

Bristol City Council

# East Bristol Intermediate Care Centre

## 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

This inspection took place on 26, 27 and 28 April 2016 and was unannounced. The last comprehensive inspection took place on 15 April 2014 and at that time there were no breaches of the legal requirements.

East Bristol Intermediate Care Centre is a multi-disciplinary service operated by Bristol City Council consisting of two teams. A feature of the service is the multi-disciplinary approach with the service having rehabilitation workers, physiotherapists and occupational therapists within the teams. One team is registered to provide personal care and accommodation for up to 17 people who are receiving a reablement service at East Bristol Intermediate Care Centre. There were 11 people living at the service during the inspection. The second team is registered to provide domiciliary personal care to people who are receiving a rehabilitation and reablement service in their own homes. The client group changes frequently as both teams offer a short term service over a six week period.

The purpose of East Bristol Intermediate Care Centre is to provide people with the opportunity, motivation and confidence to regain some of the skills they may have lost as a consequence of poor health, disability, impairment or accident.

The service had a registered manager for the domiciliary team and there was an acting manager in the reablement centre who had applied to register with the Commission. 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.

There were not suitable arrangements in place for the safe administration of people's medicines.

The provider had quality monitoring systems in place which were used to identify required improvements to the service. These systems were not fully effective.

Staff demonstrated a detailed knowledge of people's needs and had received training to support people to be safe and respond to their care needs. We have however made a recommendation about staff training on the subject of dementia.

Care provided to people met their needs. However, some care records provided basic information and did not provide personalised information about how to support people.

The staff had a variable knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely.

There was a robust staff recruitment process in operation designed to employ staff that would have or be able to develop the skills to keep people safe and support individuals to meet their needs.

People had their physical and mental health needs monitored. The service maintained daily records of how people's needs were met and this included information about medical appointments with GP's and dentists.

There were positive and caring relationships between staff and people at the service. People praised the staff that provided their care. We received positive feedback from people's relatives and visitors to the service. Staff respected people's privacy and we saw staff working with people in a kind and compassionate way when responding to their needs.

There was a complaints procedure for people, families and friends to use and compliments were also recorded.

We found two breaches of regulations at this inspection. 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?

The service was not always safe.

Improvement was required in relation to processes for the administration of medicines and PRN (as required medicine) protocols.

Risk assessments were reviewed and amended appropriately when the risk to a person altered.

People were protected from the risk of abuse. The service had provided staff with safeguarding training. They also had a policy and procedure which advised staff what to do in the event of any concerns.

The service had safe and effective recruitment systems in place.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

Not all staff had received regular supervision.

People were supported with their nutrition and hydration and accurate records were maintained where required.

The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS).

**Requires Improvement** ●

### Is the service caring?

The service was caring.

People told us staff were kind and caring. Relatives said they were happy with the care and support provided.

People were supported to maintain relationships with their family.

Relatives spoke positively about the support provided by staff. Staff understood people's needs and preferences.

**Good** ●

### **Is the service responsive?**

The service was not always responsive

Care plans did not always provide staff with the information needed to provide person centred care.

Staff communicated effectively with people and involved them to make decisions about the support they wanted.

The service had involved other professionals to support people and they were supported to access health care services.

The service had a robust complaints procedure.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

Although the provider had put quality assurance systems in place these were not fully effective.

People told us staff were approachable and said they could speak with the manager or staff at any time.

**Requires Improvement** ●

# East Bristol Intermediate Care Centre

## **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.

The inspection took place on 26, 27 and 28 April 2016. This was an unannounced inspection and was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report.

We also viewed all information we held about the service including statutory notifications. Statutory notifications are information about specific important events the service is legally required to send to us.

As part of our inspection, we spoke with fourteen people who used the service, two visiting friends or family, the registered manager and six members of staff. We tracked the care and support provided to people and reviewed five support plans relating to this. We also looked at records relating to the management of the home, such as the staffing rota, policies, recruitment and training records, meeting minutes and audit reports. We also made observations of the care that people received.

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

# Is the service safe?

## Our findings

The service did not have suitable arrangements in place for the administration of people's medicines.

