Our previous inspection of July 2015 identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to staffing. We identified concerns that people were not protected against the risks associated with the inadequate number of staff available to meet their care needs and to keep them safe.

Inadequate

Is the service safe?

During this January 2016 inspection we found that there was a continued breach of this regulation.

Although the physical numbers of staff on shift had increased per ratio of people using the service, there were still not consistently enough staff supporting people that had been appropriately trained or were sufficiently experienced and competent. Despite the use of agency staff to boost staffing levels, some permanent staff had not completed their inductions or training and some had a poor command of English and were unable to hold discussions with us regarding their roles. Some staff were moving and handling people without having completed their training. Some senior staff and management were not aware of some of the risk issues we identified and where kitchen or domestic staff were supporting people in areas such as eating, it was evident that they had not been trained or given guidance on how to do this safely.

One relative told us that when they visited they felt there were sufficient staff on duty to meet their relative's needs. They said that some staff had left and those recruited since provided good care for their relative. Other relatives we spoke with and some staff told us that generally the numbers of staff wasn't an issue now but that they were often disorganised.

We noted at various times of the day that staff were always available in communal areas and responded to people when needed. When call bells sounded they were answered promptly. At lunch time there were several staff in the dining area and they were supporting and prompting people with their meals appropriately. However, staff were very task focussed and there was little meaningful interaction with people. Most people living in the home were seated in the lounge and on one occasion we counted nine different members of staff in this room at the same time. However, many of the staff stood waiting for something to happen before they responded or engaged with people.

These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although a number of new staff had been employed since our last inspection, there had also been seven members leave the service in September 2015 alone. This meant that the service continued to be very reliant upon agency staff. The manager told us that they tried to use the same staff from one particular agency as much as possible, to ensure consistency and continuity for people living in the home. One member of staff spoken with also told us that the same agency staff were usually used, who were mostly efficient and hard working. The provider and manager confirmed that the recruitment of additional care staff was on-going.

We noted that the service now had its own dedicated housekeeping and domestic team, which meant that care staff had more time to support people, as they no longer needed to undertake cleaning duties during their care shifts.

A healthcare professional we spoke with told us that staff had not always been available in the past but that more recently there appeared to be plenty around.

The recruitment files we looked at were in good order. We saw that appropriate recruitment procedures were followed to make sure that new staff were safe to work with people who lived in the home. All staff were checked for suitability with the Disclosure and Barring Service (DBS) and appropriate references were obtained before they started working in the home. Each person's file also contained photographic identification and a complete employment history. A new member of staff described the recruitment process to us, confirming that they had provided two references and did not start work until their DBS was through.

Our previous inspection of July 2015 identified a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to premises and equipment. We identified concerns that people were not protected against the risks associated with unclean premises.

During this January 2016 inspection we found that improvements had been made and the provider was no longer in breach of this regulation.

We saw that the environment had greatly improved since our last inspection. The décor was brighter and some flooring and windows had been replaced. People's bedrooms were clean and tidy and fresh linen was on all the beds we saw. The home appeared cleaner throughout and was free from offensive odours.

Inadequate

Is the service safe?

The new team of domestic and housekeeping staff had very clear guidelines for their daily cleaning routines. There were specific instructions to ensure the thorough cleaning of all areas of the home, including people's bedrooms.

Full audits were being completed on a monthly basis for cleaning. Checklists were also seen to be completed for people's rooms, with some cleaning tasks being signed for on a daily basis as required and others either weekly or monthly, as needed.

Inadequate

Is the service effective?

Our findings

Our previous inspection of July 2015 identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to staffing. We identified concerns that people were not protected against the risks associated with the inadequate provision of training and supervision for staff members to ensure their health and care needs were properly met.

During this January 2016 inspection we found that there was a continued breach of this regulation.

