Daimler Green Care Home Limited

Sovereign House

Inspection report

Daimler Drive
Daimler Green
Coventry
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Tel: 024 76 596 064

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Ratings

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

Overall summary

We inspected Sovereign House on 5 February 2015 as an unannounced inspection.

Sovereign House is divided into three separate floors and provides personal care and accommodation for up to 60 older people, including people living with dementia. There were 55 people living at Sovereign House when we inspected the service.

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

At our previous inspection in July 2014 we found there was a breach in the legal requirements and regulations associated with the Health and Social Care Act 2008 and, we issued compliance actions to the provider for Regulation 22 Staffing. We asked the provider to send us an action plan to demonstrate how they would meet the legal requirements of the regulations. The provider

Summary of findings

returned the action plan in the allocated timeframe telling us about the improvements they intended to make. On this inspection we checked to see whether the improvements had been made. We found that staffing levels had improved, but improvements were still required to ensure there were enough staff available at all times to safeguard the health, safety and welfare of people.

People were protected against the risk of abuse, as the provider had appropriate policies and procedures in place to report abuse, or allegations of abuse. The provider recruited staff who were of good character to care for people at the home.

Medicines were managed and stored appropriately, and people received their prescribed medicines safely.

Staff were given induction and training so they had the skills they needed to meet the needs of people at the home. However, we found staff did not always use their skills to care for people effectively.

People were supported to have food and drinks that met their health needs and met their preference. People were supported to maintain their health and wellbeing through access to healthcare professionals.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make decisions for themselves were protected. People had access to advocacy services when they needed to. An advocate is a designated person who works as an independent advisor in another's best interest.

Care staff did not always communicate with people when they had the opportunity, and people's privacy and dignity was not always respected when they were being cared for by staff.

People could have friends and family visit them when they preferred, which helped people maintain personal relationships.

We found care records did not consistently record how care should be delivered to people.

People told us they knew how to make a complaint if they needed to. Complaints were investigated and action was taken if necessary.

The service was appropriately managed and the people who used the service, and their relatives, were given the opportunity to share their views on the quality of the service. Quality assurance procedures were in place to identify where the service needed to make improvements, and where issues had been identified the manager took action to improve the service.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People told us they felt safe. However, we found people were put at risk because there were not always enough staff available to meet people's needs, and protect people from harm. Medicines were managed safely, and people received their prescribed medicines when they needed them.

Requires improvement

Is the service effective?
The service was effective.

Staff were given induction and training so they had the necessary skills to meet the needs of people at the home. People were supported to have food and drink that met their health needs. The rights of people who could not make decisions for themselves were protected.

Good

Is the service caring?
The service was not consistently caring.

People and their relatives told us the majority of staff treated them with respect and kindness. However, staff did not always communicate with people when they had the opportunity, and people did not always have their privacy and dignity respected.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

Care records were in place for each person who used the service. However, these were not always up to date, and did not detail the care people needed to receive. People were able to raise complaints and provide feedback about the service. We saw complaints were analysed to identify any trends and patterns, so action could be taken to make improvements.

Requires improvement

Is the service well-led?
The service was well led.

The service was appropriately managed and people were given the opportunity to share their thoughts on the service. Quality assurance procedures were in place. The manager had identified areas that required improvement, such as care records. The manager was taking action to improve the service.

Good

Sovereign House

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 took place on 5 February 2015 and was unannounced. This inspection was conducted by two inspectors, a specialist nursing advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We asked the provider to send to us a Provider's Information Return (PIR). This document allows the provider to give us key information about the service, what it does well and what improvements they plan to make. We were able to review the information as part of our evidence when conducting our inspection.

We reviewed the information we held about the service. We looked at information received from relatives, from local authority commissioners and the statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six people who lived at the home, nine relatives, five care staff, two nursing staff, and the manager.

We observed care being delivered in communal areas and we observed how people were supported at lunch time.

We looked at a range of records about people's care including five care files. This was to assess whether the information needed about each person, and the care offered to each person was available.

We reviewed records of the checks the manager and the provider made to assure themselves people received a quality service.

We looked at personnel files for two members of staff to check that suitable recruitment procedures were in place, and that staff were receiving appropriate support to continue their professional development.

Requires improvement

Is the service safe?

Our findings

At our previous inspection in July 2014 we found there were insufficient staff to meet people's needs. On this inspection we checked to see whether improvements had been made to staffing levels. We found staffing levels had improved as more staff had been employed, however further improvements were still required.