We saw gaps in Medicine Administration Records (MAR) where records had not been completed. It was not apparent from the records if the medicine had been administered and the record not completed, or if the medicine had not been taken. In addition to this, the domiciliary service MAR did not always specify which medicines were being provided and medicines were described as 'dosette additional meds', 'boxed meds' and 'dosette' boxed meds' allocated to morning, lunch, evening and night time. Some prescribed inhaler medicines were also described on the domiciliary MAR as inhaler. For example, one person had two prescribed inhaler medicines, the persons MAR sheet did in this case describe each medicine and the frequency of dose. However, we found that staff were regularly writing 'inhaler given' or 'inhaler X 1' and it was unclear which inhaler had been administered. From these records we were unable to tell what or when medicine had been administered to the people.

Topical MAR did not always provide enough information for staff on why topical medicines needed to be applied, or the frequency. Body maps had not been used to indicate where creams should be applied. Charts had not always been signed by staff to indicate that creams had been applied as prescribed. There was a risk that when creams were not applied as prescribed that people's skin might break down.

PRN (as required medicines) protocols were not in place. PRN protocols assist staff by providing clear guidance on when PRN medicines should be administered and provide clear evidence of how often people require additional medicines such as pain relief medicines. They can be a useful tool during medicines reviews.

People's care plans did not provide guidance on how or when PRN medicine should be used and the information was not available with the MAR charts. For example, one person was prescribed a strong pain relieving medicine, the instructions on the MAR were "as required" and 'one or two tablets'. There was no information or reference to the level or kind of pain that might indicate its use was required. Because the PRN protocols were not available with the MAR it meant that staff that were unfamiliar with people's needs would not have the information required when they were doing the medicine round. In addition to this we looked at the number of times that the strong pain relieving medicine was administered to the person. Between 19 and 26 April 2016, the medicine was administered on 20 occasions. Of those 20 occasions on only five occasions was the time of the administration recorded. There were also a number of times the number of tablets given was not recorded. This meant that the staff could not ensure that they left the recommended gap between doses or that the person was staying within the maximum dose each day. The reason for administering PRN medicines was also not documented which meant it was difficult for staff to identify any trends or common themes in relation to when the person required the medicine. This also meant there was a risk that some staff may not realise a person routinely required PRN pain relief at a certain time of day because it had not been documented.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had completed an assessment of people's risks and had recorded guidance on how to manage identified risks. The risk assessments showed that assessments had been completed for areas such as mobility, continence, food and diet. We found that risk assessments were changed to suit the person when their needs had altered. For example, in one person's plan we noted that a risk assessment for moving and handling and transfers was reviewed three times in a 10 day period due to an increased risk of falls and input from a physiotherapist.

Incidents and accidents were recorded and cross referenced to the care files of the people involved in the incidents. We saw that preventative measures were also identified by staff wherever possible and that some of the risk assessments were updated if required.

The service had a policy and procedure regarding the safeguarding of people and guidance was available for staff to follow. Staff told us they had received training in safeguarding adults and the identification of actual or suspected abuse. Staff we spoke with knew what constituted abuse and how to report it. People we spoke with told us they felt safe. One person said, "I wouldn't say no if I had to come back again, I feel safe here," another person said, "Yes I feel safe here, it's a very good home." People who used the domiciliary service also told us that staff ensured that they showed them their identification and that this made them feel safe allowing the staff into their homes.

There were sufficient numbers of staff to support people safely. People in the reablement centre told us that care appointments were met by staff when they needed them and the care they needed was given. We found that the staff rota was planned and took into account when additional support was needed for planned appointments outside of the reablement centre. All of the visitors we spoke with and people using the service confirmed they felt there were enough staff and when they needed staff assistance staff came quickly. One person said, "Nobody grumbles even when I call them at quarter past three in the morning they come straight away, they are so pleasant". Another person said, "Whenever I've used the buzzer they've come straight away". Staff on duty also confirmed they felt there were enough staff to keep people safe.

People commented positively about the timeliness of the domiciliary care team. Most people told us they were supported with regular care staff. One person who told us they received care from a number of staff commented, "They are always on time within five or 10 minutes of the visit time, I have a few regular staff that visit me". Another person said, "They always arrived on time, I never had to call to check on them".

Staff told us they reported to the office if they were going to be more than fifteen minutes late for a call, and the person was informed. On call arrangements were in place so a designated member of staff or the registered manager could be contacted out of office hours.

There was a robust selection procedure in place. Staff recruitment files showed us that the service operated a safe and effective recruitment system. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS check ensured that people barred from working with certain groups such as vulnerable adults would be identified. We saw that the recruitment process included completion of an application form, an interview and previous employer references to assess the candidate's suitability for the role.