We saw that most staff had received formal supervision sessions since our last inspection and there had been an increase in the training opportunities provided for staff. Competency checks had also been completed for all the nurses. However, staff were very task focussed and there was little meaningful interaction with people. Some staff did not demonstrate that the training received had been effective and some staff clearly lacked awareness and understanding of people living with dementia. This was evidenced by their actions and lack of understanding of some basic principles required for meeting people's specific needs.

One member of staff we spoke with told us they had one-to-one supervisions every three months and that they had completed mandatory training such as the Mental Capacity Act, infection control, challenging behaviour and moving and handling. However, they told us they had not completed safeguarding or dementia awareness training whilst in their role, which meant they would not have up to date knowledge to ensure they supported people effectively.

We looked at the provider's training record and noted that training had been delivered in August 2015 for safeguarding, moving and handling, Mental Capacity Act and associated Deprivation of Liberty Safeguards, food hygiene and fire safety. However, two members of staff who had worked in the home for nearly a year told us they had not yet received this training.

No staff were recorded on the training record as having received any training in respect of dementia awareness. However, the director's audit stated that face to face training had been delivered in October and November 2015 and included dementia awareness, diabetes, first aid, food hygiene and falls prevention. In addition, ongoing online courses were being completed by staff in respect of safeguarding, the Mental Capacity Act, behaviours that may challenge and the role of the care worker.

A new member of care staff we spoke with had not yet received a formal supervision session, although the manager told us that this was booked upon completion of their induction. This member of staff had also not yet received any specific training, although they told us they had been given some E-Learning to get started with.

One member of staff confirmed that they had attended the recent medicines training. However, they were unable to tell the inspector about any other training they had received or how they had changed any practice through training received, due to their limited command of English.

Throughout the day of our inspection it was apparent that some staff were not able to communicate well with the people they were supporting, due to English not being their first language. Three staff members we spoke with had a limited command of English and one person could not understand what we asked them. This meant we could not be assured that these members of staff would fully understand people's specific care needs or be able to communicate any concerns or issues effectively.

We read in the minutes from the staff meeting in October 2015 that some staff were not following specific instructions and the manager explained how they had needed to carry out disciplinary action to try and address these issues, which were having a detrimental effect on the service.

These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Qualified nurses demonstrated a better understanding of managing diabetes with people and this area had been covered during the nurses' competency assessments. We noted that nurses who had not been deemed competent as a result of their assessments no longer worked at the service. This meant that people were being supported more effectively by nurses who were appropriately trained and qualified, particularly in respect of diabetes management.

Our previous inspection of July 2015 identified a breach of Regulation 11 of the Health and Social Care Act 2008

Is the service effective?

(Regulated Activities) Regulations 2014. This regulation relates to the need for consent to care and treatment. We identified concerns that people were not protected against the risks associated with a lack of consent, application of the Mental Capacity Act 2005 and associated code of practice.

During this January 2016 inspection we found that there was a continued breach of this regulation.

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 the 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. We checked whether the service was working within the principles of the MCA.

The service did not ensure that consent to care and treatment was always sought in line with legislation and guidance and it was not always following the principles of the MCA when making decisions on behalf of people lacking capacity.

We saw consent forms in people's file which had been signed by staff or relatives. However, not all of the people had the legal authority to consent to care and treatment on behalf of those people. The management team had not carried out checks to assure themselves that relatives had Lasting Power of Attorney (LPA) for health and welfare or had been granted authority by the Court of Protection. This meant the service was not acting in accordance with the law by ensuring that decisions made for people who lacked capacity were being made by those with legal authority to do so.

We saw that two people were given their medicines hidden in food (covertly). The nurse administering the medicines confirmed that these people did not have capacity to consent to their medicines being given in this way. A capacity assessment had been carried out for both people. The assessment determined that they lacked the capacity to consent to their medicines being administered by staff. However, there was no best interests decision relating to giving medicines hidden in food.

In one person's records we saw that their family had been concerned on arrival at the home on one occasion, to find that their relative had been moved to another room. There was no assessment of the person's capacity to make this decision and no best interests decision was recorded. The relatives had also not been consulted prior to the move.

