

Carewatch Care Services Limited

Carewatch (Morpeth)

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Carewatch Morpeth provides personal care and support to people in their own homes. This inspection took place on 17, 18 and 25 May 2017. The first day of the inspection was unannounced. The subsequent days were announced. The Morpeth branch of Carewatch registered in December 2016 and this was the first inspection at this location.

At the time of the inspection, the service was actively providing care to 311 people in the Morpeth, Alnwick, Rothbury, Heddon and Ponteland areas.

A registered manager was 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.

The registered manager had previously worked between two sites, but changes made in the organisation meant that at the time of the inspection, they were based full time at the Morpeth office.

We checked the management of medicines and found the procedures were not always followed. There were gaps and errors in medicine records. Before we finished our inspection, quality officers reviewed medicines and records in people's homes to ensure information was accurate and up to date. Additional medicines training was arranged for staff.

Risk assessments relating to individual risks to people, were not always completed or did not contain sufficient detail. Hard copies of risk assessments were not always available in people's homes, although staff were sometimes sent this information securely to their work telephone. Some were generic in style and therefore liable to misinterpretation by staff. We did not observe any unsafe practices. Environmental risks in people's homes had been assessed. Records of accidents and incidents were maintained and we observed staff reporting concerns about people's safety to the office.

Care plans were also lacking in detail and were not always available in people's homes. The registered manager confirmed that they had a backlog of care plans for completion, and in the meantime had increased the amount of information and level of detail they sent electronically to staff.

Systems of audit and quality monitoring had not picked up all of the issues we identified although the manager and deputy had already begun addressing some of the concerns we raised.

Staff had received training in the safeguarding of vulnerable adults. They were aware of how to report concerns, and safeguarding records were clear and detailed. Safe recruitment procedures were followed, which helped to protect people from abuse. The service had experienced some issues with staffing although this had improved. There continued to be some issues with recruitment in more rural areas. Some staff told

us they often worked long hours. The registered manager and deputy told us they were in the process of reviewing staff rosters and introducing a shift system to avoid staff working long days and working split shifts.

Staff were aware of infection control procedures and were praised by people and their relatives for their cleanliness and always tidying up after themselves. Staff wore gloves and aprons when necessary, for example while preparing food.

Records relating to capacity and consent were not always fully completed. This meant that we could not always evidence that the service was operating within the principles of the Mental Capacity Act 2005. We did not observe, nor were we made aware of any restrictive practices during our inspection. Staff were observed to seek consent and supported people to make decisions about their care.

Staff received regular training, and attended an in depth induction before starting work. They also shadowed more experienced staff before working unsupervised. Training was provided to staff which was relevant to people's specific health needs or specialist equipment in use, and this was carried out by professionals where necessary. Staff competency was also assessed and recorded. We identified that some staff would benefit from further dementia awareness training, as a number of relatives expressed that they felt some staff appeared to have a better understanding of the condition than others. We have made a recommendation about this.

Quality officers carried out field based observations and 'spot checks', where staff were unaware they would be visiting them. Staff also told us they felt well supported by office staff and could contact them if they had any questions.

We observed people being well supported with eating and drinking. Records regarding the level of support people required were not always sufficiently detailed.

Feedback we received from people and their relatives about the care staff was extremely positive and complimentary. We observed that care staff were kind, patient and courteous. Despite working within tight timescales, people told us, and we observed, that staff didn't rush people and supported them in a calm unhurried manner.

Staff we observed were very responsive to the needs of people and appeared to know them well. We observed habits and routines that staff and people had developed which meant that care was provided in the way the people preferred. A lack of documentation of these meant there was a risk that unfamiliar staff may not know about these if they visited, particularly at short notice to cover absence.

We received mixed feedback about the reliability of the service, and there appeared to be geographical variations in relation to this. Some people and their families told us that staff were very punctual and that they were rarely late. Other people explained that the times of visits could vary greatly, which meant that planning and personal routines or preferences could be impacted upon. We were told however, that there had been improvements in the consistency and reliability of the service and there was acknowledgement that the registered manager was trying to address this. We have made a recommendation that the timeliness of calls and the consistency and numbers of staff involved in each package remains under close review.

A complaints procedure was in place and the complaints log was up to date and contained detailed information including responses, outcomes, and lessons learnt. Responses had been provided to people

within the timescales outlined in the policy, and where this wasn't possible, people received a holding letter explaining why there was a delay. We read a number of compliments that had been received in the last 12 months. These had been passed on to individual staff where appropriate and recorded in their personnel file.

Feedback systems were in place where the views of people, relatives and staff were sought.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

Not all aspects of the service were safe.

