Maria Mallaband Limited

Bridge House Care Home

Inspection report

Farnham Road
Elstead
Surrey
GU8 6DB

Tel: 01252703035

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Bridge House Care Home is a residential care home providing accommodation and personal care to 22 people aged 65 and over at the time of the inspection. The service can support up to 30 people in one adapted building and one separate annexe building with four bedrooms which was vacant at the time of the inspection.

People's experience of using this service and what we found
People told us they felt safe with the current staffing team, however, this had not been the case prior to certain staff members leaving the home. People told us how they had felt uncomfortable with night staff workers and felt unfairly treated. Previous staff members had made some people feel that they were not always treated with dignity and respect.

People told us staff supported them with medicines. However, the previous medicines procedure had not established why a controlled drug had been unaccounted for. This had not been reported correctly through the safeguarding channels to the local authority and CQC had not been made aware of this as a police incident.

Staff had not always been recruited in a safe way. When previous employment references had raised concerns no thorough investigation or risk assessment had been completed.

We found examples where accidents and incidents were not recorded correctly or not always analysed in a timely way. This prevented the registered manager from identifying patterns and required preventative actions to protect people from risks.

Monthly quality assurance visits had not identified concerns at the home. Regular audits had not highlighted missed safeguarding referrals to the local authority, missed notifications to CQC and the effectiveness of training. Audits around record keeping, analysis of trends and patterns relating to accidents and incidents and training for staff had been implemented in the seven weeks prior to the inspection. We will check whether this has been fully embedded in to the service at our next inspection.

Although safeguarding training had been received by all staff, it was apparent it was not effective as staff were not always confident in how to report safeguarding concerns. New, thorough training was provided to staff the day after the inspection and staff feedback from this training was positive.

Staff told us how they often felt rushed in their role and people told us the home felt short-staffed. There had been a sudden gap in staff resources with five members of staff leaving the home in close succession, including the management team. We could establish by the dependency tool the staffing levels met a "safe" level, however, this level with the absence of a permanent management team was not always effective. People told us that at times staff didn't have time for much more than meeting their basic care need

support. We have made a recommendation in relation to this.

People, staff and relatives have told us that in the past they had not felt that concerns were addressed in a timely way. Since the new temporary management structure had been put in place positive feedback was received. People and staff told us about the improvements to the home that had already been implemented and ongoing improvement plans were in place.

We received mixed feedback from people and relatives with regards to the provider listening to concerns, taking action and involving people in their care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Risks to people were assessed and all staff were knowledgeable in people's individual needs.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was Good (published 14 December 2019).

Why we inspected
The inspection was prompted in part by notification of a specific incident in which a person using the service sustained a serious injury. This incident is subject to a criminal investigation, of which the provider was aware. As a result, this inspection did not examine the circumstances of the incident.

The inspection was also prompted due to concerns received about the safety of the home, the quality of recording and analysis of accidents and incidents and the safety of the recruitment processes for staff. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. Due to other information gained during the inspection the key question of caring was also added.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, Caring and Well-Led sections of this focused report. You can see what action we have asked the provider to take at the end of this focused report. The provider has taken some action to mitigate the risks and this appears to be effective, albeit these changes were only made in the weeks prior to our inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bridge House Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took

account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These relate to safeguarding service users from abuse and improper treatment safe care and treatment, correct recruitment practices and accurate and timely record keeping.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Bridge House Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors.

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

The service had a manager registered with the Care Quality Commission, however, this person was de-registering as they had resigned. There was a temporary manager in post whilst recruitment was ongoing for a new registered manager. This meant that until a new manager is registered the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the home 24 hours' notice of the inspection. This was because it is a small home and we needed to be sure that the provider or manager would be in the home to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider

sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service about their experience of the care provided. We spoke with six members of staff including the regional director, manager, senior care workers and care workers.
We reviewed a range of records. This included three people's care records and multiple medicines records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider and manager to validate evidence found. We looked at staff training data and quality assurance records. We spoke with two professionals who regularly visit the service and four relatives of people who live or have recently lived at the home.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse;