We asked the manager if there was anyone living in the home who was subject to a Deprivation of Liberty Safeguard (DoLS) authorisation. The manager told us that applications had been made for most people due to them needing care and the front door being locked. We looked at the applications present in some files and found that the reasons for the applications were very general and mostly based on people's basic care needs. No specific restrictions were highlighted and there were no mental capacity assessments or best interests assessments in place. Therefore, the service had not followed the principles of the MCA prior to judging whether the person was being deprived of their liberty or not.

Restrictive practices were observed, such as people getting up from their chairs in the lounge and being directed back and asked to sit down. In some cases, staff, albeit gently, physically made people sit back down again. For one person, there was no mention of this on the DoLS application in their care file. We saw an application for another person who had capacity to consent to their care. This was inappropriate because the MCA is in place to protect the rights of people who lack capacity to consent to their care.

We concluded that the service did not understand how to protect the rights of people lacking capacity to make decisions for themselves.

These concerns constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection of July 2015 identified a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to meeting people's nutritional and hydration needs. We identified concerns that people were not protected against the risks associated with inadequate support to prevent malnutrition and dehydration.

During this January 2016 inspection we found that there was a continued breach of this regulation.

Inadequate

Is the service effective?

Our observations, gaps in records and a lack of guidance for staff regarding people's food and fluid intake, did not assure us that people were consistently supported to eat and drink sufficient amounts for their individual needs.

Information regarding people's support needs in respect of nutrition and hydration was not consistent. One person's records that were stored in one area of the home stated that they had a normal diet, could refuse food and that snacks should be offered. In another record it stated that the same person had a poor appetite, required supplements and fortified foods. In this person's care plan for nutrition it stated that the person needed adequate nutrition and hydration but did not state how their needs should be met. There was no clear guidance for staff about how the risk of poor nutrition for this person should be minimised and food and fluid charts were not being maintained, even though a risk to the person's health had been identified.

One person had two beakers on a table near them in the lounge. One contained cold tea and the other contained juice. During a 10 minute period, three different members of staff offered this person their tea to drink. The person declined on each occasion. The third member of staff heard the person say, "I don't like it" and offered the juice instead, which the person took quite a few sips of. Because staff did not give consideration to whether people had access to drinks they enjoyed this meant that people may refuse or be reluctant to drink sufficient amounts to maintain their health.

One person who was deemed to have capacity was on a soft diet. A director's audit stated that this person had told them they were 'fed up with mushy food and wanted normal food instead'. The director's response was that this wasn't possible, as they were on a soft diet. The deputy manager told us that they knew the person from another home 15 years before and that the person ate too quickly. They told us that this was the reason why a soft diet had been decided as the best option. However, there was no input from the dietician or speech and language team to support this decision, which meant there was no assurance that the person was receiving food that was appropriate for their needs.

When we asked about nutrition and hydration, a member of staff said, "I always write it down when someone's had anything." However, this person was not able to explain further when we asked about not recording when people had sips of drinks, or refused drinks, as we had observed in the lounge. They said, "You just have to try and get them to drink when you get the chance." Another member of staff told us that they always wrote fluid and food consumed in people's charts, as they had been told to do. This meant that accurate monitoring of people's fluid intake was inconsistent.

We saw that improvements had been made for people to make choices at mealtimes and staff told us they helped people to choose what they would like to eat by showing them pictures of the food. However, this was still not always the most appropriate method of communication for all of the people living in the home. Some people we observed did not appear to fully understand what they were being shown in the context of the meals they were being offered.

People were offered a choice of drinks with their lunchtime meal and although some staff showed people the drinks on offer to help them make a meaningful choice, others did not. For example, on one occasion we observed a member of staff asking a person whether they would like orange or blackcurrant to drink. This question was repeated more than once by the member of staff, because the person didn't understand what they were being asked. There was no visual aid to help the person make an informed choice and a decision was eventually made by the person's relative on their behalf.

