Qualia Care Limited

St Mark's Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: St Mark's Care home provides accommodation, nursing and personal care for up to 39 people, some of whom were living with a dementia. On the day of our visit there were 28 people using the service.

People's experience of using this service: People's risk assessments did not consistently cover all potential areas of risk, such as poor skin integrity and behaviours that may challenge and did not mitigate risks. Medicines management was not managed safely and in line with national guidance. The provider had appropriate systems in place to support staff to raise any safeguarding concerns. However, these were not always put into practice. The provider did not maintain the safety of the building and equipment. Premises needed work to become safe and many areas were in need of a deep clean. People felt safe in the care of staff members and were happy with staffing levels. However, staff were not utilised effectively.

People told us they received effective support. Systems were yet to be put in place to ensure that staff received appropriate supervision to support them in their roles and to ensure their training was up to date. The dining experience needed improvement and we could not evidence people were supported with their nutrition and hydration needs. Staff failed to follow moving and handling assessments placing people at risk of harm.

People told us care staff were caring and kind. People's privacy and dignity needs were not always maintained by staff members caring for them. We could not evidence people were receiving regular baths or showers. We witnessed an agency staff member roughly handle a person, we acted on this straight away, making staff aware of the incident and raised a safeguarding alert. However, this person was not removed from their duties until four hours after the incident.

Care plans lacked information and were confusing as some care plans used old formats from the previous providers. Documentation was not fully completed, contained inaccurate information and in some cases, was missing.

The providers records, systems and processes in place to monitor and audit the service required improvement. The registered manager did not have oversight of the service and was slow to react to concerns raised.

Activities were taking place and people went out on a regular basis. No complaints had been received since the provider was registered.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection: This was the providers first rated inspection since becoming registered in February 2019.

Why we inspected: This was a responsive inspection based on concerns received.

Enforcement: We identified four breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 including safe care and treatment, safeguarding service users from abuse and improper treatment, nutrition and hydration, and good governance.

Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up: The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

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 safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

St Mark's Care Home

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by information of concern we received about the management of risk to the building. This inspection examined those risks.

Inspection team: The inspection team consisted of two inspectors, an assistant inspector and a specialist professional advisor (nurse).

Service and service type: St Marks Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was unannounced

Inspection site visit activity started on 29 April 2019 and ended on 1 May 2019. The registered manager was unavailable the first day therefore we visited on a second day to speak to them.

What we did: We used the information we held about the service to formulate our inspection plan. This included statutory notifications that the provider had sent to us. A statutory notification is information about important events which the provider is required to send us by law. These include information such as safeguarding concerns, serious injuries and deaths that had occurred at the service. We did not request information from the provider in the form of a Provider Information Return. Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We also sought feedback from commissioners of the service.

During the inspection, we spoke with four people who used the service and two relatives. We did this to gain their views about the care and to check that standards of care were being met. Some people who used the service were not able to speak to us about their care experiences, so we observed how the staff interacted with people in communal areas and we looked at the care records of six people who used the service, to see if their records were accurate and up to date.

We spoke with the senior care worker, six members of care staff, the head cook, the deputy manager, the maintenance man and the managing director. On the second day we spoke with the registered manager. We looked at records relating to the management of the service. These included accident and incident records, meeting minutes and quality assurance records.

After the inspection, we spoke with the Fire Service and the local NHS infection control nurse about our concerns. We asked the registered manager to provide us with certificates and reports for equipment and premises issues we had found and supervision records of staff following the unsafe moving and handling practices.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management
• The service did not ensure people lived in a safe environment. We found certificates relating to the electrical and gas safety, lifting and bathing equipment were out of date. Recommended checks regarding the prevention of legionella had also not been completed.
• The fire safety arrangements at the service were not safe. There was no evidence and staff confirmed that they had not practiced how to evacuate people from the service in the event of a fire.
• Fire records showed that staff did not fully engage in fire drills and were reluctant to take part.
• Combustible items were stored in stair wells, and evacuation routes were blocked by equipment. We asked the nurse to remove the equipment however we found on our second day of inspection the service was continuing this unsafe practice. Checks on the fire alarm had not been carried out.
• People were at risk of unsafe care and treatment. People's needs and risks had not been properly assessed and staff had little or no guidance to help them support people appropriately and keep them safe.
• We observed call bells out of reach of people which meant they were unable to call staff if they required help. Staff advised people received hourly checks but had no records of such checks been carried out.
• Care plans did not provide guidance for staff for the management of behaviours that may challenge when a person may become agitated or distressed.
• Where people were assessed as needing support to reposition in bed as part of their pressure relief, records contained gaps or were missing.

