Bristol Care Homes Limited

Field House

Inspection report

Blakeney Road
Horfield
Bristol
BS7 0DL

Tel: 01179690990
Website: www.bristolcarehomes.co.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Field House 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. Field House provides accommodation with nursing and personal care for up to 55 people. At the time of our inspection 44 people were living in the home.

At the last inspection on 15 and 16 February 2017 the service was rated Requires Improvement. We found breaches in two regulations relating to safe care and treatment and record keeping. Following this inspection, the provider sent us an action plan telling us how they would make the required improvements.

We carried out a comprehensive inspection on 13 and 14 March 2018. At this inspection, we found improvements had been made and the legal requirements had been met. We found further improvements were needed to the quality assurance systems to ensure the service provided to people is consistently well-led.

The service has improved to Good.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Sufficient numbers of staff were deployed at the time of our visit. Staff performance was monitored. Staff received supervision and training to ensure they could meet people's needs.

Medicines management shortfalls were promptly acted upon and actions taken to make improvements.

Staff demonstrated a good understanding of safeguarding and knew how to report concerns.

Risk assessments and risk management plans were in place. Incidents and accidents were recorded and the records showed that actions were taken to minimise future occurrences.

People's dietary requirements and preferences were recorded and people were provided with choices at mealtimes.

Staff were kind and caring. We found people were being treated with dignity and respect and people's privacy was maintained.

A range of activities were offered and provided people with entertainment both in and out of the home.

Systems were in place for monitoring quality and safety. Improvements were needed to make sure required areas for improvement were identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service has improved to good.

Improvements had been made to the management of medicines. Where shortfalls were identified the provider took prompt action.

People were protected from abuse because staff had received training and knew how to identify and act on concerns.

Staff were safely recruited and staffing levels were sufficient to meet the needs of people living in the home.

Accidents and incidents were reported and actions taken to reduce recurrences.

Is the service effective?

Good

The service has improved to good.

The service complied with the requirements of the Mental Capacity Act 2005 (MCA). People were asked for consent before care was provided.

People were provided with sufficient food and fluids and systems were in place to monitor and act on changes to people's intake.

Staff received training and support to enable them to meet people's needs.

People had access to a GP and other health care professionals.

Is the service caring?

Good

The service remains good.

People received care from staff who were kind, caring and compassionate.

Positive relationships had developed between people living in the home, visitors and staff.

Is the service responsive?

Good

The service has improved to good.

People's needs were assessed and care plans were in place to meet individual needs.

People were offered a range of group activities, both in and out of the home.

A complaints procedure was in place and readily available to people.

Is the service well-led?

Requires Improvement

The service remains requires improvement.

Systems were in place to assess, monitor and mitigate risks to people. Improvements were needed to make sure systems identified shortfalls, for example, in medicines management and record keeping.

A registered manager was in post. The management team had been strengthened and additional roles had been created.

The registered manager recognised their responsibilities with regard to notifications required by the Commission.

Field 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.

We undertook a comprehensive inspection of Field House on 13 and 14 March 2018. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors and an expert by experience on 13 March 2018 and one inspector and an expert by experience on 14 March 2018. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we looked at the information we had received about the home. We looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our visit we spoke with 17 people who lived at the home and 10 visitors. We spent time with people in their bedrooms and in communal areas. We observed the way staff interacted and engaged with people.

We spoke with chief executive, the head of care quality, the registered manager, the deputy manager, the operations manager and 12 staff that included registered nurses, care staff, maintenance, housekeeping, laundry, activity and catering staff. We observed medicines being given to people. We checked how equipment, such as pressure relieving equipment and hoists, was being used in the home.

We looked at five people's care records in detail and checked other care records for specific information. We looked at medicine records, staff recruitment files, staff training records, quality assurance audits and action plans, records of meetings with staff and people who used the service, complaints records and other records relating to the monitoring and management of the care home.

Good

Is the service safe?