We were told that approximately 17 people of the 27 living in the home were given soft or pureed meals and that everyone was on a fortified diet. However, not everyone had clear guidance as to the reasons for this. Some people did have guidance from the speech and language team but some did not. A member of staff told us that they knew one person from when they had lived in another home and that the person had always eaten their food too quickly, putting them at risk of choking. As a result, it was decided that pureed food was the safest option. There was no supporting information or guidance in this person's care plan from the dietician or the speech and language team, which meant that the person's choices were not considered and the action taken may not be the most appropriate for their needs.

These concerns constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

During our observations of people's mealtime experience one person's relative told us that the food was good and that their family member enjoyed their meals. However, although they visited regularly and supported their family member at mealtimes, they said they did not know what was on the menu for that day. This was due to a lack of information about the meals on offer and there was no menu on display. When we asked a member of staff what was on offer for lunch that day, they were also unable to tell us. Another member of staff told us that people got a good choice at lunch time, with more than one option.

When lunch was served, we saw that there were two main options and a selection of vegetables. The meals were well presented and colourful and comments from those eating it were positive. Different food was pureed separately and also presented as well as possible.

Some people required assistance with their meals and we saw staff sitting with people and supporting them in a discrete manner, giving them time to eat at their own pace. There was also better interaction between staff and people using the service than we had noted earlier in the lounge.

The cook told us that they worked on the menus to help ensure people had a balanced diet throughout the week. When people moved to the home the cook was told what they liked to eat, any allergies and special diets. The cook told us they had a 'best practice' book where all this information was stored, as well as writing it on a 'wipe board' for quick reference.

The cook also told us that a new monitoring system had been introduced, whereby only senior staff cleared the tables after mealtimes, so that what and how much people had eaten could be recorded. However, we noted that other meals, such as snacks, offered at other times of the day weren't always being recorded. It was also explained that a checklist was placed by the serving trolley each day, to ensure all meals were served and ensure no one was missed.

Our previous inspection of July 2015 identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to safe care and treatment. We identified concerns that people were not protected against the risks associated with the lack of access to advice or treatment from health care professionals.

During this January 2016 inspection we found that improvements had been made and the provider was no longer in breach of this regulation.

We received good feedback from visiting healthcare professionals during this inspection and saw improved evidence of appropriate referrals being made in a more timely way. We also saw that input, advice and guidance was being sought from relevant professionals on a more regular basis and acted upon, particularly by nurses and senior staff.

Following a stay in hospital, one person's care records showed that staff had contacted the dietician on their return home, due to their weight loss upon discharge. The recordings of weight showed a slight improvement and an improvement in food intake. We noted that the dietician was due to revisit again in February 2016 to check the person had continued to improve.

One healthcare professional told us they had no concerns about the home. They said that they had visited a number of times during 2015 and that it had been a difficult year, with some very unwell people being admitted and a number of deaths. This person also told us that the staff were very supportive whenever they visited and were always able to answer any questions fully.

Another professional had also frequently visited the home, to review people and carry out a recent safeguarding investigation. This person made comments such as, "Staff have been absolutely great. There have been no problems." And, "I am given lots of relevant information and full feedback. Notes tally with the information given."

This professional also told us about a person who had some behaviours that were hard for staff to manage. We were told how this person had improved greatly and that, although the behaviour issues were still difficult for staff, they were managing them very well.

Requires improvement

Is the service caring?

Our findings

Our previous inspection of July 2015 identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified concerns that people were not protected against the risks associated with a lack of respect in relation to inadequate care.

During this January 2016 inspection we found that since staffing levels had increased, people were receiving their care in a more respectful and dignified manner, because staff were not so rushed. However, there was a continued breach of this regulation, due to staff not always respecting people's privacy and dignity in general.