- People told us they had not always felt safe in the home. All negative comments referred to staff who were no longer working at the home. One person said, "They were terrible to me; but I'm quite happy now because they've gone."
- People told us they had not always been supported in their basic care needs leading to potential neglect. One person said, "There were situations when they could have helped me but they stood by and watched me struggling. It would have made all the difference [to be assisted]." The same person also said, "There were times when they just stood there, and I couldn't make it to the bathroom in time and they made me feel like I was contaminated or something."
- Staff told us that people had felt uncomfortable to ask the previous staff members who had left the service for support. One staff member said, "People have told us that they won't use the call bell during the night and would prefer to be left wet instead of calling as they were scared."
- People told us they hadn't felt confident to express concerns in the past. One person said, "I never spoke up as I was dependent upon them to care for me."
- Staff told us they had not always been sure of how to report a safeguarding concern if they were not happy with the action of the manager. One staff member said, "I reported this to (previous registered manager) who told me 'don't say anything to the night staff'. I am not sure what (previous registered manager) did next about this. I think she asked us not to say anything as she didn't like any confrontation between staff and said she would deal with it herself." There was no evidence of any action taken. The provider responded to these concerns during and after the inspection. They confirmed all people and staff had been spoken with and all concerns were appropriately addressed.
- Staff training records showed all staff were up to date with safeguarding training during the time that staff told us they had expressed concerns. Since this time the provider and manager had organised new, thorough safeguarding training to ensure staff were confident to use the whistleblowing procedure. This training was scheduled to take place the day after our inspection.

Safeguarding concerns had not been addressed in a timely way through lack of reporting and knowledge of staff which left people at risk of ongoing harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- All people and staff spoken with confirmed that they were not concerned of any future issues due to the staff in question leaving the home. People told us the level of care had drastically improved since the staff changes. One person said, "I give nothing but credit for the present carers; I know they want to care for me

and keep me safe." We were informed that the members of staff in question had been suspended pending investigation and the provider was working with the local authority and the police to support ongoing investigations wherever they could.
● Staff confirmed they found the improved safeguarding and whistleblowing training to be effective. One staff member said, "The standard of the training was very good and very informative."
● Staff told us they were a lot more confident to report concerns. One person said, "I have total trust in [manager] that she will deal with any concerns straight away."
● A relative that was spoken with said, "I definitely feel that Dad is safe. He seems a lot happier and he hasn't told me of any concerns since certain staff left the home."

Learning lessons when things go wrong
● There were inconsistencies with the reporting of accidents and incidents that could lead to trends and patterns not being recognised in a timely way. An injury report from April 2020 had been discovered on the 7th October 2020. The person who had sustained the unexplained injury had went on to experience further unexplained injuries. Therefore, impact on people's safety and care had occurred as this had not been reported correctly or analysed for trends or patterns.
● It was established that in the summer of 2020 accidents and incidents had not been analysed more frequently than once a month . The regional manager and the temporary manager confirmed this was not a timely approach, therefore not in line with their policy. This was highlighted following a serious injury of a person that had been living in the home at the time. Although incidents were documented, preventative action had not taken place until up to four weeks later so therefore was not timely in it's response to mitigate ongoing risk.
● Staff told us in the past they had completed accident and incident forms but no action appeared to be taken. One staff member said, "We used to have concerns here which we reported to the manager. We reported these to (previous manager) and she told us that things would be done but nothing would be done." The provider responded to these concerns during and after the inspection. They confirmed that they had retrospectively analysed all accidents and incidents from the last six months.
● Relatives told us they felt that any concerns they raised in the summer of 2020 were not dealt with, so therefore no learning appeared to have been taken from them. One relative said, "I told the previous manager but nothing was done, how were they ever going to improve if they didn't learn from mistakes?" Another relative said, "It wasn't always clear about how we could make the management aware of our concerns. It's been made a lot clearer in the last month or so, they seem to really want to learn where things went wrong."

A lack of proper recording and analysis of incidents placed people at risk of harm of future incidents which could have been avoided or minimised. This is a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff confirmed since the management changed, all accidents and incidents were looked into and signed off immediately after they were bought to the manager's attention. We saw evidence of the recent incident analysis and action taken to minimise risks to people, for example people used bedrails or sensor mats to minimise the risk of repeated falls.
● All people and staff spoken with confirmed that they had noticed improvements since the new management team had come to the home.

Staffing and recruitment
● Not all employment checks had been completed correctly. There was a concern mentioned in a reference that had not been risk assessed. The only investigation that could be established was one line of

handwritten writing under the concern. This did not explain a reason for or a result of the concern, or whether a risk assessment had been considered. Subsequently this had resulted in people's care being impacted. The member of staff whose references included concerns was then involved in a safeguarding and police incident at the home. As a result of this, they had been suspended.
● Other recruitment files reviewed during the inspection were thorough and showed that a safe recruitment process had been followed. There was evidence of reference checks, interviews, where necessary risk assessments and checks with the Disclosure and Barring Service (DBS). This identifies if a person is known to police so safe recruitment choices can be made.

