Grandcross Limited

Highfield House Care Home

Inspection report

28 Clifton Road
Ashbourne
Derbyshire
DE6 1DT
Tel:01335 342273
Website: fourseasons@fshc.co.uk

Date of inspection visit: 29 January & 04 February 2016
Date of publication: 22/06/2016

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on the 29 January and the 04 February 2016. It was unannounced. The service was previously inspected on the 25 March 2014. At that inspection the provider was in breach of the Regulation in relation to the administration of medicines. Medicines were found to be administered appropriately at this inspection.

The service provides nursing care to 37 people. Most of the people using the service had complex needs these included people who were living with dementia and physical disabilities.

The service is required to have a registered manager. 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. At the time of this inspection there was no registered manager in the service.

At this inspection we found the registered person had not ensured people were supported by staff who understood

Summary of findings

the right of people to have their dignity and independence promoted. There was not enough staff to meet people's needs in a timely manner. There were long delays in answering call bells.

The registered person's arrangements to assess and monitor the quality and safety of services and to assess monitor and mitigate the risks relating to people's health, safety and welfare were not always operated effectively. The provider did not have an effective quality assurance system in place that identified and addressed shortfalls in the service. The provider had identified some shortfalls but had not addressed them in a timely manner.

The provider did not ensure people received a service that was designed to meet their individual needs and wishes in relation to how they wished to live. People were not offered the opportunity to pursue hobbies and interests. This led to people becoming bored and unstimulated.

Most of the staff understood and complied with the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards. However, none of the staff we spoke with understood the implications for people who were living under different sections of the Mental Health Act 1983.

People were given the opportunity to plan their meals and had a choice of nutritious food and drink throughout the day. Most people were happy with the food. People's medicines were administered safely and people were supported to access other healthcare professionals to maintain their physical health and well-being. We saw that there were thorough recruitment processes in place and these were applied before staff started to work with people. Visitors were welcomed to the home at all times.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration Requirements) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

Risks to people's health and wellbeing were identified in risk assessments however staff were not always aware of them and therefore did not always know how to keep people safe. People were not protected from the risks of harm because staff did not recognise when people's safety was compromised and incidents of possible abuse were not reported appropriately.

We found that medicines were administered in a consistent and safe manner.

There was not enough staff available to deliver people's planned care or to respond to call bells in a timely manner.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff did not have the training the provider considered necessary to assist people to live well, in order to meet their care needs.

People's nutritional needs were met and people were happy with the quality and choice of food.

People had access to healthcare professionals.

When people did not have the ability to make decisions about their care, the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were followed.

Is the service caring?

Requires improvement

The service was not consistently caring.

People's independence and dignity was not always supported.

Not all staff had good communication skills. Improvements were needed to ensure that staff were able to interact with people in a way that met their needs and made them feel cared for.

Is the service responsive?

Requires improvement

The service was not responsive.

Care was not always provided for people in a manner that responded to people's individual needs.

People were not provided with sufficient opportunity to be involved in organised activities or pursue individual interests or hobbies.

People knew how to complain about their care and the provider had a complaints policy available for people and their relatives.

Summary of findings

People had care plans, however staff had not always read them and had relied on handovers for information so could had missed significant facts about people.

Visitors were welcomed to the home at all times.

Is the service well-led?

The service was not well led.

The provider had not ensured the service was managed in a consistent and proactive manner. The service did not have a registered manager.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that where improvements in care were needed, these were not acted on in a timely manner.

Staff's morale was poor and they lacked direction and clear management.

Requires improvement

Highfield House Care Home

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.This inspection took place on 31 January and 04 February 2016 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor in nursing care. Before the inspection we checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan. We spoke with eight people who used the service. We spoke with the relatives of four people to gain feedback about the quality of care. We also spoke with six members of care staff, the assistant manager and the regional operations manager.

We used the Short Observational Framework for Inspection (SOFI) in two areas of the home. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent significant time observing the care provided to people in the home throughout our visit.

We looked at the care records of six people to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included a medicines audit, staff rotas and training records.

Requires improvement

Is the service safe?

Our findings

At our last inspection in May 2014 we found the provider had not administered people's medicines in a timely manner. This was a breach of regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines.

At this inspection we found that improvements had been made.

We found people's medicines were safely managed. The nursing staff responsible for the administration of medicines had completed training in the safe handling and administration of medicines.