For example, on passing some people's rooms, we observed that their doors had been left open, with the person only partially clothed. In one person's room we saw a sign on the wall, setting out some personal information about them. Although the information provided staff with quick guidance about the person and their needs, it was visible from the doorway and did not respect or promote the person's dignity or right to privacy.

Just before the lunchtime meal was served, the nurse came into the dining room and took a blood sample from a person, whilst they were seated at the table with other people. This was not respectful of the individual or the other people present.

Whilst we were in the lounge, we saw that one person was given Holy Communion and a prayer recited with them. Staff did not offer them the opportunity to go somewhere private and other people's choices were also not given consideration.

We observed some occasions where there was little or no physical or verbal prompting for people, particularly when mobilising. We saw that staff provided assistance without encouraging the person to help themselves and enhance their independence, such as prompting them to lean forward more to make it easier to stand up.

People were not always able to make decisions about their own care as the service acted in a risk-averse manner. This meant that people were not able take risks if they chose to and as a result were not supported to maintain as much independence as possible. For example, one person was frequently discouraged from getting up from their chair to walk around and another person had expressed the wish to have solid food rather than the pureed food, which staff had decided was safer for them.

On the day of this inspection we saw that people were brought in to the dining room at approximately 12 noon. However, some people were seated at the tables for almost an hour, before the meal was served at 1pm. Although staff were present in the room, we observed very little interaction with people during this pre-dinner period. As a result, people became restless and one person was visibly distressed. They were crying and had their head on the table but staff did not attend to the person or comfort them.

These concerns constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new member of staff we spoke with told us that they always asked people if they wanted to have any aspect of personal care carried out before doing anything. They said that they also checked that the person was happy for that particular staff member to do it, in case they preferred someone different. This member of staff also explained how they protected people's privacy and dignity by making sure their bedroom door was closed and the curtains were drawn.

We observed some caring interactions between some staff and people living in the home, particularly when some ladies were having their nails done. Positive interactions were also noted during the lunch period, once the meal had been served. However, unless staff were prompted or responding to people's physical needs, there was very little general interaction

Personal histories had been completed for most of the people living in the home. Some of these were very detailed and descriptive, with a considerable amount of input from family members. However, these were not fully accessible for day to day use by care staff when supporting people or interacting with them, as they were stored in the nurses' office with people's main care plans. The care plans also contained a brief overview of people's needs but, again, this information was not easily accessible by care staff, as it was not copied over into people's smaller daily files that stayed with them throughout the day and night.

Requires improvement

Is the service caring?

Throughout the day of our inspection we saw visitors coming freely into the home and people told us there was no restriction on visiting times.

Information noted from relatives' meetings indicated that people and their relatives had been more actively involved in reviewing and planning their care provision. Family members spoken with also told us that they had been much more involved in their relative's care planning and reviews during the past few months.

Requires improvement

Is the service responsive?

Our findings

Our previous inspection of July 2015 identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to person centred care. We identified concerns that people were not protected against the risks associated with unsafe or inadequate care because of a lack of guidance about meeting people's needs.

During this January 2016 inspection we found that there was a continued breach of this regulation.

We noted on a number of occasions that some decisions were being made for people on a group basis, rather than individually and that staff still lacked specific guidance for providing person centred care.

For example, we found that a high number of people were on soft diets due to decisions made on their behalf by staff. We were told that everyone was on a fortified diet and we observed that everybody was given the same flavour mousse in the lounge. Staff could not explain why some of these decisions had been made and some people's care records contained no information to show that the decision making process had been centred on the person's individual needs.

Some people had recently moved bedrooms within the home, to accommodate the needs of the service by improving the logistics for staffing, since the number of people accommodated had reduced. Some communal areas had also been changed, such as one lounge and conservatory becoming a new main dining area. However, these actions had been taken without the full involvement of the people living in the home or due regard for their individual preferences or needs.