Our findings

People and relatives we spoke with told us they felt safe in the home. Comments included "I am perfectly safe. Why wouldn't I be, when there are people (staff) around popping in and out all of the time," "My [name of person] is safe here, the door is open and staff are in and out all the time" and, "I mean as far as I can tell perfectly safe, as safe as I hope she can be."

When we last visited we found medicines were not accurately recorded and people did not always receive medicines when they needed them. At this visit we found improvements had been made and where we identified shortfalls, prompt actions were taken.

We observed medicines being given to people. People were not rushed and we heard staff explaining what the medicines were for. Medicine Administration record sheets (MARs) provided details of the person, their photograph, details of allergies and preferred way of taking their medicines. For example, for one person the MAR stated, 'Likes to be given his medicines from a teaspoon and with a glass of squash.' One person said they were given their medicines, "Same time every day."

Systems were in place to record the amounts of medicines received into the home. Medicines were stored appropriately and safely in each of the two floors within the home. Arrangements were in place to store medicines that required additional security and medicines that required cool storage. Records were also in place to record medicines that were disposed of.

Amounts of prescribed medicines carried over from previous months were not always recorded. In addition, homely remedies were being used. These are a small number of 'over the counter' medicines that GP's have agreed can be given for a limited time, without the need to obtain a prescription. The stock levels for these medicines on the first floor were not accurate. An audit of these medicines in use on the ground floor was completed in February 2018 and accurate records were in place.

Staff gave out medicines to seven people 'to take later.' They told us this was agreed with people who the registered nurse felt were safe to be left with their medicines. They told us they later checked and asked the person if they had taken their medicines. However, there was no risk assessment or risk management plan in place to support this practice. This was not in accordance with the provider's policy that stated, 'Staff should directly observe the taking of medication and medicines should never be left to be taken later unless clearly identified in the care plan. Following our visit, the registered manager confirmed they had stopped this practice until they had completed risk assessments and there were risk management plans in place.

Some people were prescribed topical creams that were applied to their skin. The registered nurse signed the MARs to confirm the creams had been applied although they told us they did not witness this procedure. They showed us guidance for care staff on topical MARs that showed how to apply the creams. Care staff were not expected to sign the records to confirm they had applied the creams. The registered nurse told us they signed the MARs without actually knowing if the creams had been applied as prescribed. This meant the effectiveness of the creams may not be accurately assessed because it was not always known how and

when they were applied.

One person had their medicines crushed and we saw the pharmacist had agreed this was acceptable for two specific medicines. The current MAR sheet for the person contained the standard pharmacy instructions that these two medicines were not to be crushed. The registered nurse was clear about how they gave these medicines to people. The provider's quality assurance systems had not identified the lack of person specific information on the MAR. This could have resulted in the medicines not being given in a safe way.

The registered manager assured us and provided information after our visit to confirm the improvement actions they had taken to make sure medicines were safely managed.

Where people were prescribed medicines to be taken PRN or 'when required,' such as pain relieving medicines, the records provided guidance for staff about the circumstances in which the medicines may be needed. For example one person's records stated, 'Will indicate if he is in pain ad is able to explain where the pain is.' This meant people could be confident they would receive these medicines when they were needed.

Staff had received safeguarding training and understood their responsibilities for keeping people safe from the risk of abuse. They were able to give examples of signs and types of abuse and discuss the steps they would take to protect people, including how to report any concerns. The care home had a whistle-blowing policy that provided guidance for staff on how to report concerns in the workplace. Staff told us they felt confident to whistle-blow if necessary.

Risk assessments were in place and most were reviewed monthly. These included risks associated with skin condition, choking, use of bed rails, falls, moving and handling, nutrition and dehydration. Where risks had been identified actions were planned, along with provision of equipment such as bed rails and pressure relieving mattresses. Some of the actions needed to include specific detail. For example for one person their falls risk management plan stated they were to be monitored 'At all times.' This did not accurately reflect the frequency of monitoring checks that were actually being completed. This meant people may not receive checks of the frequency needed because their records did not provide accurate information.