Medicines' risk assessments provided staff with details of how to support each person with their medicines. We saw medicines administration records included information and guidelines regarding the use of 'as required' medicines. This ensured people did not receive too much, or too little medicine when it was prescribed on an "as required" basis.

We observed nurses gave people their medicines safely and in a way that met with recognised good practice. Staff explained to people what their medicines were for. We saw one person refuse their medicines and the staff member later offered them their medicines again. The person accepted their medicines the second time. Medicines were stored correctly and current legislation and guidance was followed. This showed medicines management was taken seriously to ensure people received their medicines safely and as prescribed.

Staff told us people were kept safe because they understood their roles and responsibilities to protect them. They said they received training in how to safeguard and protect people from the risk of abuse. The staff team were aware of local procedures for reporting allegations of abuse and told us they were confident in raising any concerns they had. The local authorities safeguarding contact details were displayed on noticeboards which meant this information was freely available to anyone using or visiting the service should they wish to report any concerns directly to the local safeguarding team.

However, staff told us that in the past year they had concerns about the care of people in the service. They felt the registered manager at that time was admitting people they were not able to effectively care for. This resulted in two safeguarding investigations by the Local Authority and the suspension of referrals to the service on two separate occasions during the year. Staff had not recognised the risk and the referrals to the Local Authority had come from outside the service.

This showed that although the training had been completed staff had not fully understood their duty of care. However, at the time of this inspection there was a new management team in place and they had started to address this issue and staff had received further training on safeguarding people.

There was not enough staff on duty to meet people's needs in a timely manner. People we spoke with confirmed this. One person said, "Staff do as well as they can do, it's very difficult to look after more than 20 people." Another said, "They have a problem getting staff, some of them are excellent and they do a fantastic job for what they get." A relative told us that they were not happy with the care offered to their relative as they had to wait too long for their care to be delivered. This meant that their relative often was left to fend for themselves in the best way they could. This sometimes left them in a difficult position. The assistant manager told us they had 'inherited' the staffing levels and were reviewing if staff were appropriately deployed and managed. They said the nursing levels had been low and they were in the process of recruiting.

People had individual risk assessments. These were reviewed regularly and recorded in people's care plans. However the information in the risk assessments was difficult to access. There was no clear and easy way of extracting the information from the care plan. For example, we had to be assisted to find information on how people who are at risk of seizures were cared for. When we found the information it was hand written and difficult to read. The directions to staff were not clear and concise.

Staff told us they did not always read the risk assessment and said they relied on information passed on through staff hand-over meetings at the end of each shift. They said this worked better than trying to read the risk assessments. The assistant manager was aware of this and was in the process of updating risk assessments. They also said the handovers were thorough. We saw the process for this and saw the meetings were recorded. Staff said the meetings were very useful. We saw staff knew how to use equipment to assist people to move and we saw staff transfer people safely.

Requires improvement

Is the service safe?

People told us they felt safe living at Highfield House. One person said they, “Feel safe, absolutely.” Another said, “The staff always make me feel safe.” Families told us they were confident their relative was safe.

Staff said they knew how to respond if anyone had an accident or an incident. We saw that accident and incident forms were completed and available in people’s care plans.

Heads of departments had a daily meeting where risks were identified and where possible addressed. However we noted that one door entering a communal area had no window to allow staff and people a clear view. We saw this created a risk of collision to people who had poor mobility and were unable to get safely out of the way in a timely manner. The provider had not noticed this but undertook to look at this as a matter of urgency.

We found that there were thorough recruitment procedures in place. Relevant checks had been completed to ensure that the applicant was suitable for the role to which they had been appointed. These were done before the person started work in the home and included identity checks, references from previous employers and a security check. This helped to ensure that only staff who were safe to work with people who lived at the home were appointed.

Requires improvement

Is the service effective?

Our findings

People told us staff knew how to care for them. One person said, "The girls certainly seem to know what they are doing." Another said, "They are good at what they do for me, although I need very little in the way of care. I'm not sure how they care for other people."

Staff told us they were starting to feel supported. They had received sufficient basic training in key areas of delivering safe and effective care. One staff member said, "We can now say what training we need with some hope of getting it." Another said, "Mostly we know what to do." They went on to say they felt the previous manager had admitted people to the home whose needs were very high, and they did not always feel confident in knowing how to provide care for them. The felt the new manager ensured they were trained to care for people.