People we spoke with told us there were not always enough staff available to care for people safely. One relative said, "I come into the home a lot, because I worry. They should have more staff, there's not enough to keep people safe." All the staff we spoke with told us there were not always enough staff available to meet people's needs safely. One staff member told us, "If everyone is in there are enough staff, but we have problems if somebody is off sick." Another staff member told us, "We struggle at weekends because we don't have hostesses at weekends."

We asked staff what impact staffing levels had on people at the home. They said, "When we are short staffed things get missed out, or delayed. For example, if we prioritise someone being taken to the toilet, then people who need moving or checking regularly are seen late, or they might be left." We saw that where people were due to be checked each hour, one person's charts did not show they had been checked by staff.

Staff involved with cleaning the home told us it was sometimes difficult to fit in cleaning tasks in the time allocated. One staff member said, "It's difficult to get all the cleaning done, it's too much sometimes and we can't clean properly." Relatives we spoke with raised concerns about the cleanliness in people's bedrooms. One relative said, "My relative's room needs cleaning under the bed." Another relative said, "Sometimes I've been in to see [Name] and their breakfast is all over the bed, it had been left there a long time."

Staff told us that to help with staffing pressures some people were assisted to get up by the night staff. Staff also told us people were put to bed early to help with busy periods of the day. People were not always offered a choice about when they got up, or were put to bed. One staff member said, "The night staff get four to six people up daily." Another member of staff said, "People are put to bed after tea, between 5.30pm and 6.00pm."

One person told us they were unable to have a bath more than once a week due to staffing levels. They felt this was inadequate in meeting their personal hygiene needs. They said, "I have a bath day here (once a week), it would be nice to have a bath every day." Four relatives we spoke with told us they were concerned that people were not supported to maintain their personal hygiene as they wished. One relative said, "My relative likes a bath every day, but they only get one once a week. I've mentioned it to staff who said they can only do it once a week." One member of staff commented, "There are not enough staff for people to be bathed more than once a week." We saw there was a bath rota on display at the home. The rota showed that people were scheduled to have baths once a week. The manager explained the bath schedule would no longer be in operation. They added people would be offered a bath according to their personal preference in future.

We spoke to the manager about how the numbers of staff were determined. We saw assessments of people's needs and abilities were used to create a dependency score for the individual. For example, the more dependent the person was on staff to support them with everyday living needs, such as dressing and eating, the higher their dependency score. The manager explained the dependency scores were used to determine the numbers of staff required at the home to care for people effectively and safely. The manager told us the dependency tool had only recently been introduced and was still under review. Permanent staff levels had not yet been agreed. We saw staff had recently been increased at the home, but we were concerned the dependency tool had not identified the need for further staff.

We found this was a breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing, which corresponds to Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at the home. One relative told us, "We visit most days and I feel [Name] is safe here." One person said, "I love it." Staff told us they felt people were safe at the home. One staff member said, "I'd say people are safe here. We've got some brilliant care workers."

There was a system in place to identify risks and protect people from harm. Each person's care file had a number of risk assessments completed. The assessments detailed the type of activity, the associated risk; who could be harmed; possible triggers; and guidance for staff to take. Some risk

Requires improvement

Is the service safe?

assessments were not up to date. For example, we saw one person was at risk of falls, and they had a recent fall. They were currently being cared for in bed. The risk assessment associated with falls was not up to date. It had not been updated following the recent fall to take into account the person's current level of mobility. This meant the current risk to the person had not been identified correctly in care records.

People were protected against the risk of abuse. Care staff told us they completed regular training in safeguarding. Staff we spoke with were knowledgeable about the procedures for identifying and reporting any abuse, or potential abuse. Information was displayed in the home so that visitors and staff had access to other organisations they could report abuse to, if this was required. Staff told us they were comfortable with raising any concerns they had with the manager.

The provider notified us when they made referrals to the local authority safeguarding team when an investigation was required to safeguard people from harm. They kept us informed with the outcome of the referral and actions they had taken. This meant the provider took appropriate action to protect people.

Staff told us and the records we looked at confirmed suitable recruitment procedures were in place which included checks into the character of staff before they started working at the home. One staff member confirmed, "I had my checks and references done before I started work." This helped to ensure they were safe to work with people who used the service.

We found medicines were managed and stored safely. We observed medicines being administered to people at lunchtime. We saw people were given their prescribed medicine at the right time, and at the right dosage level. We saw medicines were stored in locked cabinets and were audited regularly. We looked at a sample of medicine administration records and saw people regularly received their medicine as prescribed. People were protected from receiving too little or too much medicine, as there were protocols in place for administering medicines prescribed on an 'as required' (PRN) basis.

Good

Is the service effective?