The service had emergency procedures in place which included the actions to be taken in the case of fire. People also had personal evacuation plans which clearly identified their needs if evacuation was required.

People were cared for in a safe, clean and hygienic environment. The bedrooms throughout the service were well-maintained. Regular equipment and maintenance checks were undertaken.



# Is the service effective?

## Our findings

Staff received training provided by the service when they joined as part of their induction programme. On completion of their induction they also received refresher training. Training subjects included moving and handling, infection control and food hygiene. All of the staff we spoke with told us they had been given training relevant to care for the people they supported.

Training did not include specific training to support staff to recognise and meet the needs of people. For example, there were people using the service who lived with dementia. Specific training for staff to meet people's needs is good practice if staff were regularly undertaking care for people living with dementia. This would enable staff to understand people's behaviour and access the appropriate healthcare or assistance. One member of staff said, "Sometimes I feel we could do with more training in things like skincare as then we would know what to look out for."

Records we saw demonstrated that supervisions had been undertaken. In the reablement centre however, staff supervisions had not been undertaken as often as directed by the provider's supervision policy. This position was reflected in the staff records. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. The staff we spoke with told us they felt well supported by the management team and that although the care home staff had not received regular supervisions they felt that this would improve under the new registered manager. Staff told us they were given opportunities to speak with the management about any concerns they had or any development they needed and that they felt well supported.

People were supported to have sufficient to eat and drink and there were systems in place to monitor people's weight. We were told by staff that when a person lost weight their intake would be monitored. Staff we spoke with were familiar with people's nutritional needs. People received suitable food and drinks suited to their needs. We saw people who were receiving a service at the reablement centre being offered choice at meal times. In the dining area there was a clear, written display of the meals people were going to have on the day of our visit. This would help to remind people of the meals they could expect and showed them what the choices were. Meal times were not rushed; we saw staff offering people a choice of the main meal, encouraging those who needed prompting to eat their meal and observed that staff monitored people's dietary intake. People said, "They feed you very well here", "The food is cooked very well" and "The food is very good I always finish my food." Another person who was assisted by staff said, "I needed some help today, if you're having any trouble they're very gentle and kind."

Hot and cold drinks were provided to people throughout the day of our inspection and we observed staff encouraging people to drink. Snacks were also provided between meals.

Staff who visited people in their own homes provided support and assistance to some people with their meals and drinks. People we spoke with told us they were supported and encouraged by the care staff to eat. People told us the care staff also made drinks when they wanted or needed one.

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. Staff we spoke with had variable knowledgeable about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff however understood how a diagnosis of dementia might affect a person's ability to consent and make decisions. We made observations of people being offered choices during the inspection, for example where in the reablement centre they wanted to spend their day, what they would like to eat and drink and where they wished to exercise. One person said "I fancied cheese on toast last night and they made that for me."

The provider had met their responsibilities with regard to 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. People 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 Mental Capacity Act 2005 (MCA). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that people's mental capacity to make decisions had been assessed; there were no people using the service who were currently subject to a DoLS authorisation.

Consent to care and treatment was recorded within people's care records. Within people's care records there were documents that showed staff had discussed people's care and treatment with them and documented they had obtained people's consent. For example, records showed that people had signed to consent to their information being recorded and retained by the service, and that where necessary the information would be shared with other healthcare professionals as part of their rehabilitation. There was also guidance for people to read that explained why information was recorded to help people make an informed choice about giving their consent. We also observed members of staff asking for people's consent before providing support to them.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with dementia.

## Is the service caring?

### Our findings

Staff treated people with understanding and kindness. We saw people laughing and joking with staff. Staff were knowledgeable and supportive in assisting people to communicate with them. We saw that people were included in discussions and were encouraged to express their views and make decisions. We saw that the staff took time for people to consider their decisions. The staff we spoke with knew people well and understood their individual communication styles.

The people we met were relaxed and spoke well of the staff. We observed staff treating people with dignity and respect. People's personal care support was discreetly managed by staff so that people were treated in a respectful way. Staff made sure that toilet and bathroom doors were kept closed, as were bedroom doors when they attended to people's personal care needs. One person told us staff knocked on their bedroom door before entering and also said, "They are very good, they don't hurry you up they are so patient." Another person said, "They are so kind they can't do enough for you." People who received domiciliary care said, "They are very gentle no improvements required there" and another person said, "They are very good they checked my book [care plan] to make sure they got things right."