However, staff did not have specialist training. For example some people lived with Parkinson's disease and staff had not been trained to support people with this condition. We were told the nursing staff provided the training. They confirmed this, however there wasn't a system in place to ensure staff understood and put the training into practice. Staff were not able to tell us how the condition affected people they cared for or the impact of the condition on people. This showed that staff did not receive training to update their knowledge of how to meet the individual needs of people. This meant people did not always have care delivered by staff who understood their needs.

Staff training was responsive and was not planned in line with recognised training such as the Care Certificate. Staff we spoke with had received some induction training but hadn't been given protected time to get to know people and to read their care plans. However staff told us they now received management support through the use of staff supervision meetings and team meetings, we saw records that confirmed this. One staff member said of supervision, "I get good feedback". Staff also told us that the acting manager and the deputy manager were very supportive and available for advice or support if needed. They said they really appreciated this and it made delivering care to people with complex needs easier.

Staff we spoke with had some understanding of the requirements of the MCA and the importance of acting in people's best interests. The assistant manager told us how they put the principles of the MCA into practice when providing care to people. Records we looked at showed where people lacked capacity to make a decision about their care or support, mental capacity assessments had been completed and decisions taken in their best interests.

Staff followed the Mental Capacity Act 2005 (MCA) when required for people's care. The 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.

Some staff we spoke with understood the requirements of the MCA and the importance of acting in people's best interests. Records showed some people were unable to make important decisions about their care and treatment because they lived with dementia and it had advanced to an extent they could not make these decisions. Mental capacity assessments had been completed and people's care records showed how their care was to be delivered in their best interests.

The assistant manager and staff we spoke with understood the circumstances which may require them to make an application to deprive a person of their liberty and were familiar with the processes involved. 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). This meant that people's rights were protected.

Forms in relation to 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) were on some people's care plans. However we saw other information in the same care plan that clearly stated they wanted to be resuscitated. This conflicting information was confusing and did not clearly state people's wishes. We discussed this with the assistant manager who told us they would review all DNACPR to ensure they represented the wishes of people.

People had ongoing access to health care. The assistant manager confirmed people were registered with local GP's and we saw a number of health care professionals visiting

Requires improvement

Is the service effective?

the service on the day of the inspection, including a dietician, physiotherapist, GP and community matron. We spoke with a visiting GP who assured us they didn't have concerns about how people were cared for.

We looked at the choice of food and drinks offered to people during our inspection. One person said, "The quality of the food is a bit hit and miss although they have got a new chef." Another said, "There was now poorer choice although I don't see why and there is not enough variety." Relatives told us that staff tried to make mealtimes a social occasion. For example they could join their family member for lunch. One visitor said he had eaten lunch with their relative and it was, "Very good." Another said his relative, "Really enjoys their lunch." One person said although the food was variable they did, "An excellent fresh fruit salad for breakfast." People confirmed they had plenty of choice at mealtimes including hot and cold meals for tea or supper. Our observations supported this.

Food was freshly prepared, nutritious and nicely presented. Most people showed signs of enjoying their meal. We heard some staff supporting people to make a choice of food and drink. However, we saw that other staff served people their food without greeting or interacting with them in any way including making any eye contact with them.

People were offered an alternative if they did not like what was on the menu that day. The cook catered for people with specialist dietary requirements. For example, suitable choices were provided for people with diabetes. Food was also prepared in the correct consistency and calorific value for people who required soft or fortified diets because of their health needs.

People were offered hot and cold drinks at regular intervals during the day and with their meals. We also saw water available on each floor of the building and jugs of fruit squash in people's rooms and communal lounges, for people to help themselves. This meant people had ongoing access to drinks throughout the day.

Requires improvement

Is the service caring?

Our findings

People were not always cared for in a manner that supported their dignity and independence**.** We saw some staff did not make eye contact with people and carried out assisting them without much communication or checking if they were all right. We saw one person was completely ignored by a staff member when they were attempting to get up from the table and struggled to open their walking aid. The member of staff walked right past the person and didn't speak to them. Eventually another care worker came into the room and accompanied the person back to their room. We saw this left them looking sad. This meant that people's right to dignity and compassionate care was not promoted.

Meals were served in the dining room. There was limited space in the dining room and this meant staff had difficulty moving people in their wheelchairs to get to their tables without disturbing other people. We saw one person had to be disturbed and moved more than once to allow access. This showed lack of care and thought for the person.