Our findings

We observed people receiving their lunch time meal. People enjoyed their meal. One relative told us, "The food is good, and [Name] has started to put on weight." People in the dining room were given enough time to eat their meal. People ate at their own pace and staff waited for clear signals that people had finished their main meal before offering them desert.

The home catered for people with specialist diets, for example, food for people on a 'soft' diet, and for people with diabetes. In each dining room at lunchtime there was a member of staff employed as a hostess to assist people with their dietary needs. The hostesses worked five days per week, and had recently been introduced at the home. The hostess's role was to offer people fluid and food and to monitor their food and fluid intakes. This was to check that people were eating and drinking enough to maintain their health. The hostesses also maintained up to date information about people's dietary needs and preferences. We saw the hostesses checked people's dietary needs before preparing their meal. These staffing levels during the lunchtime period ensured people were supported to access food that met their individual needs effectively. One relative told us, "The hostesses are great."

People were offered drinks in specialist cups or beakers, depending on their individual needs. This specialist equipment helped people to maintain their independence, and assisted people in drinking sufficient fluids to maintain their health. We saw the hostess made sure people were offered drinks throughout the day.

Staff told us they had received an induction when they started work that included shadowing an experienced member of staff, and training courses tailored to meet the needs of people who lived at the home. Staff told us they were supported to gain nationally recognised qualifications to ensure they received the skills they needed. One staff member said, "I've done my national vocational qualifications, and we have training every six months to keep up to date." Staff told us they also received an individual training programme which reflected their personal knowledge and skills, and related to their specific job role. One staff member said, "Some staff need more specialist training than others."

We saw staff didn't always follow the training provided in practice. We observed two members of staff complete transfers for three people who had limited mobility. On all three occasions no brakes were applied to the wheelchair the person was being assisted into. This meant the wheelchair could move and potentially cause an injury. On one occasion we saw the belt was not fixed to the hoist correctly and dropped suddenly which alarmed the person being transferred. We immediately spoke with the manager who confirmed that both staff had received manual handling training, and were observed using the correct manual handling techniques as part of the training. The manager informed the staff involved that they were not to complete any more transfers until their training had been refreshed. We saw this training was organised at the end of the day.

Staff told us the manager encouraged them to keep their training and skills up to date. We saw a staff training plan was maintained to record what training each member of staff had undergone, and when training was due to be renewed. Training was delivered in a number of ways, including in-house training courses. We saw staff had their skills checked through supervised observation after undergoing training, for example, in medication administration. The manager organised training courses on a range of topics and techniques so that staff had the skills they required to meet people's needs.

Staff told us they received regular supervision meetings with their manager. One staff member told us, "I have a supervision meeting with my manager once every two months." These meetings provided an opportunity for staff to discuss personal development and any training requirements to keep their skills up to date.

The Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) sets out principles to ensure decisions are made in people's best interests when they are unable to make decisions for themselves. The manager was able to explain to us the principles of MCA and DoLS, which showed they had a good understanding of the legislation. Staff we spoke with had completed training on MCA and DoLS and were able to tell us the action they would take if a person's capacity to make decisions changed, or if they suspected this. Up to date information about MCA and DoLS was available to staff and they were able to give us examples of when they had applied these principles to protect people's rights. We saw the majority of

Good

Is the service effective?

staff asked for people's consent before they assisted them during the day. Records confirmed people received mental capacity assessments to determine if they could make decisions for themselves. We found the manager reviewed each person's care needs to ensure people were not unlawfully deprived of their liberties. We saw two people currently had a DoLS in place, and applications had been submitted to the local authority as required.

Staff explained they delivered effective care to people because they were kept up to date on changes in people's care needs. Staff handed over information at the end of their shift to new staff members coming in to work. We saw the daily handover was conducted verbally, and a communication book was prepared. Brief information was shared about changes in people's health or care needs, or any special arrangements for the day. One staff member told us, "The nurse does the handover, it's good and keeps us up to date." Another member of staff said, "In the handover we're told if someone is really poorly, although the information could be more detailed."

We found people were supported to attend regular health checks. Care records included a section to record when people were visited, or attended visits, with healthcare professionals. For example, we saw people were able to see their GP, speech and language therapist, mental health practitioner, and dentist where a need had been identified. We saw one person appeared to be in pain, and their relative called a member of staff over to help. The member of staff spoke to the person directly, in their own language, and the person was able to explain their pain. The member of staff responded by putting the person on the list to see the doctor the following day. We later saw that this had been arranged to respond to the person's health needs. This showed the service responded to people's needs effectively.

