

We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

One 2 One Private Care Services

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9QZ

Tel: 01233610542

Date of Inspection: 28 June 2013

Date of Publication: July 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓	Met this standard
Care and welfare of people who use services	✗	Action needed
Management of medicines	✗	Action needed
Requirements relating to workers	✗	Action needed
Assessing and monitoring the quality of service provision	✗	Action needed

Details about this location

Registered Provider	Ms Beverley Gregory
Overview of the service	One 2 One Private Care Services provides care and support to people who want to retain their independence in their own home. It is a small family run service providing services to people in Ashford and surrounding areas covering an approximate 10 mile radius. The office is open Monday to Friday 9am to 5pm. There is limited parking outside. The service contracts with the local authority and privately funded people.
Type of service	Domiciliary care service
Regulated activity	Personal care

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When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 28 June 2013, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We visited the office and spoke with the registered manager and two members of staff. We later spoke to four people who used the service, three relatives and four staff by telephone.

People spoken with told us they were satisfied with the service received and that their care was personalised to their needs. Care was delivered by a small team of care workers to ensure people had continuity. One person said, "They are very friendly, reliable and I have no problems". Another person said, "I really like the way they do my care, they are friendly". Most people were aware of their care plan folder, although not their care plan. We found that care plans lacked detail about people's needs, wishes and preferences. People confirmed that they had given their consent and been involved in discussions about their care, sometimes with a family member, when the service had first started. People said they got their medication when they should, although we found shortfalls in the systems to manage people's medication safely.

People felt that the service recruited the right calibre of staff. However we found shortfalls in recruitment procedures. One person said, "When one (staff) leaves, the new one shadows one of the other experienced ones before they take over". People spoken with told us they had been asked for their feedback on the service they received.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 10 August 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement

powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment

✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

People in receipt of care and support had been asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

People were able to make day to day decisions about their care and support. Most people had signed a consent form during discussions about their care and support with the manager. Care plans identified people's basic communication abilities, although were not signed by the person who used the service. People had given their written consent where the service held their keys, so that staff could gain access and people remained safe. Where people had arranged their care privately a contract was in place that had been agreed and signed by both the person who used the service and the provider. We saw that when people had made changes to their service this had been recorded and signed by the person who used the service. For example the duration of a visit.

The manager and staff told us that people who used the service had the capacity to make day to day decisions about their care and support. Staff talked about how people gave consent on a day to day basis. They talked about how they asked and talked through with people what care and support they intended to undertake on each visit in order to gain people's verbal consent. Some people had family members to support them with their decision making.

Some staff had received training in the Mental Capacity Act 2005 and the manager understood the procedure to ensure decisions were made that represented people's best interests, in line with the requirements of the Act. The manager told us that to date, there had not been any decisions required that people were unable to make for themselves. The provider may wish to note that not all staff had received training in the Mental Capacity Act 2005 and the service did not have information available for staff about people's rights. There was no information available regarding deprivation of liberty safeguards, also contained within the Mental Capacity Act, to ensure that staff were aware and acted in accordance with people's rights under the safeguards.

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People were not protected against the risks of receiving inappropriate or unsafe care, because there was a lack of care planning and risk management.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People's needs had been assessed. People said that the manager had visited them in their own home, to talk about what they could do for themselves and what they needed help with before they started to use the service. The manager told us they discussed with people what help they needed and any risks associated with their care and support. This helped give a picture of the person and made sure they would receive the right care and support. People said they were very happy with the care and support they received. They felt their care and support met their needs and was what they expected. One person commented, "You can't beat it, I've had a couple of agencies and this one is the best".

We looked at five care plan folders. Only two contained a care plan. The manager told us that care plans should have been present in the folders and that each person had a copy, which was held in the care folders within their own home. Most people confirmed that they had a care folder, although could not remember if they had a copy of their care plan. One relative told us "we have typed up a detailed routine, so the carers know what we want and the office also has a copy". The manager told us that another person who had started to use to service as an emergency, four days prior to the inspection, also did not have a care plan in place. None of the care plans viewed had been signed by the person who used the service, to confirm their agreement of the content. The care plan gave a very brief description of the tasks to be completed. They did not detail people's skills, wishes and preferences in relation to their personal care routines, or what support was needed from staff to help promote, or encourage their independence. For example, they stated "assist with showering and dressing". This lack of detail of people's skills, wishes and preferences meant care may not have been delivered consistently and in accordance with people's wishes.

Daily reports were made by staff and showed that the care which was delivered, reflected the care plan where one was in place, or the care package, which was described by the manager.

