

Mr & Mrs M Jingree

The Old Rectory

Inspection report

195 Wigan Road
Standish
Wigan
WN6 0AE
Tel: 01257 421635
Website: www.example.com

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Ratings

Overall rating for this service

Requires Improvement



Is the service safe?

Requires Improvement



Is the service effective?

Inadequate



Is the service caring?

Good



Is the service responsive?

Requires Improvement



Is the service well-led?

Requires Improvement



Overall summary

We carried out this unannounced inspection on 08 January 2015.

The Old Rectory provides personal care and accommodation for up to ten people. The home was fully occupied at the time of our inspection. The home has eight single rooms on the first floor, of which three have ensuite facilities and one shared room on the ground floor. The first floor is accessible by a passenger lift. There is a garden area to the rear of the home and a small car park within the grounds.

The last inspection of The Old Rectory took place on the 14 March 2014. The provider was not meeting the required standard relating to records and this was judged as having a minor impact on people who used the service. At our inspection on 08 January 2015 we found this had improved.

The provider of the home is also the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

On 08 January 2015 we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we took at the back of the full version of this report.

We looked at three care records and found that these contained risk assessments, which identified how people were to be protected from the risk of harm. The care records we looked also showed that people's health was monitored and referrals had been made to healthcare professionals when required.

On the day of our inspection the providers were at the home. There were two care staff on duty. The care staffing levels would have been sufficient to care for people living at the home if they had been supported by ancillary staff. We observed that the care staff were expected to carry out domestic tasks which took precedence over spending time with people living at the home. We had been at the home for two hours before we saw any staff interaction with the four people in the lounge.

We looked at the staffing rotas. There was only one member of staff on waking night duty. Rotas indicated that there was sometimes a 'sleep in' member of staff who could be woken during the night if a person required assistance. On other shifts there was an 'on call' which meant staff had to telephone the named person to come to the home and assist them. This could result in people who used the service having to wait for the care and support required.

We observed that when the care staff spoke with people living at the home this was done in a kind and caring way.

We saw no meaningful activities were offered for people during the day. There was no evidence recorded in the care files on how people had spent their day.

On checking the food supplies we saw that there was no fresh produce within the home including fresh milk. The

home used powered milk. We saw that people were offered drinks during the day, however there were no snacks for example biscuits, cake or fruit available within the home should people require them.

We reviewed the training matrix for staff at the home. Staff had received induction training for the service on commencing work at the home. We noted that staff had not received training in the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), equality and diversity and not all staff had received current safeguarding of vulnerable adults training.

We looked at the staff files and saw that the service had suitable recruitment procedures in place. However staff had no written contracts which detailed their benefits and entitlements.

We spoke with one visitor who told us they were happy with the care their relative received. They had no cause for any worries or concerns.

One person who lived at the home told us they were well cared for by the staff.

We discussed the quality assurance systems with the manager. Whilst the service performed some audits we found no evidence that an audit resulted in an accompanying action plan. We reviewed documents which the provider used to monitor the quality of the service by seeking feedback from people who use the service, their families, staff and visitor to the service. We found that only two questionnaires had been obtained from people who used the service during 2014. All other questionnaires reviewed were relevant to 2013.

The manager told us there was a procedure to receive and respond to complaints. However we did not see a copy of the complaints procedure displayed within the home.

We saw that the home was cluttered for example hoists and wheelchairs were stored in the foyer. The dining room had a new commode stored in there and a container of detergent stored behind the couch. The manager was unaware the detergent was there and removed it immediately.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Staff spoken with knew about what constituted abuse and what action they would need to take to help maintain people's safety. This was mainly due to training being completed during previous employment within the care sector.

The medication administration systems currently used within the home did not ensure people received their medication in a safe manner nor protected the staff administering them.

Staff arrangements were not managed to ensure that people's needs and wishes were supported.

Requires Improvement



Is the service effective?

The service was not effective

Some staff training and development was overdue. Staff supervision records were not available for all staff.

There was evidence of gaps in staff training and development records. The training matrix was incomplete.

People were not able to make choices in relation to their food and drink for each meal. People did not have access to snacks during the day.

People's needs were assessed and referrals to outside professionals were made as required.

Inadequate



Is the service caring?

The service was caring

We observed that the care staff were kind and caring when providing assistance and support to people.

Care staff were respectful when speaking to people.

Care staff spoken with had a good understanding of people's likes and dislikes.

Good



Is the service responsive?

The service was not responsive.

There was a lack of individual and group activities provided that reflected preferences and interests.

