Claire Meade Care Limited

Caremark (Bradford)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 16 May 2016 and was announced to ensure the registered manager would be available.

This was the first inspection carried out since the provider registered at the current address.

Caremark is a domiciliary care agency which provides care services to people in their own homes. On the day of our visit 135 people were receiving a personal care service. The agency can provide a service to adults and children, older people, people living with dementia, people with physical disabilities and people with sensory loss.

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

Most people who used the service felt safe with the care provided and we found there were systems in place to protect people from harm. However, the service had not made statutory notifications, such as notifications of abuse, to the Commission.

Risk assessments and care plans were individualised and person centred. These were reviewed on a regular basis to ensure they reflected accurate and up to date information. Staff we spoke with were person-centred in their description of the care and support they provided to people.

There were policies and procedures in place in relation to the Mental Capacity Act 2005 and Deprivations of Liberty Safeguards (DoLS).

We found some concerns around the safe management and administration of medicines, particularly in regards to appropriate gaps in between administration of medicines and the management of 'as required' (PRN) medicines.

We found that people were provided with care and support by staff who had the appropriate knowledge and training to effectively meet their needs. The skill mix and staffing arrangements were also sufficient, although some people told us they would like to see more continuity of care staff. We saw from reviewing records Continuity of care staff was provided wherever possible. Recruitment checks and systems were in place to ensure people employed by the service were safe to work with vulnerable adults, although in some instances references were not always obtained prior to commencement of employment.

People and their relatives told us staff treated them with kindness, care and respect and most people told us staff were usually punctual and reliable. People's feedback on the service was regularly sought through care

plan reviews, telephone checks, questionnaires and quality checks by management when they visited people's homes.

There was a complaints procedure available which enabled people to raise any concerns or complaints about the care or support they received.

The registered manager ensured staff received induction training, supervisions, observations and spot checks as well as annual appraisals. Staff training included mandatory subjects and additional training and development relevant to their role. However the training matrix had not been updated to reflect recent training.

There was a quality assurance monitoring system in place that was designed to monitor and identify any shortfalls in service provision. However, we found this was not sufficiently robust to identify areas that required improvement.

Staff and healthcare professionals we spoke with praised and had high regard for the management of the service, although some people and their relatives told us they felt communication could be improved.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take in relation to this 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

The service was not consistently safe.

We identified some risks associated with the ways medicines were managed. For example, time periods between the administrations of medicines were not always appropriate.

Risk assessments were in place, up to date and appropriately managed.

Recruitment processes were in place to ensure staff were suitable to support vulnerable people. However, these needed to be more robust as we found some references were not received until after employment had commenced.

Is the service effective?

Good

The service was effective.

Staff received training and development which was appropriate to their job role.

Staff were knowledgeable about the people they were caring for.

Staff supported people to maintain good health and to consume an appropriate and varied diet.

Is the service caring?

Good

The service was caring.

People told us staff were kind, caring and provided them with the care and support they needed whilst respecting their privacy and dignity.

We saw care staff had developed meaningful relationships with

the people they supported.

Mechanisms were in place to listen to people and support them to make choices.

Is the service responsive?

Good

The service was responsive.

People had their health, care and support needs assessed and individual preferences were discussed with people who used the service. People's care records had been regularly updated which provided staff with information they needed to meet individual's needs.

A system was in place to log and respond to people's complaints or concerns. Where people raised issues they were listened to and staff tried to make improvements to the quality of care provided.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The service had not made statutory notifications to the Commission.

Systems were in place to monitor the quality of the service, included regular audits, care plan reviews and seeking people's feedback. However, these needed to be more robust and some documentation required improving and updating.

Management were held in high regard by staff and outside agencies, but some people who use the service said communication could be improved.

Caremark (Bradford)

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 16 May 2016 and was announced. We gave the service 48 hours' notice because the service operates a domiciliary service and we needed to make sure the registered manager was available.

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.

During our visit to the provider's office we looked at seven care records of people who used the service, some in detail and others to check specific information, four staff recruitment files, training records and other records relating to the day to day running of the service.

During the inspection we spoke with the registered manager, operations manager, training manager and seven care and support staff. The expert by experience carried out telephone interviews with 24 people who either used the service or their relatives on 13th and 14th May 2016.

Before the inspection we reviewed the information we held about the service. This included looking at information we had received about the service and any statutory notifications the registered manager had sent us. We also contacted the local authority contracts and safeguarding teams and received feedback from the continuing care team, mental health team and fast track services.

We also asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider returned the PIR and we took this into account when we made

judgements in this report.

Requires Improvement

Is the service safe?