Another person's dignity was not respected They were eating their meal very slowly and staff cleared the table and cleaned it whilst the person was still eating their meal. The person was reduced to holding their bowl on their knee under the table to enable them to finish their meal. Staff did not speak to them or acknowledged them while clearing the table. The table was cleared without getting the consent of the person still eating. This approach to care meant that the person's dignity and respect was not promoted.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

Despite our observations, most people said they were happy with how they were cared for and staff looked after them well. People spoke of having good relationships with staff. For example on person told us, "They're my friends". Another said, "They are lovely and do their best for us." We saw most of the staff were kind and caring and we saw some examples of where staff communicated well with people. Staff greeted people using various titles such as Mr, Sir or their first name. Discussions with people and a review of records showed staff referred to people by their preferred title. People's care was delivered in private areas of the home and people were taken to their room for GP and nursing consultations and appointments. This approach to greeting people and to care delivery promoted people's dignity.

Mostly people were involved in making decisions about their own care. For example, people said they were always given a choice about what to wear or how they wanted their care delivered. People said staff always asked for their permission before starting to deliver care.

One person was not happy with how their medicines were administered. They told us staff were not giving them the right amount. We checked this and found no inaccuracies. However there had been changes in made in their medicines and these changes were not explained in a manner they understood. This meant the person was needlessly worried about their medicines. Staff told us they would ensure this was effectively communicated to the person.

People who did not have a representative had access to an advocacy service. Details of this service were freely available. This meant people had access to independent representation to ensure their rights were respected and promoted.

Requires improvement

Is the service responsive?

Our findings

The provider did not have systems in place to ensure people had their needs and wishes met within a reasonable period of time. For example, the serving of lunch was haphazard and was not managed in any way. Some people waited at their table for up to 30 minutes for lunch to be served. Once they had finished their meal, they then waited a further 30 minutes before they were taken back to their room. During this time staff were focused on tasks they had to complete such as clearing tables, and we saw that some people were ignored. One person, who was first into the dining room was last to have their lunch served. The person said, "It's like that every day." Another person we spoke with told us they had chosen to stay in their room because of the waiting and said, "Last time I went to the dining room I went down at 12.15 and didn't return until 3.15, they kept moving everyone else but me. I kept asking but it's now much easier to stay here now and watch TV." They said they would like to go to the dining room if the wait was reasonable. Overall, people we spoke with felt their wishes and preferences were known and catered for by staff although not always in a timely manner. All the people we spoke with said the wait was too long.

People also told us that whilst they felt staff were really good, there was not enough of them on duty to respond to their needs in a reasonable amount of time. For example, people said they had to wait too long for their call bells to be answered. One person said, "I can wait up to 20 minutes and that is too long." Another said, "Staff do their best and I am not blaming them, but the wait is usually too long." Staff confirmed call bells could take too long to answer. This meant that people were not having their needs met in a timely manner and this could impact on the quality of their lives. We discussed this with the assistant manager who told us they were aware of this and plans were in place to review staffing levels and the deployment of staff.

Care plans had been written for all of the people who lived at the home and they told us they were involved in discussions with staff about how they could meet their needs. One person said, "I am involved in my care planning". A relative told us, "I was involved in discussions about [relative's] care and was informed of any changes or concerns." . Another person told us the service, "Changed their room to accommodate their new chair with no bother." However staff told us they did not use the care plans on a regular basis as the information was difficult to access. They told us this was because the information within the care plans was not set out clearly and some areas were written in hand writing that was found difficult to read. This meant that care plans were not being used as working documents to aid and assist staff to deliver care based on up to date information on people's needs and wishes.

Care plans were based on people's physical needs and were not person-centred. People's personal histories, aspirations and wishes were not always included. Information was not easily available in care plans and directions to staff were not clear and informative. Staff said that they did not read all the care plans and relied on staff handover meetings for their information. The acting manager was aware of this and care plans were being reviewed as a matter of urgency. This meant that important information that was not used on a daily basis could have been missed and not used to enhance the life of people.

People were not always stimulated or supported to follow their hobbies and interests. People told us they were bored as there was little to do. One person said, "Luckily I like to read so I can entertain myself, otherwise I don't know where I would be." Another said, "It's the same day in day out." The went on to say that staff knew, "I like reading magazines and have a daily newspaper delivered every morning I'd miss it if I didn't have it."

Two relatives told us they had concerns there were not enough staff to motivate or encourage people to undertake activities or interests. One relative said, "There is a general impression that people don't want to do anything, but I feel they are not motivated enough by the staff as there is not sufficient staff to do that." Another said, "The caring side is brilliant but would be nice to see them [staff] sitting down with people, there are not enough staff to do that." They said there was little or no time for staff to sit with people on a one-to-one basis and get to know them.