Medicines were not always managed safely. We found gaps and errors in medicine records.

Risk assessments regarding specific risks to people were not always fully completed and some information contained within these was ambiguous and unclear to staff. Environmental risks were assessed and recorded.

Safe recruitment procedures were followed. The provider had experienced difficulties recruiting in rural locations but staffing numbers had increased.

Staff had received training in the safeguarding of vulnerable adults, and knew how to report concerns. They were aware of infection control procedures.

Is the service effective?

Requires Improvement ●

Not all aspects of the service were effective.

We were not able to evidence from the records we checked, that the service was working fully within the principles of the Mental Capacity Act (2005).

People were supported well with eating and drinking by staff during our inspection although written instructions regarding people's dietary needs were not always sufficiently detailed.

People and relatives told us staff were competent and capable to carry out their roles. Staff told us, and records confirmed they received regular training and an in depth programme of induction when they commenced employment.

Is the service caring?

Good ●

The service was caring.

People and their relatives provided very positive feedback about the kind, caring, warm and friendly approach of staff. We

observed staff caring for people and the close yet professional relationships they had formed with them.

People were encouraged to maintain their independence and staff were unhurried in their approach while supporting them.

The privacy and dignity of people was maintained, and we observed staff offering support discreetly and sensitively.

The service provided care to people at the end of their lives and support and training from nursing staff was sought where required.

Is the service responsive?

Not all aspect of the service were responsive.

Care plans were not always in place and provided in hard copy in people's homes. Information was sent securely to staff via their work mobile telephones but this was not always sufficiently detailed.

Care plans that were in place were not always sufficiently detailed or person centred which meant they did not adequately record people's individual likes, dislikes, interests and preferences.

There were mixed reports about the reliability of the service which appeared to vary between geographical locations. There were no missed visits reported.

A complaints procedure was in place and records we viewed showed that complaints had been responded to in line with the organisation policy. A number of compliments had also been received.

Requires Improvement ●

Is the service well-led?

Not all aspects of the service were well-led.

Care records including care plans, risk assessments, medicines and mental capacity records were incomplete or insufficiently detailed.

Quality assurance systems had not picked up all of the issues we had identified.

People, relatives and staff told us the service was not always well organised. Action had been identified by the registered manager

Requires Improvement ●

to improve the consistency and reliability of the service.

Feedback systems were in place to seek the views of staff, people and their relatives about the quality of the service.

There had been recent changes within Carewatch which meant the registered manager was able to base themselves full-time within the Morpeth branch.

Carewatch (Morpeth)

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 17 May 2017 and was unannounced. This meant the provider and staff did not know we would be visiting. We also visited on the 18 and 25 May 2017. These visits were announced. The inspection team consisted of two adult social care inspectors 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 care service.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us.

We looked at 23 care plans, and sampled medicine administration records. We looked at eight staff files, and a variety of records related to the quality and safety of the service. We spoke with 12 staff, 22 people who used the service and 12 relatives.

We contacted the local authority commissioning and safeguarding teams. We took the information they gave us into account when planning this inspection.

Is the service safe?

Our findings

People told us they felt safely cared for. One person told us, "I have a shocking balance problem. The carers are very, very, helpful. I couldn't manage things without them; they make me feel safe."

A policy and procedure was in place for the safe handling of medicines. Staff received annual medicines training and assessments to ensure their competency to administer medicines safely. On the second day of the inspection we visited people at home and found that safe procedures for the administration of medicines were not always followed. We found gaps in medicine administration records (MARs). This meant it was not always possible to ascertain if medicines had been given as prescribed. We also found that some medicines to be given once a day had been signed for twice. We were advised that this was an error and that people had not been given more than the prescribed dose. Before the final day of our inspection, quality officers visited the people we identified and had reviewed medicine records and spoke with staff. They ensured clear instructions were available for staff and identified training needs. Additional training to support staff to administer medicines safely had been arranged. The registered manager informed the local authority safeguarding team about the errors identified.

Care plans and risk assessments were not available in each home, and risk assessments that were in use were not always correctly completed or were generic in style, and therefore liable to misinterpretation. They also lacked detail in some cases therefore staff were not always clear about the action they should take in certain circumstances.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe Care and Treatment.

Environmental risks were assessed to ensure the safety of staff working into people's homes. This included an assessment of environmental hazards such as tripping, poor lighting or pets present in the home. We observed staff caring for people and did not observe any unsafe care practices.