Staff understood people's needs and demonstrated they knew how people preferred to be cared for. We observed that staff responded promptly when people needed help or reassurance and that they knew when people were in pain or suffering discomfort and acted to alleviate that in a timely way. One person said "Last night I had a fall and they looked after me very well." We also observed staff encouraging people to walk as part of their rehabilitation and saw that they anticipated people's pain and stamina when exercising.

Domiciliary staff told us the service aimed, where possible to ensure that the same care staff supported people. Staff said this ensured they were able to know people well, learn their preferences and understand what was important to them in relation to their care. This was reflected in what people told us. One person said, "I have the same regular staff they are all very well trained." Another person said, "I'm very happy with the staff they are very good and I know them all well now."

People's visitors to the reablement centre were made welcome. A visitor whose relative was leaving during the inspection told us they had visited regularly and they could see an improvement in their relative's health. The visitor told us, "I think it's very good here, they have been excellent with [person's name] and really helped her walking."

People were given important information about the service. People were given a 'service user guide' when they commenced a care package. The guide contained information about the service, for example the provider's statement of purpose that explained the aim of the service and how they would achieve their aim.

People who received domiciliary care had the main contact number and the out of hour's emergency number so they could contact the service at any time. People told us they also received other information promptly such as their scheduled care appointment times and information on who would be providing their

care. They told us this was received sufficiently in advance of when the appointments were scheduled for.

The provider maintained a log of compliments received from people. The compliments reflected the positive feedback we had received from people over the course of our inspection. The compliments were from people who received care directly from the service and people's relatives.

## Is the service responsive?

### Our findings

We found that pre-admission assessments were undertaken to gather information about a person's individual needs prior to their admission or use of the domiciliary service. These assessments were a pro forma document which covered a number of areas such as the person's mobility, transfers, personal care, domestic skills and skin integrity.

Each person had an individual care plan which contained information about the support people needed. We found that people and their relatives also had input into the care plans and choice in the care and support they received. Care plans contained information such as people's medical history, mobility, communication and care needs including areas such as: continence, diet and nutrition. These plans provided staff with basic information so they could respond positively. We found however that the care plans lacked detailed information to reflect personalised support people required. Care plans across the service were not personalised and did not contain unique individual information and references to people's daily lives. For example, in one care plan the information relating to support for someone who required assistance with washing and dressing the care plan simply stated 'assistance required'. This meant that the information provided did not instruct staff to provide care in a way that was personalised to be safe, comfortable and acceptable to the person concerned. This information is of particular relevance when new staff are employed at the service to aid these staff in knowing and understanding people's needs.

Staff recorded the support that had been given to people in care notes. Staff recorded information regarding daily care tasks, including the support that had been provided and personal care tasks that had been carried out. This information provided evidence of care delivery and how staff had responded to people's needs.

People received their care in a person centred way. Staff recognised and responded to people's needs. Staff said that if people wanted to sleep late they could and some people chose to do this. When we asked a member of staff about a person's care, they knew the content of the person's care plan and understood their role in the person's rehabilitation.

People told us they were involved in decisions about their care and treatment. Care records showed that people had been involved from the outset of their admission to the service. Records showed that a 'goal setting' meeting was completed shortly after admission to the service. This recorded what the person wished to achieve prior to being discharged, for example one person's record showed they wished to be independent with their personal care and mobility. The records showed how the person was going to achieve this, for example with assistance from an occupational therapist and an exercise programme. One person who received the domiciliary service said, "I had a conversation with them before they started my care, we agreed my package and they were brilliant and signposted me to other services that were useful. I have my care plan which I can read and discuss with them when I want to."

People made decisions in relation to their discharge from the service. A discharge planning meeting was undertaken with people. We saw records that showed people discussed their discharge and what additional

level of support they may need following discharge. For example, people discussed if they felt they may need additional community care when at home, or what mobility equipment they would find helpful within their home to keep them safe. One person we spoke with said, "I was supposed to be going home soon but they went through my assessment and said I would need to stay a few more days so that they could make sure that when I go home I'll have a care worker because I live alone and still need some help."