Systems were not in place for people who use the service and their relatives to express their view, complaints and comments to improve the service.

Requires Improvement



Summary of findings

Is the service well-led?

The service was not well-led

The home had a registered manager in post.

Some audits had been carried out. However there were no issues from any audits that resulted in an accompanying action plan.

Staff members spoken with told us that their views, ideas and opinions were often disregarded by the management.

Staff told us they did not feel they were supported by the manager.

Requires Improvement



The Old Rectory

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 checked 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 took place on 08 January 2015 and was unannounced. This meant the service did not know we were visiting that day.

The inspection team consisted of two inspectors from the Care Quality Commission.

We looked at the information we held on this service and spoke with the commissioning team from Wigan local authority and used the information to help us plan the inspection.

We looked around the home and with people's consent spoke with them in their bedrooms and in the lounge. We spoke with six people who used the service and one relative.

As there were only two members of staff on duty, we contacted other members of the staff team by telephone following our inspection to give them the opportunity to tell us their views and opinions about the service.

We looked at three care records and the staff personnel files of all the people who worked at the home.

We looked at the maintenance and service records for the premises and equipment.

Is the service safe?

Our findings

Two people we spoke with told us they felt safe living at the home. One person said, “I am fine here. The girls are great, they look after me well”. One relative told us they had no concerns about the care their relative received.

During the inspection we looked around the home. We saw the home was clean and free from any malodours. We saw that bathrooms had been fitted with aids and adaptations to assist people when bathing and toileting. We saw that liquid soap and paper towels were available in the bathrooms and toilets. However, we did see that cloth hand towels were in the bathrooms and toilets and in the staff toilet. Cloth towels are acceptable in people’s own bedrooms, but to reduce the use of cross infection should not be left in communal areas.

The home was adequately maintained and we saw evidence recorded for the servicing and maintenance of equipment used within the home to ensure it was safe to use. We saw the service had a current fire risk assessment. In addition, gas and electrical certificates were valid, a legionella certificate was in place and the passenger lift had been serviced according to the manufacturer’s instructions.

We saw that people who wished to remain in their bedrooms had access to a call bell system and we observed staff responded swiftly when required.

We spoke with the staff on duty on the day of our inspection and contacted other staff members so that they could have the opportunity to voice their opinions. During our conversations with staff we asked them what systems were in place to help protect people from the risk of harm or abuse. Staff spoken with had a good understanding of what constituted abuse and what they would do if they had any concerns. Some staff confirmed that they had not received updated safeguarding training and their knowledge was due to working with other service providers at their previous places of employment. We discussed the overall training of staff with the manager who told us that staff were trained by the providers. However, through further discussion the providers told us they had not been trained to a higher level to cascade training to staff.

On the day of our visit the staff care team were relatively new to the service. One person had been at the home since September 2014 and the other person since December 2014. Both had previously worked in care settings and

knew what the job entailed. There was no consistency of care from the staff care team as the manager told us that no staff had worked at the home longer than 12 months. The staff turnover was high which and we were told by staff that three people had recently left.

We asked staff if they thought staffing levels were adequate to meet the assessed needs of people living at the home. Staff told us they would be suitable during the day if they were not expected to complete domestic tasks such as making beds, tidying bedrooms, laundry and preparation of the afternoon teas.

There was only one member of staff on waking night duty, this gave us cause for concern as we saw that some people required regular positional turning. We were told by staff for one person if they required the toilet during the night they would not be able to get to the bathroom without the assistance of two staff. This compromised this person’s dignity as people should be able to go the toilet when they want to and not have to wait for staff. Information in one care plan we looked at documented that the person required transferring by use of a hoist and this required two carers to action safely. We were told by the staff that if they needed support during the night they had to wake a member of staff from upstairs to assist them. Staff told us that sometimes there was no ‘sleep in’ staff available and they had to contact the provider at their own home to come and assist them. The staff rotas provided by the management indicate clearly that they are ‘on call’. This meant that anyone requiring assistance would have to wait for one of the managers to be contacted and have to wait until help arrived. We found there was a breach in Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported by sufficient numbers of staff at all times.

We reviewed all the personnel files held at the service. We found that systems were used to make sure that people were only employed if they were suitable and safe to work in a care environment. We looked at the records around staff recruitment. We saw that all the checks and information required had been obtained. However we saw no evidence of interview questions and responses recorded when interviewing prospective employees.

Is the service safe?