Accidents and incidents were recorded and actions taken to reduce future risks of injury. We spoke with people who had fallen and one person told us they had fallen twice when trying to be independent and go to the toilet unaided. They told us staff responded quickly to their call for help, had checked them over and they had not suffered any injury. A relative of one person told us the person no longer remembered they were unable to walk unaided, and this had resulted in them falling. The relative told us they had been informed by the care home staff.

The registered manager showed us the monthly review they completed for accidents and incidents, falls, unexplained bruising and skin tears. They told us how they looked for patterns or trends to make sure actions taken where needed. They gave an example of actions taken when one person had fallen on more than one occasion. The advice of a specialist nurse was sought and a sensor mat was put in place to alert staff when the person moved from their chair or bed.

Most people and relatives told us staffing levels were sufficient most of the time and staff responded to calls for help and support in a timely manner. People had access to call bells or wore pendants so they could call for support when needed. However, people and relatives also commented about the staff turnover and expressed concerns that staff they had got to know well, were leaving. We spoke with the recently registered manager and senior staff who told us about changes they were making in that they were moving staff around the home, so they became familiar with the needs of everyone. Staff were divided in their views

about the changes with comments ranging from, "It is so much better now. When I started I wasn't made welcome and I don't think the care was that good," to, "We don't like the changes and being moved from floor to floor."

The registered manager told us they had recruited successfully and they were less reliant on the use of agency staff then when they first started in post, just over a year ago. The provider's employed group of bank staff was also used on a regular basis, and as one senior member of staff commented, "It's so much better with our own staff, and we make sure we look after them too."

Staff were safely recruited. Staff files included application forms, proof of identity and references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Additional checks were completed to make sure registered nurses had current registration with their regulatory body, the Nursing and Midwifery Council.

The environment was maintained to ensure it was safe. For example, water temperatures, legionella control, electrical and gas safety, lift maintenance and hoist checks had been completed. Fire safety measures and checks were in place. Personal emergency evacuation plans were recorded for each person. They provided guidance about how people could be moved in an emergency situation if evacuation of the building was required. A business continuity plan was in place and this set out the procedures to be followed in the event of an emergency situation, such as power failure or significant equipment failure that caused significant disruption to the normal running of the home. This meant people could be confident their care needs would continue to be met in the event of such a situation occurring.

The environment was clean throughout. We spoke with two members of the housekeeping team who described their role and responsibilities. They told us about the cleaning routines and how the housekeeping team were allocated to different areas within the home. We observed staff using gloves and aprons when needed which showed good infection control practices.

A redecoration programme was in place. At the time of our visit, new flooring was being laid and corridors on the ground floor were being painted. Replacement kitchen flooring was planned and quotes had been obtained. This programme of redecoration showed the provider's commitment to investing and making continual improvements to the environment.

Good

Is the service effective?

Our findings

People told us they felt staff were knowledgeable and understood their needs. Comments included, "Staff know what I need and how I like things done, I have no problems with them at all" and, "Staff are good at their job. I believe they must have had good training. I often hear them talking about doing training." Staff told us they received sufficient training to enable them to carry out their roles.

When new staff started in post they completed an initial four day induction programme at one of the provider's local care homes and then shadowed colleagues to gain practical experience. The induction programme incorporated the care certificate, a national training process introduced in April 2015. This was designed to ensure staff were suitably trained to provide a basic standard of care and support. A senior member of staff told us how they provided additional support for staff during induction, to make sure the programme met their individual learning needs.

The registered manager told us one of their aims was to strengthen the planning of staff supervisions, and to make sure all staff had supervision meetings with their line manager on a regular basis. They told us they had identified improvements were needed. We looked at the supervision planning document for 2018 and saw plans were in place to make sure all staff were provided with regular supervisions with their line managers.