The provider had failed to ensure safe recruitment checks had been completed prior to staff working at the service. This is a breach of Regulation 19 (Fit and Proper Person Employed) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There was not always staff available to meet people's needs. People told us staff were often rushed and seemed to have limited time to talk to them. One person said, "The girls come and chat to me but not often because they don't have the time. I wouldn't want to say anything because they are so good. It's just that they are too busy." Another person said, "Staff do as well as they possibly can. They meet my immediate needs but have little time for anything else, they're too busy." And a third person said, "How quickly staff come to me and get things done depends on how short staffed they are. To be honest, it's a little shambolic at times. One carer can be doing three jobs at the one time; it's too much for a person."
● Staff told us there were times when there was not enough of them to provide people with quality care. One staff member said, "We always get things done, but it's tight, we have very little spare time to speak to the people. To see if they're okay or if they need to speak to us about anything." Another staff member said, "I would like to have some more staff here at the home. I think there is enough staff to be able to get tasks done but then not to spend quality time with people."
● At times during the inspection, staff were seen to be rushed and on occasion difficult to locate in the home as they were busy completing tasks.
● The provider used a 'dependency tool' which determined how many staff were required to meet people's needs safely. The records showed safe numbers of staff were deployed. However, due to the shortage of a permanent management structure that would ordinarily be supporting staff with care tasks on a daily basis, people and staff felt the home was short staffed. The manager confirmed they would review the dependency tool, staffing numbers and deployment.

We recommend the provider reviews their dependency model and staff deployment to ensure people feel supported with all of their needs as well as their basic care needs.

Using medicines safely
● People and relatives told us staff supported them well with their medicines. One relative said, "I have no concerns, the staff are all very knowledgeable in all his needs."
● There was a robust system in place to audit all medicines in the home including controlled drugs. This procedure had been introduced following an incident where a controlled drug had been misplaced on one occasion.
● Staff received regular medicine training to ensure they were up to date with their knowledge around the safe storage, recording and administration of medicines. They were knowledgeable in the new audit system for controlled drugs and their responsibilities around safe management of medicines.
● There were protocols is place for "when needed" (PRN) medicines. This detailed individual people's needs, possible side effects and administration advice.

Assessing risk, safety monitoring and management

● Aside from the recording of accidents and incident and safeguarding concerns, risks to people's safety had been identified, assessed and monitored. Where individual risks to people changed, this was clearly documented in their care plans and action was taken to mitigate those risks. An example of this was a person who had lost weight prior to moving in to the home. The person's nutrition had been monitored closely when they had moved in to the home and as a result they had successfully gained a healthy weight.

● Staff were knowledgeable about people's individual risks. One staff member said, "[Person] is at risk of falls and can get forgetful so often forgets to use her walking aid. We always gently remind her, it's about constantly watching out to try to reduce her falls." This information was also present in the person's care file with advice for staff.

● Where new risks to people were identified, staff took action and worked with other healthcare professionals to mitigate these. For example, the district nurse had been contacted in order to gain their input to support a person with a pressure ulcer. This person no longer had any pressure area changes and staff showed good knowledge in how to support them to minimise any ongoing risks to their skin integrity.

● Personal Emergency Evacuation Plan (PEEPS) were in place. This gave guidance and advice to staff on what support each person needed in the event of an emergency.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us in the past they had not been treated well by staff who no longer worked at the home. One person said, "We had a carer here and he wasn't very nice; very rude he was. He just barked 'get in bed'. Imagine, trying to put an old lady to bed at 7pm, it's not right." Another person said, "I just wanted a little more understanding of my needs from those two men. Now, 99% of my time living here is good." A third person said, "Quite simply, I could have been treated a little more kindly, but this is limited to the work of two people who are no longer here."
- All people and relatives told us they were happy with all areas of their care since the changes in the staff team. One person said, "[Named carer] is lovely; they will do anything for you, nothing is too much." A relative told us, "Dad seems so much happier now. It was only a couple of staff and all it needed was for them to leave. It was sad to see him so unhappy."
- Staff had received updated equality and diversity training. A staff member said, "I think it was good training, my colleagues thought so too."