The registered manager told us they had recruited new staff but acknowledged they had difficulties recruiting and retaining staff in rural areas. People and their relatives told us they always received their visit but that the times of these varied daily and their visits were often carried out by multiple staff members. We spoke with the registered manager about this who told us staffing was improving, and they were looking closely at the deployment of staff to try to improve the reliability and consistency of call times and reduce the number of care staff visiting.

Safe recruitment procedures were followed. We checked staff files and found that application forms had been completed, and gaps in employment history had been checked. Checks were carried out by the Disclosure and Barring Service (DBS) prior to staff commencing employment. The DBS carry out checks on the suitability of applicants to work with vulnerable people, which helps employers to make safer recruitment decisions. DBS numbers to evidence these checks had been carried out were not held in all staff files, but were provided later. These checks had been completed but were not immediately filed.

Staff had received training in the safeguarding of vulnerable adults and knew what to do if they suspected abuse or mistreatment. Safeguarding records held in the office clearly documented concerns, and recorded what action had been taken, and noted any learning points.

Accidents and incidents were recorded. One person told a staff member that they had fallen when they were on their own the day before but hadn't mentioned it to staff. The staff member checked they were okay and explained they would need to report this to the office, because although they said they were unhurt, bruising or ill effects might appear later. We observed the staff member reporting this to the office.

Staff received training in infection control, and we observed them using the correct equipment such as aprons and gloves during our inspection. People and relatives we spoke with told us staff cleaned up after themselves and followed the correct procedures to maintain health and good hygiene.

Is the service effective?

Our findings

People and relatives were complimentary about the standard of care provided. They told us staff were capable of carrying out their jobs to a good quality. One relative told us, "We are very happy, everything is good and I have no complaints, just very happy." Another relative told us, "I think she is very safe with the staff, she normally has one of three carers and they also liaise with the district nurse so there is good communication all round."

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

Records did not always reflect that the provider was working within the principles of the MCA (2005). Documentation related to people's mental capacity was inconsistently completed. Some people, who were deemed to have capacity, had their care plan signed by a relative or representative. Care records included a section entitled, "How do I make decisions about my day to day care support?" This was completed in some files, but in others was left blank. This meant there was no record in some care records about the level of daily support required.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

During our inspection we observed staff seeking consent, and did not observe any restrictive practices. Staff were aware of the level of support people needed and decisions they were able to make, although these were not always recorded. Unfamiliar staff would not necessarily be aware of this information.

Training considered mandatory by the provider was delivered to staff annually. This included training in health and safety, moving and handling, and infection control. We checked the training matrix and found that 74% of all mandatory training had been completed, and plans were in place for further training to be delivered. A five day induction course was provided to all staff followed by a period of shadowing more experienced staff. We spoke with a new staff member who told us, "The training was amazing, I couldn't have asked for anything better." Quality officers also visited new staff in people's homes to assess their performance. All staff we spoke with confirmed they had completed 25 hours shadowing experience. One staff member told us, "I found the shadowing useful, to get to know people and how different people like to be cared for." People using the service told us new staff shadowed more experienced members of staff when they began working for the provider. Records of the shadowing period were not always fully completed or signed by the quality officer or employee. We spoke with the registered manager about this who told us they

would ensure these were completed by all parties following induction.

A supervision and annual appraisal system was in place. Quality officers carried out visits to staff while they were working. One staff member told us, "Yes we have supervision, the quality officers carry out field observations and spot checks." Some staff told us they hadn't been visited yet but were new to the team.

Specialist training was provided to staff as required. We observed staff caring for people who required nutritional support via Percutaneous Endoscopic Gastrostomy (PEG). PEG is a form of specialist feeding where a tube is placed directly into the stomach and by which people receive nutrition, fluids and medicines. We observed that staff were knowledgeable about the procedures to follow and confirmed they had received training from a nurse and had their competency checked to ensure they were able to provide safe care. Staff confirmed they received other specialist training as required. One staff member told us they had received epilepsy training to help them to support a person they cared for. Another told us they had received training from a stoma nurse prior to supporting a person with a colostomy.

Through speaking with relatives and staff, we identified that some staff would benefit from more training in relation to supporting people living with dementia, particularly in relation to encouraging people with eating or bathing. This was particularly important when supporting people who lacked insight into the level of help they needed. We spoke with experienced staff who described appropriate strategies to encourage people to accept help, which demonstrated a degree of skill and detailed knowledge of people. Relatives told us that some staff had a better understanding of the condition than others. We discussed this with the registered manager and deputy manager who said this was something they planned to develop further, including the introduction of more detailed care plans and additional training.

We recommend that training to meet the person centred care needs of people living with dementia is provided to all staff.