We asked the member of staff responsible for the administration of medication to describe what arrangements were in place for the safe administration of medicines. We accompanied the member of staff to the room where the medications were stored. Medicines were stored in a locked drugs trolley. The member of staff began to take the medicines out of the packs and place them in a medicine pot. We heard another member of staff from outside the door say “I am here X”. This person had come to take medicines off the other member of staff and give them to people living at the home. We asked the member of staff what the reason was for secondary dispensing medication. We were told, “I know this is wrong, I have never done this in the other places I have worked at. I have been told by the manager that I have to do this”. We raised our concerns about this with the registered manager and the member of staff then continued with the medication round in the correct way.

We spoke with other staff who worked at the home and they confirmed the practice of secondary dispensing was common practice. The person administering medicines was responsible for dispensing, administering and recording medicines to ensure they are given safely. We also noted that not all the Medication Administration Record Sheets (MARs) had a photograph attached to them to identify that it was the correct person receiving the medication. We found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, which corresponds to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 . People were not protected against the unsafe management of medicines.

Is the service effective?

Our findings

The care plans we looked at contained pre admission documentation that showed us people's needs had been assessed prior to moving in to the home. We did see that people's care had been reviewed and if there were any changes to people's health needs this was reflected in the care plans. We saw that referrals to other healthcare professionals such as GPs, the optician and the district nursing team had been made as required.

We asked about the choice of menus and how the food was presented. On arrival at the home at 09.15am there was no evidence of breakfast being served. Nine of the ten people living at the home had finished breakfast. This was confirmed by the staff on duty. We spoke with one person who told us they had not had anything to eat yet. A member of staff spoken told us this person not slept well during the night so had missed breakfast and that they were going to make them some toast. We saw the member of staff return with the toast. There was no inviting aroma of food preparation when we walked in the home. We asked if people were given the choice of a cooked breakfast or a bacon sandwich and were told by the staff it was cereal or toast, a cooked breakfast was not an option. We asked one person about the breakfast served and if there and cooked breakfast was available, this person told us, "Well I have never seen anyone one have anything but cereal and toast. I have never been offered anything else".

We asked the registered manager about the lunch time meal and where told that food is brought in from an outside catering company. We observed the lunch time which was corned beef hash or cheese and onion pie with creamed potatoes and vegetables, followed by rhubarb crumble and custard. One person we spoke with said the main meal was alright but they didn't like rhubarb. We asked if there was an alternative and were told by the person nothing was offered. The dining experience was sombre. The table had a plastic jug of juice on it, however there were no condiments or relishes offered; one person had to ask for some salt. Staff put food down in front of people and there was little interaction. Only four people out of ten sat at the dining table, other people had their meal in their bedrooms. Some people were not well enough to come downstairs and were assisted with their meal by staff.

During the afternoon we looked at the food storage in the kitchen. There was no fresh milk; the home used powdered milk for drinks and cereals. We saw there was a separate milk machine in the kitchen to store and keep chilled fresh milk. This was empty. We were told by staff that it had been brought in as a 'free trial' and when the milk had been used it had not be refilled. We looked inside the fridges; one fridge was turned off and only had a half packet of mints in it. The other fridge had nothing to eat in it; there was a bottle of tomato ketchup and a bottle of mayonnaise. We saw that there were three over ripe bananas and three loaves of bread on the kitchen unit. There was no other fresh produce for example fruit or vegetables in the home. There was no cake or biscuits apart from three small Asian cakes (the home had one Asian person living at them there). Should anyone want a snack with their drink nothing was available.

We observed that there were some tinned foods on the shelf for example two tins of hotdog sausages, two tins of sardines, two tins of salmon, four tins of beans and four tins of macaroni cheese. We asked the registered manager what was for the evening meal and were told soup, ham or cheese sandwiches or omelettes and yogurts. None of these ingredients were in the home. At 4.00 pm we saw that two tins of tomato and two tins of chicken soup and dozen eggs had been brought into the kitchen.

We asked about milky drinks such as Horlicks or hot chocolate for people before they retired for night. We were told by the manager, "No one likes them but we have Horlicks". The registered manager did eventually produce from another room a large tin of Horlicks. On speaking with staff we mentioned drinks at night and one said. "I wondered where the Horlicks had come from; it must be because you mentioned it to them (the manager)". We were shown that in the chest freezer there were some a few frozen crumpets and pancakes which the manager said people could have for supper. However no weekly menus were displayed so choices were not promoted.