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People and relatives told us they had not felt comfortable to express their concerns and views in the past. One relative said, "It's difficult because of the Covid situation to see if they are listening to family members. I raised concerns about the staff that have gone now and I have repeatedly requested face time or video calls for Dad but they've only managed to arrange two during the pandemic. It's difficult to believe we are being listened to."
- Following the recent change in management some relatives told us they had received feedback forms to complete and voice any ideas or concerns. One relative said, "It feels like they are trying, but it's difficult to say because it's so soon."
- People told us they were now confident to raise issues and tell staff how they want to be supported. One person said, "Oh yes, I can make decisions about my care and am confident to speak up."
- People told us that in the past staff had not respected their dignity. One person said, "I was disappointed when they [staff members no longer working at the home] would not come to my aid when I felt I desperately needed it."
- All people spoken with told us that their only past concerns were with people that no longer worked in the home. People were very positive about all the other members of the staffing team. One person said, "[Carers] always knock before entering my room; I keep my door open, but they will knock before they cross the threshold." A second person said, "I give nothing but credit for the present carers. I know they want to

care for me and keep me safe." A third person said, "The staff look after us and ask us what we want. I don't have a bad word to say about any of them now."

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

- Relatives did not always feel communication about important events had been relayed to them. Relatives told us how they were not always happy with the communication between them and the past management team. One relative said, "We were told of an incident where police had come to the house but no further information given. We understand if there is an ongoing investigation, but is it still going on? What was the outcome? We've had no updates for two months."
- It is the provider's legal responsibility to inform the local authority of any safeguarding concerns. On one occasion there was a controlled drug misplaced. The police were not informed, neither were the local authority notified of this safeguarding incident and CQC were not made aware of what should have been documented as a police incident, the only action that had been taken was a notification to the NHS controlled drug support team.
- The local authority confirmed in the past they had not been informed of all unexplained injuries which would normally result in a safeguarding referral. These had been recorded on accident and incident forms, however, were only discovered by the local authority in a later safeguarding enquiry.
- The previous management team on occasions had not recorded accidents and incidents correctly and not analysed for trends and patterns in a timely way. It was also unclear as to why a reference check had not been investigated or risk assessed correctly.
- The provider completed monthly quality assurance (QA) audits but these had been ineffective in their use. Over the months where concerns had been raised this had not appeared on the QA audits. Training checks for staff had also not identified inefficient training in safeguarding and whistleblowing procedures. Whilst we acknowledge, the impact of the pandemic and limited access to the home by the QA team, there was limited oversight and effective audits resulting in a lack of effective governance at the service. Since the inspection we have been assured that an investigation is being carried out in to the alleged abuse and into concerns that have been identified regarding information and concerns that may have been withheld from the QA team.
- Supervisions for staff members had been inconsistent. One staff member said, "I can't remember the last time I had a supervision." Another staff member told us about staff meetings, "There was no feedback from [previous manager] about anything and we never got a chance to put anything across or have a say."
- However, the provider demonstrated other examples of good practise during and after the inspection. They confirmed more effective quality assurance audits were being completed and evidence was seen of

this. The home was also working with the local authority regarding retrospective investigations of safeguarding incidents

There was a lack of oversight and effective audits resulting in a lack of effective governance at the service. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

● Since the temporary management team had been put in place staff told us how they were confident to raise concerns or bring forward ideas. One staff member said, "[Manager] will make sure we are doing ok and she makes sure we know everything we need to know. I feel very supported by [manager] to be able to do my job and you can see by the changes in residents and the staff confidence."

● The manager confirmed that the improvements were a work in progress. The manager also confirmed that she was actively trying to organise supervisions as a priority.

● Relatives told us that communication had improved. One relative said, "I am happy to see and hear of improvements at the home. I think it's getting better."

● The new management team had been keen to work alongside the local authority and CQC to address past concerns and go forward with a good working relationship.

● Bridge House Care Home had a good working relationship and rapport with the local GP surgery. The visiting practise nurse said, "The staff will raise concerns to me each week and any urgent concerns are called up on the day. Equally they are responsive to any thing that I may ask them to do such as observations, fluid charts, etc and are happy to be present if required during any visits/consultations with the residents."

● Prior to the pandemic the home had a good relationship with the local community which included many events and activities. An example of this was where children from the local school would visit residents. During the pandemic the same community have remained in contact and plans to re-start visits are in place for after the pandemic.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Due to the lack of proper recording and analysis of incidents this is a breach of Regulation 12; Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Due to concerns around safeguarding issues not being addressed in a timely way through lack of reporting and knowledge of staff this is a breach of Regulation 13; Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Due to the lack of safe recruitment, lack of notifying the relevant authorities of notifiable incidents, ineffective audits and lack of communication with relatives and staff this is a breach of Regulation 17: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

Due to the lack of safe recruitment on this occasion this is a breach of Regulation 19: Fit and Proper Person Employed - The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014