We saw in the records of one person living with dementia that a family member had visited and found that their relative was not in their room. They were told that their relative had been moved to another room and were unhappy about this, as they had not been consulted. We noted that this person had been moved without their personal items, which meant they lacked familiar items or surroundings. This person's care plans had not been updated to reflect the change and still stated that they were in the previous room. This could cause confusion for staff delivering care, particularly new and agency staff which the service was heavily reliant upon and put the person of risk of receiving support that was not personalised for their needs.

There were 'snapshots' at the front of people's care files and some were kept with daily notes in people's rooms. The snapshots contained some good information and provided staff with a pen picture of people's needs. However, there was a lack of consistency regarding where various records were kept and some were not always easily accessible to staff.

In one person's records it stated that they liked to watch TV. However, we observed the person to be sitting in an area of the lounge where they could not see the television. Their records also stated that they were visually impaired and that staff should stand in front and near to the person when talking with them so that the person could see who they were. When we observed three members of staff hoisting this person we noted that they did not take this into account.

We observed one person in the lounge at approximately 10.30am and noted that they were very 'sleepy'. We were told they had not yet had their breakfast and the nurse was unable to administer their medicines due to their sleepy state. We noted that the person also appeared to be chesty when breathing and pointed this out to the nurse, who said they would get the GP to check the person when they visited the home later that day. The nurse also commented that the person was usually more vocal and that it may be an indicator that they were unwell. We were not confident that this person's needs would have been responded to, if we had not prompted it.

One person's relative told us that there were often occasions when staff did not complete the cleaning procedure required for their family member's personal medical device. They told us this caused them great concern, as it left their family member prone to infections. The relative told us that they had raised this with the manager, who had said they would address the issue. When we looked at this person's records, we saw that a nurse was required to clean the device twice daily but there were a number of gaps. On some days there were no signatures at all and on most days there was only evidence of cleaning having been completed in the mornings, with some of these occasions having been completed by the person's relative only. During a discussion with the

Is the service responsive?

manager, they acknowledged that whilst the person's relative remained actively involved in their family member's care, the nurses should still be completing the cleaning at other times, as required. They reiterated to us that they would address this issue with the appropriate staff.

Although care records and risk assessments were in place and we saw that regular reviews and monthly evaluations had been recorded, most were very task orientated. Two members of staff told us that they did not really use the care plans and relied more on the handovers. One person told us, "Handovers are very thorough, the nurse on duty always hands over how people are and if there are any changes." This meant that although staff would be up to date with relevant health related and clinical information for people, they would not be knowledgeable about people's individual wants, needs or choices.

The activities co-ordinator told us that they supported people with various activities, depending on what they wanted to do. They said, "Some of the ladies, I clean and do their nails and have a chat, they love that and the company." They also told us that they were continuing to develop the activities role and had put together an activities programme.

However, although sufficient staff were available the support provided for social stimulation and occupation was limited. During one 30 minute observation during the morning we noted one staff member encouraging people to drink but besides this, there was no interaction with people in this lounge. One person was doing a word search and another person was looking at a photo album, however 10 people were doing nothing but occasionally watching as staff went by. Later in the morning we did observe some people having their nails painted and the activities person involved a number of people in a game of bingo. We also saw that senior staff and management were more pro-active with people and interacted naturally with them at every opportunity.

We looked at some people's life history books, which contained some good person centred information. However, we noted that this information had not been used in care planning or for providing more meaningful activities for people. Due to these documents being stored in the office with people's main care plans, it meant that they were not being used as a live document that could help stimulate the person they related to and help improve staff interactions.

These concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that, since the increase in staffing levels, people's individual needs were being met in respect of being supported to get up in the mornings and go to bed at times more of their choosing. People were not being rushed when having their personal care undertaken and staff responded to people in a more timely way, when supporting people with their continence.

One relative we spoke with said that they had been involved in planning their relatives care. They told us the service always involved them in decisions made and communicated well with them when there were changes to their relative's health.