Failures to ensure the safety of the building and equipment and identify and respond to risk are breaches of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We alerted the Fire Service about our findings. They visited the service and made a number of recommendations including the practice of safe evacuation, removal of the combustible items and maintenance of the fire alarm.

Systems and processes to safeguard people from the risk of abuse
• The service did not respond to safeguarding issues in an appropriate manner. We observed an agency staff member roughly handle a person, we immediately alerted a senior staff member. However, this person was allowed to continue supporting the person and was not removed from their duties until four hours after the incident. After the inspection we raised a safeguarding alert to the local authority.
• Staff disregarded people's care needs. Staff did not always follow people's moving and handling assessments. On two occasions staff failed to use the appropriate equipment authorised by an external healthcare professional. This placed the person at risk of injury.

The service failed to take immediate action upon becoming aware of an allegation of harm. Staff disregarded people's care and treatment needs. This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

Using medicines safely
• Medicines were not managed safely. We saw gaps in recording on people's medicines administration records (MARs), which meant it was unclear whether they had received their medicines. Where people had refused their medication, reasons were not always documented on the MAR.
• Room and fridge temperatures were not regularly recorded. We noted the temperature in the treatment room was above the appropriate temperature for a number of days and no action had been taken to address the matter. High temperatures can affect some medicines.
• Guidance for the use of 'as required' medicines were not always in place. One person had been prescribed anti-psychotic PRN medicines. There was a limited PRN protocol in place to assist staff in their decision making about when it would be used for example "to reduce agitation", however there was no record of diversional techniques to be used prior to administration.
• Certain medicines required a body map for staff to record the position of a patch on the person's body. This is to support the removal of the last patch and to stop the repeated placement on the same area which can cause side effects. We found these were not always completed.

This failure to manage medicines safely demonstrated a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Preventing and controlling infection
• Standards of infection control were not satisfactory. We found bath chairs with faeces on the seat, dirt and mould in corners of bathrooms, broken cracked tiles and paintwork down to bare wood.
• People's personal items such as shoes, dolls and bathing products were left in shower rooms.

The lack of infection control measures increased the risk of cross contamination and spread of infection demonstrating a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

• Personal protective equipment was readily available throughout the building and appropriate used by staff when observed during lunch.

Learning lessons when things go wrong
• Accidents, incidents and safeguarding concerns were collected and reviewed for trends or patterns.
• Recordings of people's daily care and handovers between shifts were not robust enough to ensure messages about changes in people's needs and risks were passed on. For example, one person's sling was identified as worn and not to be used with a request for a new one to be ordered. This message had not been recorded in the handover to be actioned, resulting in staff trying to locate the sling and using another person's sling, placing the person at risk of harm.

Staffing and recruitment
• We asked to see the services dependency tool to make sure staffing levels were based on people's needs. A senior staff member said they did not have one and staffing depended on what hours staff worked. They went on to say that on a night there was sometimes four care staff and a nurse but more often three care staff and a nurse. We asked what would determine this number and we were told it depends what hours people worked.

• On the day of inspection there was a nurse and two care staff upstairs and a senior and three care staff downstairs. Due to the layout of the building and many people being cared for in bed, we noted people were left alone for long periods of time and when people needed support, for example at lunch time care staff were not always available.
• Pre- employment checks were carried out prior to employment to ensure staff members were safe and suitable to work with vulnerable people. For example, a Disclosure and Barring Service check (DBS), previous employer references and proof of identification. However, the files we looked at had no job description or health declaration checks.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met

Supporting people to eat and drink enough to maintain a balanced diet
• The service did not always ensure it supported people to receive enough to eat and drink. The registered manager told us two people were now receiving fortified meals to support them due to weight loss. This information had not been passed to kitchen staff and had not been added to people's care records. The head cook said they constantly had to request for updates on people's dietary needs
• Where people required their food and drink to be monitored we found records had not been fully completed. We could not evidence people received enough to drink as people did not have adequate eating and drinking plans in place to advise staff of their needs and risks. For example, one person was on a fluid chart, with a fluid target for each day of 1764 mls. Charts had gaps and days missing and were not calculated to see if the target had been achieved.
• Fluids were not readily available for staff to support people who were cared for in bed.
• People who had been identified as risk of malnutrition did not always have their weight monitored. One person had been identified as at risk and required weekly weights however we noted this was not taking place. We found weight calculation tools were not fully completed and failed to record people's risks.
• The senior kitchen staff member expressed concern about the amount of food that was returned to the kitchen when 'certain' staff were on duty. For example, one day a full pie came back to the kitchen and staff said they did not know it was there.
• There was a menu on the wall in the dining room. However, it did not match what was been offered that day. The menu was in very small print and did not support people with visual impairments and people living with a dementia.
• Staff did not recognise when people needed support at meal times. We observed one person kept dipping their spoon in their soup and therefore looked like they were eating but in fact they just poured the soup back in the bowl. At the tea time meal some people ate in the lounge area. One person was leaning in their chair with their food on their lap which was tipped over so the food spilt on their clothes. Another person had their food on a small low table and had to lean forward to reach their plate which resulted in them spilling food before it reached their mouth.