Staff told us they were provided with regular update and refresher training for topics such as fire safety, moving and handling, safeguarding, mental capacity act, infection control and food safety. In addition, where registered nurses needed training to meet the specific needs of people living in the home, they told us this was provided with one registered nurse telling us they had received, "Syringe driver, venepuncture and catheterisation training." They told us they also received support from other health professionals, and said a tissue viability nurse provided support for one person with a complex skin condition.

We received mixed feedback about the quality of the food served in the home. Peoples comments ranged from, "Food is lovely, if you don't like what is there they will cook you something else, you just have to ask," to, "The meals are constantly overcooked, the cabbage is usually soggy and the meat hurts my teeth. I have complained about it but nothing seems to change." When we observed meal service, we found the lunch time meal, which was a roast dinner, looked appetising and nutritious.

We observed meal service to people in the dining rooms and to people who stayed in their rooms. The dining room tables were laid in advance and meal service was unrushed with people being supported as they needed. On the first day of our visit, we brought to the attention of staff one person who struggled to eat their meal with a knife and fork. This meant their dignity was compromised. On the second day, the person was provided with adapted cutlery and ate their meal more easily. This meant the service responded and acted on feedback to make sure people's needs were met.

Where people needed softened or pureed food this was provided and staff were able to tell us about specific needs. In addition, a senior member of staff had complied 'Special diet' files that were kept in the dining

rooms. The files provided details about people's specific dietary requirements, such as textured diets, with supporting advice sheets. The files also contained details of peoples' drink preferences, such as for tea or coffee and whether they liked sugar in their drinks.

We observed one member of staff who asked people what they would like before they served drinks or spoke with the person to confirm their preference. We observed another member of staff who did not ask and placed drinks in front of people without asking what they wanted. Four people told us this often happened. They told us some, but not all staff just placed a drink in front of them without first asking what they would like and how they liked to take it. This meant there was a task led rather than personalised approach to care at times. We brought this to the attention of the registered manager during our visit.

Care plans contained nutritional assessments and people's weights were monitored. When people had lost weight, support and advice was sought in a timely manner. People were referred to the GP and prescribed supplements if needed. In addition, monthly records were maintained to enable the registered manager to effectively 'track' the progress of people who had lost or gained weight. One person commented, "They told me I was losing weight so the doctor came and prescribed special drinks." A relative told us, "They are not afraid to call a doctor. They do not leave anything to chance. They contact us to let us know too."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Consent to care and treatment was generally sought in line with legislation and guidance. People had been assessed for their capacity to consent to specific aspects of their care. When people lacked capacity to consent, best interest decisions were made in consultation with relevant others, such as relatives or GP's. People told us that staff asked before they provided support. One person told us "Staff know me well, we have a good relationship. They always ask me, they never tell me." "During our visit we saw and heard staff asking people for consent with questions such as, "Are you ready?" and, "Shall I help you?"

People who lack capacity can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm.

We found that the service had submitted DoLS applications for eight people that had yet to be processed by the local authority. A further three people had DoLS authorisations in place. We checked one authorisation with a condition in place. The registered manager was able to tell us how they had met the requirements of the DoLS condition.

Good

Is the service caring?

Our findings

We received positive comments and feedback from people using the service and from relatives. People told us they felt staff were caring. Feedback included, and, "I feel like they care here, they come sit with me and chat. That's all I want."

Throughout the two days of our visit, we observed people being treated in a kind and respectful way. Staff were helpful and friendly and people looked relaxed and comfortable in their presence. During meal service in the dining room, staff were attentive and we saw staff discreetly watching to make sure people who chose to eat independently, were managing their meal. One person looked to be struggling, due to their medical condition. A member of staff told us the person preferred to manage unaided and would ask for help if needed.