We saw that a copy of the complaints procedure was available for people on the notice board and this was up to date. Staff told us that people's relatives would normally make a complaint on behalf of people if needed but that staff also supported people in this area when necessary.

We saw that formal complaints were being recorded appropriately, with information to show what action had been taken. However, we noted that some informal complaints had not been recorded. For example, a recent verbal complaint raised by a person's relative was noted in the person's care records but the information had not been logged in the complaints folder at all.

Most of the people we spoke with said that any concerns were listened to now and responded to appropriately by the new manager, although two relatives we spoke with told us they still weren't completely happy. We noted that for one person, there was a current issue that we saw was being dealt with by the manager but had not yet been resolved. The second person explained that their concerns were more of a confidence issue regarding the running of the home in general.

Inadequate

Is the service well-led?

Our findings

Our findings during this inspection on 5 January 2016 showed that the provider had failed to "…meet every regulation for each regulated activity they provide…" as required under the HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3). In addition, the provider had consistently failed to sustain improvements where non-compliance and breaches of regulations had been identified during our previous inspections in March and July 2015.

This was a breach of Regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection of July 2015 identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to good governance. We identified concerns that people were not protected against the risks associated with unsafe and inadequate monitoring and assessment of the quality of the service provided.

During this January 2016 inspection we found that there was a continued breach of this regulation.

A number of audits had been completed since our last inspection and we saw that the director's audits had been carried out on a regular basis. However, the systems for monitoring, assessing and improving the service being delivered were ineffective and appropriate measures were not being taken to consistently identify and mitigate risks for people living and working in the home.

For example, There were multiple gaps in the medication administration records and, in some cases there were only dots where the administering staff member's initials should be. Although medication audits had been carried out, these omissions had not been identified or acted upon.

Our observations regarding poor moving and handling practices and untrained staff using equipment were not identified or addressed by qualified or senior staff, when they were present.

One person had a care plan for 'sleeping', which stated they needed repositioning every four hours but there were no records to show that the person was being repositioned during the night.

Staff were required to complete records in people's daily care files, to show what support had been provided during the course of the day and night. Staff were not always completing this required information and the gaps and missing information in people's records had not been identified and acted upon, following the audits that had been carried out.

One person's personal hygiene chart had only been completed on four days out of seven and their continence chart indicated that their eliminations had been minimal over a period of 40 days. The fluid charts for one person stated that on one day the person had only drank 200mls and 1050mls on another day. No records had been completed to show what, if any, action had been taken. This meant that we could not be assured that people were receiving the care and support that they required or that appropriate action was taken because concerns were not being identified.

The deputy manager told us that they believed these to be recording issues, rather than people not being supported appropriately but the gaps and missing information in people's records had not been identified and acted upon, following the audits that had been carried out.

Changes to the service had recently been made, such as moving people to other rooms and changing the dining room and lounge arrangements. This, we were told by the manager, was to try and improve the overall environment by bringing people closer together, since the number of people accommodated in the home had reduced. However, people living in the home had not been fully consulted about these changes and it was unclear who had taken part in making these decisions, or whether the best interests process had been followed.

These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the manager had been in post since July 2015, they had not yet submitted an application to become registered with the Care Quality Commission. This meant that the provider was failing to comply with the conditions of their registration in respect of Brundall Care Home.

Inadequate

Is the service well-led?

We saw that the cleaning and housekeeping schedules and audits were in good order and our observations supported what we had seen written. The guidance and audits for the use and maintenance of portable oxygen was also very clear.

Quality assurance and satisfaction surveys had been sent out to people living in the home, their relatives and healthcare professionals in October 2015. We noted that people living in the home had been supported to complete their questionnaires by an independent volunteer who visited the home on a regular basis. Whilst we noted that most of the responses were generally positive, it was not clear what action was planned or had been taken to improve the quality of the service for people, where some negative responses had been received. The manager told us these were being addressed as part of the overall improvement programme.