Our findings

We asked people how they were supported with their medicines. One person said, "They do write everything down on the chart and I think they give me things in the right order at the right time." Another person told us, "I think they give me my tablets at the right time and they write everything down but I don't know really because I just have to trust them."

In most cases we found medicines were safely managed, although we identified this was not consistently the case. A medicines policy was in place detailing how staff were to handle medicines in a safe way. Staff received training in the safe handling of medicines and their competency to administer safety was assessed. Where people were supported with medicines, medicines profiles were in place. These provided clear and person centred information on support required. A medicines pen picture also stated the medicines people were taking, the dose, when to give and any contra-indications. This ensured the office had up-to-date information on the medicines people were taking.

Each individual medicine people took was listed on Medication Administration Records (MAR) to provide a clear record of the support people were given. Overall, MAR charts were well completed, indicating people received their medicines consistently from day to day.

We saw in most cases MAR charts were printed by the pharmacy reducing the need for hand written entries by staff. Hand written entries can increase the risk of errors, particularly if they are not checked by a second member of care staff. In one case, we identified a hand written MAR which had not been double signed by care staff, increasing the risk of errors.

Although staff we spoke with had a good understanding of when to administer 'as required' medicines, there was no guidance within care plans to instruct staff on when to administer these types of medicines. For example one person was prescribed Lorazepam for anxiety but there were no details recorded on when it was appropriate to administer this medicine.

Systems were not fully in place to ensure people received appropriate gaps between doses of medicines. On reviewing one person's MAR chart, we saw they were prescribed Paracetamol to take up to four times a day. In most cases we saw the time gap between these administrations was safe i.e. at least four hours. However this was not consistently the case. For example on 31 March 2016, the MAR chart indicated that administration was given at both the lunch and early evening care visits. Daily records showed these visits took place at 12.43 and 15.52, a gap of only 3 hours and 9 minutes. The gap on 30 March 2016 was 3 hours 42 minutes and on the 28 February the gap was 3 hours 33 minutes. We were concerned this had not been considered during care planning; for example, this need for at least a four hour gap was not detailed within the medication profile and pen picture. In addition, on one of this person's March MAR charts the planned time of administration had been written as 17.00 and 20.00, a gap of only three hours. Although administration had not occurred at these times, the fact that it had been written on the MAR showed a lack of understanding that it was inappropriate to administer these medicines at these times.

This was a breach of Regulation 12(1)(2)(b)(g), Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us they felt safe with their care staff and relatives we spoke with confirmed this. One person told us, "I feel quite safe with the carer."

Safeguarding procedures were in place and where concerns had been identified, we found appropriate referrals had been made to the local authority. Concerns were fully investigated by the service and where appropriate measures put in place to prevent a re-occurrence. Where staff handled people's money, for example if they went shopping for people, protocols were in place to reduce the risk of financial abuse. One person told us, "The girl takes my list and the money and then when she comes back she gives me the receipt and the change and then she signs and I sign." Staff we spoke with had a good understanding of safeguarding and emergency procedures and what to do if they were concerned about the safety of people they were caring for.

People who used the service were regularly asked if they had any concerns about the service through care reviews, spot checks and informal telephone contact with the registered manager and office staff. This provided people with opportunities to report any concerns they had, demonstrating the provider had appropriate arrangements in place to help reduce the likelihood of abuse going undetected and helped protect people from the risk of abuse. A whistleblowing policy was in place.

Risks to people's health and safety were assessed and appropriately managed. Risk assessment documentation was in place which covered areas such as manual handling and the environment in which care was being delivered. Where any specific risks presented such as epilepsy, behaviours that challenge or risks associated with providing personal care were identified, clear and personalised protocols were in place instructing staff on how to keep the person safe.

We saw evidence accidents and incidents were recorded with detailed information provided and signed and dated by the staff member. We saw evidence that action was taken following incidents to keep people safe and prevent a re-occurrence.

In some cases we identified safe recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. This included completing an application form, undergoing an interview, a Disclosure and Barring Service (DBS) check, and obtaining two written references. However, we identified one instance where a staff member had commenced employment before references had been obtained. The references we viewed were all acceptable, however the manager recognised that it was not acceptable practice for people to start work without these and was taking steps to address this.