Requires improvement

Is the service caring?

Our findings

People and their relatives told us the majority of staff treated them with respect and kindness. One relative said, “Some staff are brilliant. Some are really caring.” Another relative told us, “The staff are kind, but some are better than others.” A third relative told us, “Some carers are very good and are dedicated.”

We saw people were given everyday choices. For example, people were asked their meal preference before meals were prepared. We saw there were several meal choices available daily. Staff members told us, “Sometimes if people can’t make a choice we try to give them something we know they would like, using their likes and dislikes information.” Another member of staff told us, “Sometimes relatives choose meals for people, if they can’t choose themselves.” People could make alternative choices at mealtimes if they did not like their pre-ordered meal. This was because in each dining room a trolley with hot food was provided, and people could see what was on offer before their meal was given to them. One relative told us, “There’s a choice, but sometimes the menu doesn’t always cater for [Name’s] specific tastes.” They added, “Sometimes we bring in [Name’s] favourite foods.”

We saw the staff supported people who needed assistance to cut up their food, or who needed specialised equipment, without being prompted. This helped people to maintain their dignity, and demonstrated staff knew people well. We saw people were provided with plate guards and adapted cutlery to help them eat their own meals without assistance.

We saw staff in the dining room tried to meet the needs of each person according to their wishes. For example, one staff member told us about a person who always wanted to eat their meal very quickly, and then leave the dining room. Because of their preference the member of staff made sure they had their meal promptly and we saw they left the dining room immediately after finishing their meal.

People told us some members of care staff didn’t always understand their wishes when they spoke to them, and didn't communicate with them when they had the opportunity. This was due to a language barrier. One relative told us, “Some staff do not speak very good English, and therefore it’s difficult for [Name] to communicate with them.” One staff member told us, “Sometimes there’s a language barrier.” We spoke with two members of staff whose first language was not English. We found they were unable to understand some of the questions we asked them with regard to the care people needed at the home. A lack of communication skills meant staff may not always understand people’s needs.

We saw care staff did not always respect people’s privacy and dignity. For example, we saw one person being moved using specialist equipment. The person looked uncomfortable and as they were moved their clothing got caught and exposed their bare skin to people’s view. Staff did not cover the person to respect their privacy.

People were supported to maintain links with family and friends. There were a number of rooms, in addition to bedrooms, where people could meet with friends and relatives in private if they wished. People told us they made choices about who visited them at the home. One relative told us, “I’m not aware of any restrictions on visiting.”

People told us they had access to advocacy services. Advocacy information was available on display in the reception area of the home. An advocate is a designated person who works as an independent advisor in another’s best interest. Advocacy services support people in making decisions, for example, about their health and care requirements which could help people maintain their independence.

Requires improvement

Is the service responsive?

Our findings

We saw that people's individual preferences were not always accurately recorded on their care records. For example, we saw one person's record stated the person preferred their own company. However, staff told us the person enjoyed being with others and enjoyed a 'sing-a-long'. The care records had not been updated to describe the knowledge staff had about the person's preferences, which could result in the person receiving inconsistent care.

In two care records we looked at, people were assessed as not having the mental capacity to make decisions related to their health and well-being. We saw that a decision had been made in their best interests, and after discussion with health professionals, that they should not be resuscitated if they suffered from cardio pulmonary arrest. We saw that documents relating to this decision (DNACPR) were not filed prominently at the front of the care file, following the service's own guidance. In addition, we saw one person's DNACPR form had not been fully completed and signed. The home did not have a separate list of people who had DNACPR's in place for staff to access quickly. There was a risk these documents may not be found in an emergency, or were not valid, and incorrect action could be taken.

Information was not consistently recorded about the care people received. For example, we saw one person needed to be checked or observed by staff members each hour. We saw that these observations were recorded on a chart. The person's chart had not been completed for a period of five hours on the day of our inspection. Staff told us they had observed the person, but we could not confirm this had happened each hour, due to the lack of recording.

We saw one person needed to be moved frequently as they had limited mobility, and were at risk of developing damage to their skin. We saw the person had a chart in place to record when they were moved by staff. However, the person's care records did not state how often the person needed to be moved. One member of staff told us, "We don't know the turning times, as it's not written down." This put the person at risk of inconsistent care.

In one person's care record we saw information was not recorded consistently to provide clear information for staff on how the person should be cared for. We saw the person was receiving treatment for wounds. The records were not clear but indicated that the number of wounds had increased since the person moved into the home. The wounds were not documented clearly. The records did not give clear instructions to staff about how to care for each of the wounds in a safe and consistent way. For example, some records indicated bandage changes should be every two to three days, but other records indicated the bandage was changed every six days. As the records were not clear, we could not determine when the bandage change should occur. This inconsistent recording compromised the person's health as staff did not have the necessary information to manage the person's skin wounds and promote healing.