A part time activity worker had been recently appointed. Activities and stimulation had improved because they had introduced an activity programme. The assistant manager acknowledged that they needed more time and support from the team to develop a broader range of resources and activities for individual people as well as groups. There were plans to include people in the drawing up of an activities programme.

Requires improvement

Is the service responsive?

However due to work patterns the hours of organised activities were not defined and constant. They changed from morning to afternoon without a clear pattern. People were not always aware of when they were available. This had not been taken into consideration and meant people needs were not always put before those of the staff members. However, we saw when available the activity staff member connected well with people. We saw people who had not communicated all day become active and responsive to this staff member. This demonstrated that people wanted to be engaged in social activities and enjoyed the interaction with others. Care staff did not understand the importance of supporting people to stay mentally and physically active. They said that activity and stimulation was not part of their role. This meant that people were left for long periods of time without stimulation and contact.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

The provider had a complaints procedure in place. One person told us, “Complaints are soon dealt with and suggestions considered.” The provider kept a log of complaints. We saw they were responded to and addressed in line with their policy and procedure. One person gave us the details of a complaint they had made in relation to their care. They said the provider responded well. They said they were happy with the timing of the investigation and the conclusion to the complaint. This showed the provider had a responsive complaints process in place.

Requires improvement

Is the service well-led?

Our findings

The service had no registered manager and the home lacked consistent management. The previous registered manager was in post for less than a year. A temporary manager was in post at the time of our inspection. People, relatives and staff said they found the lack of consistent management very difficult. The consequence of this was staff were struggling to understand the type of service the provider wanted them to deliver. This meant that people could not be sure the service recognised and met their needs.

Staff said they were fed up of not having consistent managers. One said, "All the new managers come in want things done differently and as soon as we change they go." Another said, "We try to steer a certain path and do the best for the residents." A third said, "We have no idea who the new manager will be, we have not been told, but that happened before, we get used to it." This left staff struggling for support and guidance.

The provider had not conducted effective quality audits. They had not put effective systems in place to hand over to the new management team and they struggled to find information on how the service had been managed in the past year. Staff told us that they were particularly unhappy with the management of the home during that year. They said they had concerns about the management of the service but were not sure who to go to. The provider was not aware of this and did not act until a staff member 'whistle blew'. This meant that their monitoring of the service was not effective and had not recognised failings and risks in the service. This resulted in the Local Authority investigating two safeguarding referrals and suspending referrals to the service twice in the last year.

Staff who had been working in the service for many years said they wanted stability in the management team. Relatives said that there was also a lack of consistency in sharing information and plans for the future management of the home. They said this was causing uncertainty and confusion in the staff group.

The provider did not have systems in place to ensure staff worked in a way that supported people. There was an uncoordinated approach to providing people's care and support. For example care staff did not understand the importance of social stimulation for people. This meant stimulation and promoting interests and hobbies was down to one staff member in a part time capacity. The results of this were people were unstimulated and bored.

Staff did not respond to call bells in a timely manner. This left people uncomfortable and in some cases distressed.

Discussions with the management team showed that some staff had a 'dated' way of working. By this they meant staff worked in a manner that focused on the task they were performing rather than focusing on people they were caring for. They said they were having difficulty in moving them to a more practical way of meeting people's needs. The lack of consistent management meant staff were reluctant to embrace new management in case this proved to be short term. This had a detrimental effect on the home as staff retention was difficult and staff who had worked in the home long term had not embraced change. The results of this was a service based on tasks rather than on personalised care. Care staff did not see stimulation of people as being relevant to their post.

We were told by staff "Some staff go unchallenged for poor attitude." Staff told us they did not always feel supported by senior managers but all acknowledged the current management team were starting to put systems in place to support them. Staff told us they were anxious about trusting them as there was a presumption based on the past that the team would not be settled.

The provider told us they was aware of how staff were feeling and said they were working to gain staffs' trust. They acknowledged that the past record of management in the home was not good enough and told us they were taking the appointment of a new management team as a matter of urgency.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: The registered person had not ensured people were supported by staff who understood the right of people to have their dignity and independence promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The provider did not ensure people received a service that was designed to meet their individual needs and wishes in relation to how they wished to live.

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 How the regulation was not being met: The registered person's arrangements to assess and monitor the quality and safety of services and to assess monitor and mitigate the risks relating to people's health, safety and welfare were not always operated effectively. Regulation 17(1) (a) and (b).