People were supported with eating and drinking. We observed staff supporting people sensitively and discreetly during the inspection. One staff member told a person, "I'll get you some fresh water; that has been there since this morning." A relative told us, "[Relative] has been well supported by [staff member]. It was their idea to cut the crusts off their sandwich and they have been managing so much better." Dietary advice was followed, although as outlined, some training needs were identified in relation to supporting people with cognitive impairment. Where required, records of food and fluid intake were maintained. Meals that were prepared by staff were very well presented. Two people needed their food cut into small pieces, and we observed that staff were aware of this.

Written instructions to staff regarding dietary requirements were not always clear. We spoke with the registered manager about this who confirmed they had clarified that they had the most up to date information available, and were awaiting new care plans for some people which had been delayed by the cyber (computer hacking) attack affecting NHS computers. They were able to send updated information to staff electronically on their work telephones.

People were supported with health needs, and a range of professionals supported people where necessary. We observed staff reporting health concerns they had about a person to the office following a visit, and recording this in daily notes.

Is the service caring?

Our findings

The feedback we received from people and their relatives was very positive. People and their relatives told us that staff were caring, helpful and respectful. Comments included, "We get on very well with the carers, two in particular are very good, and really caring", "We are all friends now; they fully understand me" and, "They work hard to help me maintain my independence and my self-respect."

We observed staff during our visits to people's homes. We saw that they were polite and friendly and took their time while supporting people. A number of people and their family members told us they never felt rushed and that staff took their time. We observed staff being attentive and checking how people were feeling. One staff member who was returning to someone they had visited earlier, asked how they were feeling because they had a headache earlier in the day.

They also told us staff encouraged people to maintain their independence. One person told us, "They always clear up after themselves, and they encourage me to do what I can for myself, they don't rush me they are very good." A relative told us, "The carers are all very good, they encourage him to maintain his independence, they never rush him and they talk with him, I think he enjoys their company." Another said, "They encourage him to do everything for himself, including cooking and housework, he is getting on very well, and he enjoys their company."

Staff were aware of the need to maintain privacy, dignity and confidentiality. One person told us, "I can trust them, I feel safe with them and they are very confidential." We observed that staff knocked on people's doors, and checked with them if they minded us accompanying them before inviting us in. We were not present during any personal care, but staff told us they were aware of the need to maintain people's dignity at all times. Some people had specifically requested a particular gender of staff member to support them. We found that this had not always been provided, due to staff shortages or absence. We spoke with the registered manager who was aware of this issue and had taken steps to improve scheduling to try to avoid this happening in future.

We observed staff and people joking together, and warm caring relationships. One person said, "I'm over the hill!" The staff member replied, "No you're not, you're still under the hill." Another person told us, "We are getting to know each other. They know my sarcastic ways. I like a bit of banter, it keeps me going." A member of staff told the person they were visiting, "I'll be back tonight" the person answered, "Roll on tonight!"

We overheard calls between office staff and staff, and found that office staff also frequently demonstrated a caring approach to people. A staff member contacted the office to say they were unable to locate daily records, which might have been moved by the person they were supporting who was living with dementia. The office staff member offered suggestions but told the staff member not to go looking for the paperwork if this in any way caused the person distress.

Staff supported people who were approaching the end of their lives. They received training in end of life

care, and were supported by district nurses when necessary.

There was no one using the services of an advocate during our inspection, but the registered manager told us they were aware of how to arrange this if they felt anyone required this. An advocate supports people to express their views and helps to protect their rights.

Is the service responsive?

Our findings

We checked care files in the office, and people's homes. We found care plans were not always fully completed or not available in hard copy in people's homes. Staff and the registered manager told us that staff were always given information via their work telephone prior to visiting new people. They said that more detailed information had been sent to staff in this way more recently.

Some staff told us they received sufficient information to support new people receiving the service effectively. Other staff told us they were concerned about the lack of care plans available in people's homes and they were aware that there was a backlog of care plans requiring completion. We observed staff delivering individualised care that was person centred, but this was not recorded in the person's care plan. For example, one person asked the staff member "Is my toddy in my bedroom?" The staff member replied, "Yes, I haven't forgotten." They explained that the person liked to have a glass of whisky and tonic in their bedroom each night. This was not recorded in their care plan to enable unfamiliar staff to be aware of this.