We found this was a breach in Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records, which corresponds to Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

On arriving at the home, we saw there were activity posters displayed around the home offering people support to take part in interests and hobbies. We observed a resident's meeting took place on the morning of our inspection, run by the activities co-ordinator. The meeting involved people on all three floors of the home, and was designed to ask people what they would like to take part in for future planning. We saw people engaged in the meeting, and an action plan was drawn up to meet people's preferences. People we spoke with told us they were content with the activities on offer. We found additional activities staff had recently been employed to increase support available to people. The activities coordinator told us people living with dementia were supported and encouraged to engage in stimulating physical and sensory activities on a one to one basis, such as hand massage and manicures. Some activities were also now planned for evenings and weekends following the increase in staff.

We saw there was information about how to make a complaint available on the noticeboard in the reception area of the home. It was also contained in the service user guide that each person received when they moved to the home. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. There was a complaints log, and previous complaints had been investigated and responded to in a timely way. For example, we were able to review one complaint where the manager had invited the complainant in to the service to meet with them. The complaint had also

Requires improvement

Is the service responsive?

been looked into by the organisation's quality officer to make sure the complaint had been responded to adequately. We saw complaints were analysed to identify any trends and patterns so action could be taken to reduce the number of complaints in the future.

Good

Is the service well-led?

Our findings

We saw the manager was accessible to people and their relatives, the manager was available each Wednesday afternoon to meet with people or their relatives at a 'Manager's surgery' session. Relative's told us they could speak to the manager or deputy manager during the day. One relative said, "The managers listen to me, and try and make things better." Another relative told us, "If I wasn't happy I'd go to the manager, and in a second it would be sorted, straight away."

Staff told us the home was a nice place to work. One staff member said, "I think it's a good place to work, the team work is good. The managers are good and they get onto things quickly." Staff told us they had an opportunity to raise any concerns they had, or provide feedback and ideas about how the service could be improved, through frequent staff meetings. One member of staff told us, "We have regular staff meetings." Staff surveys were undertaken by the manager to allow staff to provide feedback. Staff could also provide feedback anonymously through a suggestion box. Information from surveys, meetings, and the suggestion box was analysed. A recent suggestion had been made to introduce a 'keyworker' system at the home and this had been implemented. 'Keyworkers' were designated members of staff assigned to each person who lived at the home, to quality assure care delivery for each person.

We found the manager had recognised the need to improve care records at the home, and had a plan in place to make improvements. For example, a care record audit was planned in February 2015. In addition, a 'keyworker' system had recently been put in place to improve care records. 'Keyworkers' had been made responsible for people's care records to make sure things were not overlooked in the future.

A range of different meetings took place to gather views from people and their relatives, and to involve people in the running of the service. We saw these meetings were advertised around the home. People were asked for their feedback in six monthly surveys. Survey information showed people had provided feedback, and an action plan had been produced to drive forward improvements. For example, a suggestion had been made that people should be involved in interviewing new staff. We saw people had been involved in staff interviews in January 2015. Information in the PIR confirmed people were to be involved in recruitment of staff in the future to increase involvement of people at the service.

The service completed regular audits of different aspects of its service. This was to highlight any issues in the quality of the service, and to drive forward improvements. A recent audit had been completed on infection control procedures, and we saw that all identified actions resulting from the audit had been implemented.

The service was part of a larger organisation. The area manager from the organisation frequently visited the service to support the manager in audits and quality assurance procedures. The manager told us the wider organisation was supportive of the service, and offered regular feedback and assistance to them to support them in their role.

Records we looked at showed staff recorded when an accident or incident occurred. We saw they analysed the incidents to identify patterns or trends. These patterns or trends gave the service information about whether processes or procedures needed to be changed, or care plans needed to be updated to reduce the risk. We saw that a recent incident had been investigated and procedures had been altered following a root cause analysis by the manager. This is a method of problem solving and tries to identify the root cause of the problem. This demonstrated the manager wanted to improve the outcome for people who used the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found there was not enough suitably qualified, skilled and experienced persons employed in order to safeguard the health, safety and welfare of service users. This was a breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing, which corresponds to Regulation 18 HSCA (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Service users were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them, as an accurate and complete record in respect of each service user was not available. We found this was a breach of Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records, which corresponds to Regulation 17(2)(c) HSCA 2008 (Regulated Activities) Regulations 2014.