Whilst we saw people were being provided with sufficient food and drink and the weight records we looked at in the care files did not indicate any concerns about weight loss we had concerns over the lack of choices, availability and variety of the food offered in line with people's preferences. This was a breach of Regulation 14 – (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations,

Is the service effective?

which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not provided with food that met any reasonable requirements arising from people's preferences.

We reviewed the training matrix for staff at the home. Staff had received induction training for the service and records were kept in personnel files, certificates were also in files for such areas as manual handling and infection control. We noted that these certificates related to the sister service. When asked, the provider stated that training was performed in house by the provider, but we noted that those training staff (the providers) had not been trained to a higher level which provided them with the knowledge to deliver it to others.

We noted that the training matrix showed that staff had not received training in equality and diversity and not all staff had received current safeguarding training. No staff had received training on the Mental Capacity Act 2005 (MCA) and in Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards were introduced to ensure that people's rights were protected in a way that does not restrict their liberties or freedom. We saw that for one person a DoLS application had been made and approved by the local social services department who were responsible for authorising and

reviewing any DoLS imposed and ensuring and conditions recommended on the DoLS were met. We questioned the manager how staff could meet the needs of this person if staff did not have up to date training in this area. We were told that staff training in this area was planned.

We reviewed staff training, staff supervision and appraisal information to ensure that the provider was offering on going support to its staff and monitoring quality of their work within the service. Documentation we saw stated that each staff member should receive supervision six times per year. We noted that the provider had fallen short in this area and we saw that only two members of staff had received supervision during 2014. No staff member had had appraisal, we were told that this was because all staff had been employed for less than 12 months. We also saw from the staff training information provided there were gaps in staff training for example staff had not received up to date protection of vulnerable adults training. This was a breach of Regulation 23 – (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to ensure that persons employed received appropriate training, personal development, supervision and appraisal.

Is the service caring?

Our findings

We spoke with two people who were complimentary about the staff. One person told us, “I am fine here. The girls are great, they look after me well”.

We observed people were treated with kindness and dignity during the inspection. Care staff spoke with people in a respectful manner. We saw that the care staff knocked on people’s bedrooms doors and waited for a response before entering.

For one person living at the home for whom English was not their first language, one of the owners was able to communicate with them in their own language. The provider introduced us to this person and explained the nature of our visit.

We saw that people living at the home were well groomed and nicely presented. On the day of our inspection a hair dresser visited the home so people could have their hair done if they wished.

We were told by the care staff that two people were cared for in bed. We saw these people looked comfortable and

their care needs were being met. We saw that staff undertook regularly checks to make sure they were alright and if they required anything. However due to time constraints staff did not have the opportunity to spend meaningful time with them.

We were told that one person liked to stay in their own room, which was their choice, however time should be factored in for staff to spend quality time with people so they do not become socially isolated.

Staff spoken with knew about the term ‘person centred care’. One member of staff explained this as treating people as individuals and meeting their needs. We were told by the member of staff that this was not the model of care used within the home and the care given was task driven.

We saw in the care files we looked at that for some people and their relatives they had been consulted about their plan of care.

The home was lacking in atmosphere, we did not hear any much chatter or laughter between staff and residents. We saw that when staff were sat in the lounge they were completing paperwork.

Is the service responsive?

Our findings

We looked at three care records and these contained sufficient information to guide staff how people who used the service liked to be supported. People's choices and preferences were documented in the care records, however it was difficult to ascertain whether people's choices and preferences were adhered to, for example choice of food. This was limited to what meals were brought in to the home by the outside catering company. If people living at the home did not want what was offered there was no option of another main hot meal as we saw food supplies were limited. Evidence was in care records about people's interests and what they liked to do. There was no evidence available to show us that people that these preferences had been actioned.

We found there was a bathing record in place to record when people had a bath. There was nothing recorded on the bathing record to show what steps had been taken to ensure the personal hygiene needs for one person had been addressed. When we asked about this an explanation from the registered manager was that this person's personal care had been provided but nothing had been recorded on the bathing record to evidence this. Information in the care plan did inform staff that this person could be restraint to bathing and for them to encourage and support this person with personal care. We also saw some weights charts had not been completed as required.

Throughout the day there was no evidence of any meaningful activities offered. One member of staff said they had thrown a ball with people in the lounge for 10 minutes in the morning. We did see in the afternoon that dominoes had been tipped out on a tray table in front of one person but no one was involved in playing a game. The television was on in the lounge, this had championship darts on, which was interesting to one gentleman. One person had a puzzle book and entertained themselves. People living at the home sat all day in the lounge with people they could not communicate with or for one person's understanding what was being said on the television and no stimulation was offered to them. We did see some pictures of activities that had taken place displayed on the wall but there was no information which would suggest when they had taken

place. One person did tell us they had been out on their mobility scooter with one of the providers. We asked one person about how they spent their day. We were told. "There's not much to do, but it's alright here".