Staff clearly knew people well and were able to describe people's interests and preferences. One member of staff told us they knew one person long before they moved into the care home. They told us how they had spoken with the person and gave them the option of not being involved in their personal care. The member of staff had thoughtfully considered this may be embarrassing for the person. After a conversation, with lots of laughter, they agreed the member of staff would provide personal care for the person. Another person told us "I am never embarrassed when I am being seen to, even by male staff. I have surprised myself."

Everyone we spoke with told us that care staff were mindful of their privacy and dignity. We were told that staff always knocked before entering rooms. One person told us that staff, "Shut the curtains and door when giving me care." Care staff also told us they made sure people were fully covered and that others didn't enter rooms when they were supporting people with personal care. A senior member of staff told us how they focused on this aspect of care and supported staff during their initial training and induction to the home. They told us, "We show staff why it's important to provide person centred care and tell them, it could be their relative."

People's equality and diversity was recognised and respected. We heard staff referring to people by their preferred names, using appropriate volume and tone of voice. Staff tried to communicate in ways that were meaningful to people. One person whose first language was not English had communication boards and their weekly menu was given to them in their first language. A member of staff told us, "We always know what she wants and have got to know her really well." A relative of another person told us that staff were using a white board to aid communication although acknowledged this was not always successful due to the person having memory problems in addition to their hearing difficulties. Another relative told us, "They are kind and considerate here and try to engage with my [name of person] although it is difficult.

People's rights to a family life were respected. Visitors were made welcome at any time and some relatives chose to have meals with their loved ones on a regular basis. One relative told us, "They (staff) are all obliging. This is the best home I have ever come across and staff are the same. They do what's best for my [name of person receiving care] and have a way of encouraging her."

Staff reassured and offered support to people when needed. People told us they felt comfortable expressing their views, and as one person said, "I can speak to any of the staff. I am not scared to say if something is not right, which is rare, but there is one I would prefer to speak to and know I will be listened to. Our connection is special."

We read recent compliment cards and letters received in the home. They included the following, 'It was a great comfort for us to know she was safe and well looked after in the last few months of her life' and, 'To all who nursed and brought nourishment, comfort and understanding to our brother…for the months he spent at Field House where he told us he received all these things which he so very much needed and appreciated at the end of his life. We know he would have been so grateful and no doubt still is.'

Good

Is the service responsive?

Our findings

Before new people moved into the home they were assessed by the registered manager or senior staff to make sure their care needs were known. Electronic care plans were designed to reflect individual needs, choices and preferences. Care was well planned and records were checked and reviewed every month. People and relative told us they were kept up to date and involved when there were changes and in making decisions.

Care plans provided details of people's physical, mental, emotional and social needs. For example, one person's communication plan provided details of the difficulties the person experienced and noted the person paused and sometimes struggled during a conversation and they needed to be 'given time to respond to greetings or questions' and they, 'enjoy conversations with staff.'

At our visit in February 2017, we found accurate records were not maintained. At this visit, we found significant improvements had been made. We saw most charts that were fully completed. However, two people who were at increased risk of developing pressure ulcers required support to change position every two hours. Records showed gaps in the recording of these positional changes which we brought to the attention of the Deputy Manager at the time.

'This is me' records were incorporated into care plans and these were aimed at providing more personal and historical information about the person. In addition, laminated charts which were just being introduced when we last visited were now in place. These provided 'at a glance' information about people, likes and dislikes and things that were important to them. Staff told us these were useful especially for new staff who were still getting to know people and helped to initiate conversation with people.

People told us their preferences and choices were respected. They gave examples such as choosing when to get up and go to bed, what to wear and where to spend the day. One person also told us they had moved bedrooms three times at their request, and they were now settled in a room that met their individual needs and preferences.

We saw a range of activities were provided. On the second day of our visit, a volunteer group ran a 'pop up' playgroup in one of the lounges. People using the service joined a group of parents with babies and toddlers. There was lots of smiling and laughter as people held babies and interacted with the parents and the children. The activity organiser completed written reflections following group activity sessions and for one of the recent previous playgroup sessions noted, 'Session was very well received…They all got involved in both the cake decoration and children's games during the session and look forward to the next edition.'