The registered manager and deputy manager confirmed they were working through the backlog of care plans and in the meantime had increased the amount of information sent to staff securely by telephone. Care plans which were in place had gaps in key pieces of information which meant they were not always person centred. A "This is Me" section was used to record things that were important to people, including pets, pastimes, hobbies and interests, likes and dislikes, important dates and events. We found that this section was frequently left blank or was unavailable. This meant that person centred care plans were not in place to enable staff to support people in the way they preferred. We spoke with relatives who told us they were keen to contribute to the care planning process, but did not feel they had sufficient opportunity to do so. Other relatives told us they had read care plans and had been involved in reviews but this was inconsistent.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

We had mixed feedback about the responsiveness of the service. Some people and their relatives told us that lateness and erratic timings of calls could be an issue. This also impacted upon people's routines and preferences and was directly attributed to organisation and planning. This appeared worse in particular geographical locations. One relative told us, "They should be finished well before the nurse arrives, but sometimes they are still there because of their time keeping", another told us, "They always turn up, but not always on time", and "Oh it's just higgledy piggledy, the times are erratic."

Other people and their relatives reported that staff were punctual. One person said, "They are normally on time, and they have never missed a call." Another told us, "Their timekeeping is normally very good, it's very rare they are late." Relatives told us, "Their punctuality has improved, they are usually on time for her calls, which is very important" and "Routine is important and the company send him a rota each week, and it is normally true to the letter." A number of people commented upon a recent improvement in this area.

We spoke with commissioners who told us they were aware that the service was very busy in some areas in particular due to their being a lack of domiciliary care provision in that locality. There had also been an increase in the number of people requiring support, due to the closure of another service. We spoke with the registered manager about this who was aware of these concerns and had plans in place to address these. There were no missed calls reported.

We recommend that the provider continues to closely monitor the punctuality of calls.

A complaints procedure was in place, and people and their relatives told us they knew how to make a complaint. One relative told us, "I haven't had to complain but would know what to do. If I wasn't happy, believe me I wouldn't hesitate to complain." Another relative told us, "The company took on board everything we asked for and delivered."

We reviewed records of complaints received and found these had been responded to in a timely manner in line with the provider's policy. Where there was a delay due to further investigations, a letter was sent to the complainant explaining this and reassuring them their complaint was being dealt with. Complaint responses were detailed and recognised lessons learnt. They also included action taken to address concerns. Some complaints were still under investigation at the time of the inspection and we have asked to be notified of the outcome of these.

A record of compliments about the service was kept. There had been 20 compliments received from people who used the service, their relatives and professionals since January 2017. These included praise for individual carers; which was then passed on to them by senior staff.

Is the service well-led?

Our findings

People and their relatives told us that not all aspects of the service were well led. There were numerous concerns raised about the organisation and management of the service. One person told us, "The staff are very good, well organised and capable but I think the company just flies by the seat of its pants." A relative told us, "The firm I don't think an awful lot of, but the care staff are really lovely." Some people told us they had noticed an improvement in this area, and comments included, "I think they are trying to improve, we have noticed some improvement."

Records, including risk assessments, care plans, staff records and those related to mental capacity and consent were incomplete and varied in quality. Quality assurance systems had not picked up all of the issues we identified, including those related to the safe administration of medicines. Quality officers were in post, but required additional support from the registered manager to oversee their work and ensure they were fully able to meet the demands of their role.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

We spoke with the registered manager and deputy who agreed that improvements were needed and confirmed they had been working towards addressing a number of these issues. During the inspection, the registered manager confirmed that they had moved staff responsible for planning and coordinating visits to their Newcastle office, to ensure they were able to work undisturbed and could focus solely on that aspect of their work.

There had also been recent changes within the company which meant that the registered manager would no longer be working across two services and would be focusing solely on the Morpeth Carewatch branch. They felt confident that this would enable them to make the necessary changes to improve the service.

Most staff told us they felt well supported by the managers and office staff. One staff member told us, "If I am ever unsure of anything, I can call the office and they are very helpful." Another staff member told us, "I feel well supported. The office staff are helpful. I have no issues, I would ask and they would help." Other staff told us they had raised concerns about the number of hours they sometimes had to work, or the fact that they sometimes had to start early in the morning, have a gap through the day, and then go back out until 10pm. We spoke with the registered manager and deputy manager about this and they showed us plans they had in place to introduce a system of early and late shifts, to reduce the numbers of long days worked, and split shifts.

Feedback systems were in place. Staff told us they had completed a survey via email, and people and their relatives told us they had filled in questionnaires about the quality of the service. They also told us that office staff contacted them periodically to ask if they were happy with things, which they appreciated.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Procedures for the safe and proper management of medicines were not always followed.</p> <p>Regulation 12 (2) (g)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Records were not satisfactorily maintained in relation to care plans, risk assessments, and MCA. Systems to monitor the quality and safety of the service had not picked up all the shortfalls we identified.</p> <p>Regulation 17 (1) (2) (b) (c)</p>