The care records we looked at contained information to demonstrate that referrals had been made to other healthcare professionals and GPs as required. We saw risk assessments were in place with regard to falls and mobility. We saw that weight and bathing records were in the files we looked. However, these were completed in an ad hoc way, for example, for one person the bathing record stated that they had 'refused' to bathe from the 01/12/14 to 07/01/15. We asked the registered manager to clarify this and were told that this person had 'full strip' washes, however the records did not indicate this.

We did speak with some members of staff by telephone following our inspection to ask them their opinion about the service. One member of staff was reluctant to talk to us in case there were any repercussions from the management. One person told us, "We are not allowed to write in the care plans, we are expected to do the cleaning and make the breakfast and teas". Another member of staff said, "There is only one member of staff on waking night duty and sometimes a 'sleep in' member of staff upstairs. If there is no 'sleep in' staff available we have to ring the managers at home who will come to the home if needed.

We spoke with one visitor who told us they had no concerns about the care their relative received. However, this person was eager to end the conversation with them. They were not comfortable and at ease speaking with us.

We did see some good interaction from the care staff at the home when providing support to a family of a person who lived at the home who were distressed.

The provider had procedures in place to receive and respond to complaints. However, we did not see a copy of the complaints procedure displayed in the home. We saw that the complaint file was checked monthly and we were told that the service would endeavour to resolve complaints initially at a local level. The service had no on going complaints at the time of our inspection. One person we spoke with was not sure what they would do if they were not happy with something, they said they would probably tell one of the girls (staff).

Is the service well-led?

Our findings

The provider of the service was also the registered manager. From our observations and conversation with staff the management structure of the home was a 'one way' process. We were told by staff that they did not feel included in the way the home was run. Staff said that any suggestions or ideas they put forward were not listened to or considered.

We asked about team meetings and were provided with the minutes and saw the last one took place on 21/11/14. There was no agenda and the minutes were all instructions from the manager of what staff had to do. For example one instruction stated, 'people who stayed in their rooms need an observation chart'. There was no explanation why or if people were to be consulted if they wanted to be observed. We asked one member of staff about the meetings and where told, "The meetings need to be improved so that staff feel their opinions are valued

We noted that no care staff had a contract within their personnel file which detailed benefits and entitlements. When we raised this with the provider we were told that they had verbal contracts. During the inspection the provider showed us evidence of contracts they planned to implement.

During our inspection we reviewed the systems the service had in place to monitor the quality of the service. The service conducted regular risk assessments of each person's room, records were kept of accidents and falls and running totals were maintained. The service conducted regular checks of the equipment used within the home.

We saw that an annual Health and Safety audit had taken place 27 May 2014 and the service also reviewed medication annually, this was last done 25 July 2014. We did not see that medication was being reviewed weekly or monthly.

We saw records that showed that the equipment in the home was serviced and maintained regularly to ensure that it was safe to use. We saw that the service had current fire risk assessment, gas certificate, legionella certificate and that the lift within the service was maintained according to manufacturer's instructions.

Whilst the service performed audits it was noticeable that no issues arose from any audit and we found no evidence that an audit resulted in an accompanying action plan. This was evident when we viewed a hoist stored in the foyer of the home; we were told that this belonged to a stakeholder. The service could not use this hoist as it required maintenance, but no actions had been documented to either arrange for maintenance or removal.

We reviewed documents which the provider used to monitor the quality of its service by seeking feedback from people who use the service, their families, staff and visitors to the service. We found that only two questionnaires had been obtained from people who used the service during 2014. Questionnaires we reviewed were relevant to 2013; this included Visiting personnel survey (30/11/13) Visitor questionnaire (30/11/13) and Staff questionnaire (24/07/13).

The last Residents' Meeting took place on 07/03/14. We found a breach of Regulation 10 (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to regularly seek the views of people who used the service and people acting on their behalf.

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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Care and treatment was not provided ensure the proper safe management of medicines.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

The nutritional needs of service users were not being met as reasonable requirements of services preferences were not provided.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The registered person had not taken appropriate steps to ensure that at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed to carry on the regulated activity.

The registered person had failed to ensure that people working at the home received appropriate support, training, professional development, supervision and appraisal.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

The registered person had failed to seek and act on feedback from relevant persons and other persons on the services provided.

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.