The weekly activity programme for the week of our visit also included a visit from a harpist, seated dance class, art club, church service, arts and crafts and 'Saturday Night at the Movies.' The provider supplied a vehicle to enable people to be taken out of the home and the week following our visit a trip to Chew Valley lakes was planned. We were told by one of the activity staff they visited people who stayed in their rooms and provided activities of their choice, such as puzzles or quizzes. This was not always recorded and the

people we spoke with did not recall having participated in these activities in their rooms.

A complaints procedure was in place that was readily available to people and relatives. Everyone we spoke with told us they would feel comfortable to raise concerns if needed. We looked at the complaints file and saw that complaints managed in accordance with the provider's policy. One recent complaint related to food provision in the home. We received confirmation following our visit, of actions being taken to make improvements to the overall quality of food provision in the home.

Staff had discussed end of life plans and recorded what people wanted to happen if they became very ill. Relatives were involved in discussions about circumstances in which people may wish to be transferred to hospital or stay in the home, and when DNACPR's had been agreed. This is a way of recording a decision not to resuscitate a person in the event of a sudden cardiac collapse. We spoke with relatives of a person receiving end of life care. They told us they had discussions in preparation, and the care had been planned and was being given as the person wanted. The person looked comfortable and pain free at the time of our visit.

Requires Improvement

Is the service well-led?

Our findings

When we last inspected the home in February 2017, there was no registered manager in post. We found a lack of systems in place to identify shortfalls in record keeping. At this visit, there was a registered manager in post. We found sufficient improvements had been made and, overall, record keeping was more accurate and reflected current needs. However, we found further improvements were needed to make sure these improvements were sustained and consistent.

Systems were in place that identified shortfalls, a range of audits and monitoring checks were completed by the management team. However, shortfalls, such as those reported on in the safe section of the report, relating to medicines management had not been identified.

The chief executive explained how they had one overall improvement plan in place. This incorporated actions taken in response to the last CQC inspection, in addition to actions arising from shortfalls or areas for improvement identified within the provider's own quality assurance systems. The improvement plan included actions relating to policy and procedure updates, care plan audits, monitoring records, people surveys, and staffing levels. In response to our visit, further improvement actions were added to this plan. This showed the provider's commitment to making continuous improvements to the service.

The registered manager confirmed in writing to us the actions they had taken following our visit, to make sure people were safe. The registered manager must make sure they further develop robust systems to monitor the service and recognise where actions are needed to mitigate risks to people's safety and to make improvements.

People using the service and relatives spoke positively about the management arrangements. Most people spoke about the 'managers' rather than referring specifically to the Registered Manager. The management team had been strengthened since our last visit, and there was a registered manager, operations manager, head of care, deputy manager and care supervisor in post who formed part of the management team.

The provider's survey had not been completed since our last inspection. However, the operations manager, responsible for the management of the catering, housekeeping and maintenance staff devised and circulated theme specific surveys. They told us the most recent survey was about meal service. Following that survey it was agreed for feedback forms to be placed in each person's bedroom, to enable timely feedback to be provided.

People using the service and relatives were provided with opportunities to provide feedback at meetings. We read the minutes from the most recent meeting, held in November 2017, where a range of topics were discussed. They included a discussion about the actions implemented and changes made following the last CQC inspection. For example, they discussed how they were making improvements to people's care records.

Staff had the opportunity to express their views at general staff meetings. Minutes were recorded and

circulated. The registered manager told us they were making changes to improve consistency in the quality of the service people received. For example, they told us they had made changes to how care staff were allocated to make sure they became familiar with the needs of people throughout the home and not just in one area of the home.

The registered manager was able to tell us how they kept up to date with current practice. They also told us they attended clinical updates with the NHS and local authority and read nursing journals. The provider employed a registered nurse as a head of care quality who also provided up to date guidance and information for staff.

The registered manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.