Care and support was planned and delivered in a way that did not always ensure people's

safety and welfare. We found that some risks associated with people's care were identified and guidance about how to reduce the risk was recorded, in order to keep people safe. For example, there were risk assessments in place for the environment, fire, falls, medication and moving and handling. However the actions necessary to reduce such risks were not always recorded. For example, where staff were involved in moving and handling people the action stated to reduce the risks was "supervision required" or "assistance is necessary". This did not inform staff how to move or handle the person safely, without risk to themselves or the individual. Some risks had not been identified or assessed. For example, there was no guidance for staff about how to recognise if a person became unwell, as a result of their diabetes. This meant there was a risk that the condition may not be managed safely or according to latest guidance.

We saw that although some care reviews had been undertaken by the manager, there was no evidence that this had included updating or reviewing care plans or risk assessments. We found that where the manager had had concerns about the care and welfare of a person that used the service, they had contacted the family involved, or appropriate health and social care professionals. For example, they were concerned that one person was not eating. They informed the family, who arranged for a health professional to undertake an assessment. The manager had also obtained some information about conditions people suffered. For example, we saw information about Parkinson's from the Parkinson's Disease Society.

Discussions with people who used the service confirmed that they received the support that they wanted. Staff told us that they encouraged people to do what they could for themselves, so that they could retain as much independence as possible with daily living tasks and skills.

People were complimentary about the way the care was organised. One person said, "When I have wanted to change the time of my call due to an appointment this is accommodated". The manager told us that when a person started to use the service they looked carefully to marry the person's individual needs with a member of staff. People said they knew or "mostly knew" who would be coming in advance. People said that staff arrived when expected and mostly stayed the full time, but always completed everything that was needed. People said the care and support was delivered by a small team of staff, to ensure continuity and consistency. One person said, "I only have one carer, I don't like lots of different ones, they are very punctual". Another person said, "They are very reliable I usually get two carers 99% of the time and a third one on a Sunday".

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines, because the provider did not have appropriate arrangements in place to manage medicines. There was insufficient guidance in place for staff on the use of some medicines.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There was a medication policy and procedure in place to provide guidance for staff on the safe management of medication. However this contradicted what the manager told us was happening, as it stated that medication administration records (MAR) charts should be ticked when medication had been administered. Staff told us, and we saw that the templates of MAR charts asked for staff to initial, which was good practice. The manager told us a new medication policy and procedure was to be implemented and discussed at a staff meeting within the following two weeks. We saw this procedure was more in-depth and followed good practice.

Most people we spoke with did not receive help with their medication. One relative told us the care workers gave their family member medication each evening, but they were not sure what records were made of this. The manager told us that only two people who used the service had assistance with their medication. We saw that a medication risk assessment had been completed, which detailed staffs involvement in people's medication administration. However we found that other people were prescribed creams, which were applied by the staff. The manager told us that at the time of the inspection MAR charts were not in place for any prescribed creams, which meant that staff were not following the correct procedure for these prescribed medications. Staff had usually recorded in the daily notes they had applied the cream, but there was no record of what cream had been applied, or where the cream had been applied. There was no written guidance in the care plans to detail what creams should be used, when and to what areas, which leaves people at risk, as they may not receive their medication safely, according to the prescribers instructions.

Two staff spoken with told us they were involved in medication administration, but both used different methods for recording that people had received their medication. Staff spoken with said they had either not received training, or that any training had taken place some years ago. Staff said the manager "had shown them what to do". The manager told us that only two of the staff team had received training in medication administration. The

manager said that one staff member who was regularly involved in handling medication, but had not received training, had had the procedure explained to them by the manager, who had then checked their competency. This lack of training posed a risk for people, where staff may have had to administer medication and did not know how to do this safely.

A list of people's prescribed medication was included in their care folders. Although in two cases this did not contain details of prescribed creams. No completed medication administration records were available during the inspection, so we were unable to ascertain from records that people had received their medication when they should and in the correct dose.

The manager told us one person who had recently started to use the service was prescribed a medication "as required", but at the time of the inspection none had been administered by staff. However, there was no written guidance in place detailing what the medication was for, when it should be given and in what doses. There was no indication about the period of time it should be used for and what action staff should take if it continued to be administered, to ensure it was administered in a safe way.

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was not meeting this standard.

Recruitment checks were not completed as robustly as required, which could leave people who used the service at risk.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People felt that the service recruited the right calibre of staff. Comments included, "They seem to be good". "Mine are absolutely fine". "Ninety-nine per cent of the time, yes" they recruit the right calibre. "It's like having an extended family".

We looked at three staff files for the purpose of checking compliance on staff recruitment. The files showed that there was not an effective recruitment and selection process in place to help ensure that staff who were employed were safe to work with vulnerable people.

The regulations required that certain information be obtained from people seeking employment at the service, in order to check their fitness to work with vulnerable people. This included a recent photograph, proof of identity and health declaration. We found that the files contained this information. However other information required was not present on files, or had been obtained after an employee had started working at the service. For example, two references from previous employers were dated after the employees had started working at the service.