The concerns identified in relation to people's nutrition and hydration demonstrate a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
People had their needs assessed prior to moving into the service.
• The pre-admission assessment looked at how people preferred to communicate, their day and routines,

what support would be needed and their likes and dislikes. The pre-assessments did not ask questions to support all the protected characteristics of the Equality Act. The registered manager advised that some documentation belonged to the old provider.
• Where people's needs had changed these were not reflected within people's care plans. For example, one person's GP had instructed them to be on permanent bed rest due to stopping a certain medicine. This had taken place the week before and was to be in place until the GP returned. There was no care plan in place to address this new care need or any guidance for staff.
• We found staff had limited information on people's choices and needs and agency staff had no information at all.

Staff support: induction, training, skills and experience
• Not all staff training was up to date. The managing director assured us training was planned and due to only having the service for ten weeks they had not yet had time to cover all the training needed.
• At the time of the inspection staff were not fully supported with supervision and appraisals. Supervision is a process that involves a manager meeting regularly and interacting with worker(s) to review their work.

We recommended the registered manager reviews staff training to make sure it is all in date and completes supervisions in line with their policy.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• We saw evidence of staff working with external healthcare professionals such as the speech and language therapists and GP. However, recommendations were not always documented.
• One person had been seen by the intensive community liaison team due to certain behaviours that challenged they were demonstrating. Nothing had been documented following this visit and no plan was in place to support this person or to minimise the behaviours.

Adapting service, design, decoration to meet people's needs
• People living with a dementia did not have enough adaptations to the service to help them to orientate themselves, such as clear signage of doors and use of colours in areas to prevent falls.
• Bathrooms were locked with a bolt at the top of the door, so people would be unable to use them independently. Also, bathrooms were used for storage of hoists and other items such as old shoes.
• One en-suite bathroom had tiles falling off the wall. Staff had laid towels all over the bathroom to make sure the tiles did not damage the bathroom suite. Due to this the bathroom was out of use. No alternative arrangements had been made nor a risk assessment in place.

Ensuring consent to care and treatment in line with law and guidance

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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on

people's liberty had been authorised and whether any conditions on such authorisations were being met.

• On arrival we were told by a senior staff member that everyone except one person was subject to a DoLS, which would be 27 people. DoLS documentation was available for 17 people, a number had expired and it was unclear if renewal requests had been made. One person's request had been refused and care plans contained old DoLS applications even though a new one had been authorised.
• The service was using the old provider's documentation and notes. Mental capacity assessments were not always in place. No new DoLS applications had been made in the last 10 weeks.

We recommended the registered manager and staff updated themselves on the best practice around assessing people's mental capacity and the application of DoLS.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity
• We could not evidence people were receiving enough baths or showers. Records showed people received no oral care. Some people's clothes were dirty, their nails were dirty and one person's teeth badly needed cleaning.
• One person told us they were unable to bathe or have showers as often as they would like and were unable to brush their teeth without assistance but were offered these things irregularly. The person's documentation showed that they had only been assisted to brush their teeth twice in a 14 day period.
• Staff were task orientated and provided care for people as and when needed. However, there was little interaction with people between care tasks.
• We discussed the lack of evidence to show personal care was taking place with the managing director who said they would address this straight away. The registered manager told us people were being supported to have baths and showers and it was poor record keeping by staff.
• Information regarding the protected characteristics of the Equality Act which includes age, disability, gender, marital status, race, religion and sexual orientation was not gathered by the provider. This meant the service could not ensure people were not discriminated against.

Supporting people to express their views and be involved in making decisions about their care
• The new provider had only been in place for 10 weeks at the point of our inspection. The registered manager had introduced meetings for the people who used the service or their relatives.
• Some care records did not show if people and their relatives were involved in their care.