We noted that there continued to be a high staff turn-over, which meant that consistently knowledgeable and experienced staff were limited, with the continued reliance on agency staff. We also identified from minutes of staff meetings and heads of department meetings that some staff had been resistant to change and had displayed some negative attitudes toward management and seniors. The manager and provider told us that in some cases disciplinary action had been required. In addition to this they explained how they were continuing to work with staff to improve this culture, such as having more experienced staff working closely with others on the floor to lead by example with good practice. We noted that there had recently been occasions where the manager and provider's operations manager had worked shifts alongside staff in order to try and raise standards.

Three staff told us that they felt happy to raise any concerns with the manager and one person told us, "She is wonderful, she is fair, but if you don't do your job properly she will keep checking on you until you get it right." One visiting relative said that the new manager was good and that they felt she was approachable and kept them well informed.

Good feedback was received from some relatives and the healthcare professionals we spoke with. Some people told us that they felt that improvements were evident but that there was still a lot of work to be done.

The cook told us that they had worked in the home for five years and had recently seen a lot of changes for the better. This person said they felt fully supported by the manager and the owners.

One person's relative told us that they had seen a great many changes since our inspection in July 2015 and they said that these changes had vastly improved the service provision. This person told us, "This manager has done more in the last six months than was ever done in the two years prior to her being in post. I love this place and would not move [Name]." They also said, "Just look at the place and notice the improvements. The manager has worked long hours to move this place on and it is working. I have no complaints what so ever." This person also told us that monthly meetings were held with relatives and people living in the home. They said that, prior to this manager, any concerns raised were not acted on but now action was taken straight away. They said, "This manager is working 80 hours a week to put things right and it is working."

Another person's relative told us that the manager had an open door policy and would act on any concern constructively and quickly. For example, a problem with the curtains in their family member's new bedroom needed replacing and this was done the next day. We were also told that at one time this relative would, "have to hunt for staff" to discuss their loved one, whereas staff were now readily on hand. They also said that the small file in the bedroom kept them up to date with day to day actions.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use services were not protected against the risks associated with unsafe or inadequate care because of lack of guidance and knowledge about meeting people's needs. Regulation 9 (1)(a)(b)(c)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People who use services were not protected against the risks associated with not being treated with dignity and respect or having their right to privacy upheld. Regulation 10 (1) (2)(a)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with unsafe and inadequate assessment of and action to reduce identified risks. People who use services were not protected against the risks associated with staff not being appropriately skilled in some areas of their work. People who use services were not protected against the risks associated with the lack of safe management and administration of medicines.

This section is primarily information for the provider

Enforcement actions

Regulation 12 (1) (2)(a)(b)(c)(g)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People who use services were not protected against the risks associated with a lack of consent, application of the Mental Capacity Act 2005 and associated code of practice. Regulation 11 (1)(2)(3)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People who use services were not protected against the risks associated with inadequate support to prevent malnutrition and dehydration. Regulation 14 (1)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services were not protected against the risks associated with ineffective monitoring and assessment of the quality of the service provided. People who use services were not protected against the risks associated with the lack of consistent and accurate record keeping.

This section is primarily information for the provider

Enforcement actions

Regulation 17 (1) (2)(a)(b)(c)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services were not protected against the risks associated with inadequate numbers of staff that are suitably qualified, competent, skilled and experienced. People who use services were not protected against the risks associated with the inadequate provision of training for staff members to ensure their health and care needs were properly met. Regulation 18 (1) (2)(a)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment. People who use services were not protected against the risks associated with a lack of staff's understanding of all types of abuse and inappropriate restrictions. Regulation 13 (2)(4)(b)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 8 HSCA (RA) Regulations 2014 General

This section is primarily information for the provider

Enforcement actions

People who use services were not protected against the risks associated with the provider's failure to "…meet every regulation for each regulated activity they provide…", as required under the HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3).

Regulation 8

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.