Discussions with people who used the service and staff led us to conclude there were sufficient staff deployed to ensure people's needs were met and that people received consistent care. Staff we spoke with said they had enough time in calls to carry out safe care and support. On reviewing daily records it was clear that overall people received consistent call times indicating there were sufficient staff to ensure a reliable service that met people's needs. However, some people told us they felt staff were rushed, saying, "Everyone who comes is always in a big rush" and, "When she's here they'll be rushing her because she has to get to the next job." One person also told us, "There are always a lot of new people" and some people told us they would like more continuity with the care staff that they saw. The registered manager told us that although turnover was high, she had introduced measures to try to retain staff, such as a bonus system for 'carers of the month'. The service was currently recruiting for extra care and support staff. We saw staff had completed 'Lone Worker' risk assessments to help ensure their personal safety whilst carrying out care or support

duties alone.

Good

Is the service effective?

Our findings

We saw information on people's health care needs was built into their care and support plans. Where people had specific medical conditions, information had been sought on the condition and placed in the care file to provide staff with a level of awareness of the condition. Care records showed where the service identified changes in people's health, they liaised with health professionals or the person's family to ensure appropriate action was taken to ensure health care needs were met. This was confirmed by people who used the service, for instance, one person we spoke with told us, "The carer noticed a black patch on her heel last week and she was the one who alerted us. The district nurses came and then the doctor and currently my relative is in hospital but it was the carers who made sure she was seen quickly."

Where people were supported with food and drink, information was present within their care records on how to deliver appropriate care. For example one person's care records specified exactly how much cereal to put in the bowl, and the colour of the bowls to use. Daily records provided evidence people received the required support at mealtimes. We saw one person was having their food and fluid input monitored. Records demonstrated care staff were encouraging regular fluids and consistently documenting fluid input and output.

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 when this is in their best interests and legally authorised under the MCA. In the case of Domiciliary Care, applications must be made to the Court of Protection. We found no people were currently subject to Deprivation of Liberty Safeguarding.

We found the service was working within the principles of the MCA. People were supported to make decisions and their choices were respected. Where people were unable to make decisions for themselves, care records showed the opinions of relatives and health professionals was considered as part of a best interest processes.

The service employed a full time training manager and quality assurance manager both whom were new in post who assisted with the management of training. We saw the service had a dedicated training suite, with a large training room and separate practical room containing a bed, hoist and other moving and handling and care equipment. There was also a separate computer room for eLearning.

We saw there was a training matrix in place which included mandatory training and other subjects such as peg feeding, epilepsy and end of life care. However, this needed updating to reflect actual training done. The registered manager told us the service's separate live database would not allow people to be allocated calls unless all mandatory training was completed and up to date. They showed us how the system alerted them

when a member of staff required update training. The operations manager explained they had had a period of four months without a training manager in post which had led to systems not being updated in a timely manner, but told us the quality assurance manager was going to be updating the system more effectively. We concluded staff had been provided with appropriate training but the systems had not been updated.

We saw specialist training had been provided to some staff, for example one member of staff had completed a 'train the trainer' in 'cough assist' and was training others in this technique.

We spoke with one member of staff who delivered care to a person with complex needs. They demonstrated a good understanding of the person and said they had been provided with appropriate training from health professionals in order to care for the person effectively.

We spoke with the training manager who we saw was committed to tailoring the training to the service needs and told us, "I want to introduce a fuller process, not just a paper book exercise." For instance, all staff were encouraged to work through the 'Supporting Children' eLearning and workbook as well as all new staff completing the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

We saw from the training matrix and from talking with the training manager that existing staff had or were working towards a qualification in care and they told us the aim was that all staff would be training towards a NVQ/QCF level two or three qualification by September 2016. The service had a robust induction training programme, with new care staff attending a full week of classroom based training, including policies and procedures, moving and handling theory and practice, basic epilepsy training and other mandatory subjects, followed by shadowing an experienced care worker on week two. After this time, the care worker would receive their rotas and be observed after another two to three weeks, followed by a review to discuss their goals and development needs within the service.

We saw evidence in staff files that a system was in place to make sure staff received an annual appraisal of their performance. In addition to this, supervisions,'spot checks' and observations were carried out on care staff to make sure they were applying their learning to their practice in people's own homes.

Good

Is the service caring?

Our findings

A person we spoke with said, "My relative couldn't have better care. They are brilliant." They also told us that although their relative was in hospital, the care staff had phoned to see how they were and sent a card. Another person told us, "The carers themselves are superb. I don't need much help but I can't say more than that. They are brilliant and very kind." We spoke with a number of health care professionals. One health care professional told us the service was always trying to help and accommodate people's care needs. Another told us, "No concerns. Good care provided."

Care records contained information on people's biographies and life histories. This demonstrated the service had learnt about people's past experiences in order to deliver individualised care and support. One person we spoke with told us, "They spend lots of time writing stuff down and they have asked me lots of questions about what I like and that sort of thing." Staff we spoke with knew and were able to tell us about the people they were offering care and support to.