Respecting and promoting people's privacy, dignity and independence
• Staff did not always respect people's privacy. We asked a senior staff member if they would ask a person who was in bed if they would not mind if we checked their room. The deputy opened the door without knocking and said these people want to see your room. This is not requesting permission.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• We found care plans confusing and unorganised. A mixture of the new provider's and the old provider's paperwork was being used.
• People's care plans did not contain sufficient information about their needs, risks and preferences to enable staff to provide, safe, effective and responsive care.
• Where people had specific health conditions, there was a lack of adequate information on what these conditions were and what they meant for the person in terms of their health, wellbeing and day to day living.
• Care plans provided staff with little or no guidance on how to meet people's needs in a person centred way. The support people needed was not clearly identified.
• The activity coordinator was on annual leave at the time of our visit. Therefore, no activities were taking place. However, records showed people often went out and visited the local area.
• People's communication needs were not considered. From August 2016 onwards, all organisations that provide adult social care are legally required to follow the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss and in some circumstances to their carers. When we asked the registered manager how AIS had been adopted into the service. They responded that they didn't know what it was.

Improving care quality in response to complaints or concerns
• The provider's complaints procedure was displayed in the entrance area of the home. It was displayed in small print and was not available in other formats.
• Complaints from 2018 were recorded, acknowledge, investigated and responded to with a full outcome to the complainant.

End of life care and support
• Although no one was receiving end of life care at the time of our inspection we did not see any advanced care plans to evidence people's end of life choices had been discussed with them and planned for in relation to their future care.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• Inadequate fire safety arrangements placed people at risk of harm, premises and equipment were not maintained as legally required, the premises were not clean or safe, medicines were not administered safely, the delivery of care was not safe or person centred, and people were not monitored to ensure they received enough food and fluids to meet their hydration and nutritional needs.

• Record keeping was poor across the service. Documentation relating to people's care and support was not completed with gaps in recording including safety checks, positional changes and food and fluid monitoring.

• The service did not have effective systems in place to monitor the quality and safety of the service. The provider's quality inspection conducted in April 2019 failed to identify the need for action to ensure maintenance checks were up to date.

• The registered manager did not have oversight of the delivery of care and support and the safety of the service. They told us they were not aware of the issues relating to the out of date equipment and premises safety certificates. No actions had been taken to remedy issues we found on the first day of our inspection and we found a fire evacuation route remained obstructed.

• Staff gave mixed views of the management of the service. Some staff reported a 'clique' between staff and the registered manager. Staff told us that they had approached the registered manager with concerns about the safety of the building and staff sleeping on duty and felt these concerns were not dealt with. Whilst other staff told us the registered manager was approachable. We noted in a fire drill record, a report that staff were reluctant to take part and threw the paper flame in the face of the staff member leading the drill. We asked the registered manager what action was taken. They told us they were not aware of such an incident.

• Although some issues were clearly visible we had to directly tell the registered manager to address the matters. For example, the obstruction of evacuation routes and staff failing to follow moving and handling guidance.

The lack of oversight of records had resulted in a failure to assess, monitor and mitigate risks to the health and wellbeing of people using the service. These concerns demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Continuous learning and improving care

• There was no adequate assessment or planning of person-centred care.

• There was no evidence that the registered manager and provider used information in the day to day delivery of the service such as care plan reviews, resident meetings, safeguarding incidents, accident and incident data to learn and improve the care provided to people.
• Whilst the managing director was responsive and gave us assurances that all the premises and equipment inspections would be completed by a set date. We had to repeatedly contact the service for updates regarding the completion of this work. The registered manager failed to recognise the urgency of this matter.
• The registered manager received written feedback on the second day of the inspection. It was only following the request of the local authority commissioning that the registered manager put an action plan together to address the concerns identified, eight days after the inspection.

The lack of oversight of records had resulted in a failure to assess, monitor and mitigate risks to the health and wellbeing of people using the service. These concerns demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• The provider worked in partnership with people's local authorities, multidisciplinary teams and safeguarding teams.
• The service had plans to gather feedback from staff, people and relatives.

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
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Environmental and individual risks were not always identified and mitigated. The service did not ensure regular checks of equipment and the premises were conducted. Medicines were not managed safely. Poor infection control practices placed people at risk of cross contamination. 12(2)(a),12(2)(d),12(2)(g),12(2)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service failed to take immediate action upon becoming aware of an allegation of harm. Staff disregarded people's care and treatment needs. 13(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure the nutritional and hydration needs of service users were met. 14(1).

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 17 HSCA RA Regulations 2014 Good governance

The service did not have effective systems and processes to assess, monitor and improve the quality and safety of the service. The service did not maintain an accurate and complete record of people's care and treatment.

17(1)(2),17(2)(c).