We were told by senior staff that due to the short term nature of the service there were no planned activities for people who used the reablement centre part of the service. Activities such as board games were undertaken with people on an ad hoc basis. On the day of our inspection there were no activities taking place. There were however members of staff engaging with all of the people present in the lounge and dining areas providing some companionship to people in between their rehabilitation exercises. People expressed that it could be 'boring' living in the reablement centre but that as they knew they were not going to be there long term they were not concerned. One person said, "It's difficult to get people to take part in things because we're all different, you can't always get people together to enjoy the same things and so many people come and go quickly." Another person said, "It can get boring, but I'm leaving soon so I'm not bothered by it." There was outdoor space available for people to access during better weather and the communal garden had seating and planting areas, we observed people sitting outside enjoying good weather whilst we were there.

People and their relatives felt able to complain or raise issues about the service. The service had a complaints procedure available for people and their relatives. Everybody we spoke with said they knew how to complain, and all said they had never had cause to. We checked records for the last year and found that when complaints had been made they were dealt with as per the service's complaints procedure.

People were supported to maintain their well-being and good health. We saw from records that people had regularly accessed health care services. When a person required additional regular clinical support this was provided. We saw within everyone's care plan that regular visits or appointments with GP's, Opticians and Dentists had happened when required and that staff had then acted upon the actions agreed at the respective appointments.

## Is the service well-led?

### Our findings

To ensure continuous improvement the senior staff team conducted regular audits to monitor and check the quality and safety of the service. They reviewed issues such as care plans and training. The observations identified good practice and areas where improvements were required. We saw that supervisions and care planning for people had already been recognised as requiring improvement through the provider's own quality checks. The senior staff were working towards improving these areas. There were however no effective governance systems in place to prevent the medicine shortfalls found at this inspection. This meant the quality monitoring systems in place were not effective.

We found there was not an effective system in place to ensure that visits by the domiciliary care team were not missed. For example, whilst reviewing one person's care record we found that they had not received their daily morning visit. There had been an error in communication between the staff which meant the visit had not been made. This was not noted until some 24 hours later when a member of the staff team attended to carry out the next visit. The person had dementia and had not contacted the service. Senior staff told us that they relied on people or staff to inform them if a visit had not taken place. We found however this approach exposed people to the risk of not receiving care in line with their assessed needs, particularly given that some people receiving a service may not have been able to make a telephone call without assistance.

People using the domiciliary service were asked to respond to a one question questionnaire in relation to the service once they had completed their care package. The question was; 'Do you agree/disagree that you feel able to live independently with or without support as a result of your treatment?'. There was no quality assurance process in place to provide any feedback to the service about the quality of care, timeliness of visits or any space on the questionnaire for people to make further comment if they wished to. This meant that the provider failed to take the opportunity to improve upon the service provided by encouraging feedback.

These failings amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to ensure regular maintenance was completed and audits to ensure that the reablement centre premises, equipment and health and safety related areas such as fire risk were monitored and that equipment tests were also completed. We saw that where actions were required to improve the service there were action plans in place.

People using the reablement centre were encouraged to provide feedback on their experience of the service to monitor the quality of service provided. People and their relatives were given questionnaires for their views about the quality of the service they had received. We saw the results of surveys had been analysed and comments were positive.

People told us the senior staff were very approachable and they could talk with them at any time. The senior

staff also told us they welcomed feedback on any aspect of the service and that relatives and staff could talk with them if they had any concerns. We also saw records that demonstrated that relatives and other people important to people living in the reablement centre and using the domiciliary service were communicated with if there was anything urgent that they needed to know.

Staff told us they were regularly consulted and involved in making plans to improve the service. All of the staff we spoke with said they felt well supported by the senior staff. They said they attended regular staff meetings and that there was an open culture. Staff said that staff meetings were supportive in discussing and resolving staff issues. One member of staff said "We have very good management we can talk to them about any problems we are facing they always make time for me". Another staff member said "[senior staff name] is lovely and approachable; if you've made a mistake they talk it through with you". All staff we spoke with told us they knew how to report any concerns about the delivery of care and would not hesitate to do so.

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We found that the senior staff had made appropriate notifications.



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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Personal care	Medicines were not managed in a safe way. Regulation 12 (2) (g)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Personal care	The provider had failed to assess, monitor and improve the quality and safety of the service and mitigate the risks relating to people's safety. Regulation 17 (2) (a) and 17 (2) (b)