Prospective employees must provide a full employment history, together with a satisfactory written explanation of any gaps in employment. We found that there were either gaps in employment history with no explanations, or no dates had been recorded against each previous employment, so the provider had been unable to check that it was a full employment history. In discussion with the manager they told us that they were not aware that a full employment history was required and the application form did not ask for this. This meant the provider had not undertaken thorough checks, in order to protect people who used the service.

Providers were required to obtain a disclosure and barring service (DBS) check (formerly a Criminal Records Bureau (CRB) check) before employees worked with vulnerable people. In emergency circumstances providers could obtain an Independent Safeguarding Authority (ISA) Adult First check, whilst waiting for the staff member's full DBS. The Care Quality Commission had issued guidance for the arrangements that must be in place,

when a member of staff was working in this way, in order to protect people who used services. We found that the manager was not aware of these arrangements and they were not in place.

We saw that one staff member did not have a CRB, or DBS check carried out by the provider. We saw that two files contained CRB checks that were dated after the staff members had commenced their employment with the service. We found that ISA Adult First checks had been undertaken, but were also dated after the employee started working for the service. The manager told us that employees had not worked alone with people who used the service as they had worked with them. However, one staff member had worked for a period of seven months and there were no records that people who used the service had been consulted and agreed to this arrangement, in order to protect and safeguard their rights.

There was a requirement under the regulations to check a job applicant's reason for leaving their previous employment, where they had been employed working with children or vulnerable adults. We found that this information was not always recorded.

Interviews were carried out by the manager. As part of the interview process staff undertook a competency test, which included areas such as recording and reporting. Staff also undertook an induction period, which included shadowing the manager. Staff told us they were also introduced to people who used the service, before they worked with them on their own.

Assessing and monitoring the quality of service provision

✘ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People who used the service said they were asked for their views about their care and support and they were acted on. The manager told us that they undertook a review of care after three months, a client feedback questionnaire after six months and then annually with the person who used the service. Records showed that during both these processes people had the opportunity to feedback their views about the service they received. We saw that all the comments were very positive. One person had commented, "I am 100% satisfied with the service being provided". Where people had raised issues appropriate action had been taken by the manager. For example, one person was not managing in the time that care workers were allocated for the visit and we saw that the duration of their visit was increased.

The manager told us that the majority of quality monitoring was undertaken informally. They said that they visited people that used the service to manage risks and resolve any concerns at an early stage. However these visits were not recorded. Staff supervision was undertaken informally by the manager who worked with care workers to ensure they met people's needs, but again these supervisions were not recorded. Records showed that annual appraisals were undertaken and occasional staff meetings were held.

Effective systems to identify, assess and manage the service against the regulations and published guidance were not in place. The service did not have any audits and checks in place to identify the shortfalls as evidenced during the inspection. We found that the manager was not aware of the services' responsibilities under the regulations. For example, they did not know what information was required to be obtained in respect of a person seeking employment. Although staff had received some training there were no systems for ensuring that staffs' knowledge and training remained up to date with the law and current guidance. This lack of effective systems left people at risk of inappropriate or unsafe care.

A complaints procedure was in place and people had received a copy of this. The

manager told us that a new complaints procedure would be introduced within the following two weeks. The new complaints procedure was more detailed and included details of the local government ombudsman, should people not be happy with how their complaint had been investigated. We saw that a record of any complaints was kept, although none had been received since the last inspection. One person said, "They have told me if I've got any problems just tell them". Another person said, "one time I had an issue with the bill, but it was sorted straightaway".

This section is primarily information for the provider

✘ Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</p> <p>Care and welfare of people who use services</p> <p>How the regulation was not being met:</p> <p>People were not protected against the risks of receiving inappropriate or unsafe care, because there was a lack of care planning and risk management. Regulation 9 (1)(b)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</p> <p>Management of medicines</p> <p>How the regulation was not being met:</p> <p>People were not protected against the risks associated with medicines, because the provider did not have appropriate arrangements in place to manage medicines. There was insufficient guidance in place for staff on the use of some medicines. Regulation 13</p>
Regulated activity	Regulation
Personal care	<p>Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010</p> <p>Requirements relating to workers</p>

This section is primarily information for the provider

	<p>How the regulation was not being met:</p> <p>Recruitment checks were not completed as robustly as required, which could leave people who used the service at risk. Regulation 21(b)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</p> <p>Assessing and monitoring the quality of service provision</p> <p>How the regulation was not being met:</p> <p>The provider did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others. Regulation 10(1)(b)</p>

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 10 August 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

 **Met this standard** This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

 **Action needed** This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

 **Enforcement action taken** If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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