Care records showed that care outcomes and goals of care delivery focused on ensuring people were treated well with dignity and respect.

Information on how to communicate with people was clearly recorded within people's care files. This helped ensure staff could effectively communicate with people. We spoke with one staff member about how to communicate with someone who could not speak. Their responses demonstrated a good understanding of the person and how to identify what they wanted from their body language.

The care manager told us they tried to ensure staff continuity when delivering care and support and most people using the service told us they received support from the same group of carer workers. One person told us, "There are three or four different ones but it's always those same people." However, some people told us they felt staff were not focused on one aspect of the delivery service and this impacted on the care provided, for instance either elderly services or children's services. One person told us, "There are always a lot of new people." However, our review of records and discussions with staff showed continuity where possible. For example we saw that one person who required 24 hour care and support had just five core support workers. Information we reviewed indicated this person was very happy with these staff and that they knew their care team well, stating, "team are now part of family." We looked at another person who required four calls a day by two staff. We reviewed daily records and saw a good level of consistency in the staff used. The service also used a 'compatibility screen' on the computer system which indicated which care workers attended which people regularly, for instance in case their usual carer worker was off sick.

Care records provided evidence people were listened to. For example daily records showed people's comments were listened to on a daily basis and choices respected. More formal mechanisms were also in place to listen to people including care reviews, telephone quality checks and visits by management. One person we spoke with told us how the service had changed the care staff due to their relative not responding well to them. They said, "One person who came was lovely and really nice but my child didn't respond to her so I had to ask for someone else."

We spoke with staff and the care manager about those involved with end of life care. We saw care staff involved were suitably trained and allocated due to their skills with supporting people at the end of their life.

Good

Is the service responsive?

Our findings

A person we spoke with told us, "I'm very happy with them. I tell them what I need and they are always obliging." However, some people felt they would like the service to be more flexible in being able to take their relatives out. One person said, "I asked if they could take [person] out in [person's] wheelchair just to see people and get some fresh air. At first they said yes but then they phoned the office to check and then said sorry the office won't let us do that." We saw comments about how the service had met people's needs in the compliments file. These included, "Needs have been met in such a reliable, professional and caring manner" and, "All tasks are completed." A health care professional told us, "They offer a very reactive service. I would always use Caremark as my first point of contact if needing a speedy care package for one of my patients."

Care records demonstrated people's needs were assessed prior to commencement of the service. Each person had an 'individual care and support agreement' which provided instruction to staff on the care required. These were detailed and person centred. For example one care record provided in depth details on how to meet a person's personal care needs, including details of the colour of flannel the person preferred staff to use. The operations manager told us it was important to ensure that care records reflected people's individual preferences. They told us they had achieved this by involving people and care staff as much as possible in the creation of care records. We saw care records were reviewed and were generally kept up-to-date.

Staff we spoke with had a good understanding of people's individual needs and how to deliver appropriate care. It was clear they had built up good relationships with people. Wherever possible, carer workers were matched with people with similar interests, for instance a shared love of sport. This was recognised by the registered manager as a way to build good relationships between people and care staff.

People's preferences, likes and dislikes were clearly recorded, such as what they liked to eat, do and any interests. Care records focused on ensuring people were offered appropriate choices in all aspects of their care and support.

Information was present within people's care records on social interaction they wanted. Some care packages were heavily focused on social inclusion and activities. We saw clear guidance was provided to staff on the type of activities these people were interested in. Care planning focused on giving people choices about their preferred activity on a daily basis.

There was evidence in people's care records that people and/or their relative had been involved in periodic care plan review. Where people's needs changed or complaints were received we saw evidence that additional care plan meetings took place.

Each person who used the service had an agreed set of call times. We compared agreed call times with the time that calls were actually taking place in people's daily records. Overall, we found call times were acceptable and consistent from day to day. This helped ensure people's individual needs were met.

The service had a complaints procedure in place with information documented including action points and outcomes. We saw there had been nine complaints documented since January 2016 and the correct provider procedures had been followed. We discussed a number of complaints with the registered manager and operations manager and concluded from our discussions with them and other health care professionals that the service handled complaints in an appropriate and responsive manner.

Requires Improvement

Is the service well-led?

Our findings

The service had not notified us of the required statutory notifications as it had not notified us of allegations of abuse. For example, we reviewed the safeguarding log and saw five safeguarding alerts had been made to the local authority within 2016. However the Commission had not been notified of these. This meant we could not fully monitor events which occurred in the service. We warned the provider about the need to notify us of these types of incident in the future.

This was a breach of Regulation 18(2)(e) Care Quality Commission (Registration) Regulations 2009

Systems were in place to assess and monitor the quality of the service but they were not always sufficiently robust. For instance, more analysis was needed of complaints with final outcomes and lessons learned documented as part of a robust system of quality assurance.

The lack of an updated training matrix made it difficult for us to see if all staff had received up to date and relevant training. The registered manager and operations manager agreed the system required updating and assured us the quality assurance manager who was currently on leave had been tasked with this action plan.

Care records such as daily records and medication records were reviewed on a periodic basis. We saw evidence these were identifying some issues such as medication errors and action was taken to address. However we identified these checks were not always sufficiently robust. For example one person's MAR charts had not been audited in March and April 2016 by the date of the inspection on 16 May 2016. It is important to review these promptly to ensure errors are picked up in a timely way. Another MAR chart we reviewed had been audited but the audit had failed to identify that the gap between administrations of pain relief was not always appropriate.

In one person's records, daily records were only present in the office for the period 27 September 2015 to 21 November 2015, and therefore audits of these records only went up until November. This meant there was a six month period where records had not been reviewed. Although this risk was mitigated in the main by the presence of an electronic time and task record, the more detailed and person-centred daily records were not subject to regular review. This also showed us that systems to bring back records consistently and at set interviews for review were not sufficiently robust.

In one person's daily records we identified the details of three visits were missing. Through investigation on the electronic call monitoring system we identified these calls took place but care staff had failed to document the details of the care and support provided. The audit of these records had not identified this omission.

In another person's care records we identified visit times were often significantly less than the 30 minutes agreed. For example in one case the visit time was 12 minutes. Although it may have been possible that the

person did not want staff to stay for the full allocated time, this should have been identified, documented and investigated by the provider.

This was a breach of Regulation 17(2)(a)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An electronic call monitoring system was in place which allowed staff to see in real time if staff were attending calls on time. If any call was over 20 minutes late this was flagged up on a large screen in the office to ensure action was taken to investigate.

Care plans showed evidence that each person's feedback was sought on a regular basis. This was through care plan reviews, telephone reviews and quality checks by management where they visited people's homes to check the quality of documents and ask people opinions on the quality of care and support they were receiving.

People who used the service had been asked to complete questionnaires about the service in 2015 which showed most people were satisfied with the service. The 2016 questionnaire was slightly overdue, although the operations manager told us this would be sent out within the next month.

Staff appraisals were done on an annual basis. However, we saw these were not always up to date, although we saw evidence of regular feedback at supervisions and regular staff meetings. We saw there was a monthly staff newsletter sent to all staff which included company news, update information, training information and opportunities as well as 'carers of the month'.

There was a registered manager in position. Staff and healthcare professionals we spoke with praised and had high regard for the management of the service. One healthcare professional told us, "We have regular meetings with the managers and we have a close working relationship with them" and, "If I ever have the odd concern they have been easily resolved on speaking to the manager." A staff member told us they felt supported by the management team and said, "If we have any concerns there's always someone able to help." Another staff member said, "If we have a problem they'll make time for us." However, some people who used the service expressed concerns about communication with the management team. One person told us, "The communication is awful. People arrange to come for meetings and then change the day or the time or sometimes just don't come and then I'm ringing to see what's happening." Another person told us, "They don't respond very well."

During our visit, we saw management engaging with staff that came into the office. The interactions we witnessed were open and friendly. The registered manager told us they had an 'open door policy' for staff to discuss issues or concerns. We observed staff speaking with people on the telephone in a calm, professional and caring manner. The care manager told us they wanted to foster an open and positive culture and were committed to improving the service to provide the best possible care and support to people. Each month, both the care manager and the operations manager spent time working within the main office alongside frontline staff to ensure they maintained good contact with people that use the service and to 'lead from the front'. The management team appeared committed to making a difference to the people they provided care to and the care manager told us, "We want to improve all the time."

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
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service had failed to notify the Commission about statutory notifications. Regulation 18(2)(e) Failure to notify the Commission about any abuse or allegation of abuse in relation to a service user

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always administered accurately, in accordance with prescriber instructions and in line with current legislation and guidance and at suitable times to make sure that people who use the service are not put at risk. 12(1)(2)(b) Doing all that is reasonably practicable to mitigate any such risks. 12(1)(2)(g) The proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Lack of robust audit systems and processes to identify and respond where quality and/or safety were being compromised and failure to maintain up to date records. 17(2)(a) Assess, monitor and improve the quality and safety of the services provided. 17(2)(c) Maintain securely an accurate,

complete and contemporaneous record in respect of each service user.
17(2)(d) Maintain securely records in relation to persons employed by and the management of the regulated activity