Mrs Eleni Panayi

Bolters Corner Nursing Home

Inspection report

Bolters Lane
Banstead
Surrey
SM7 2AB

Tel: 01737361409

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Bolters Corner is a care home providing personal and nursing care to people with a range of needs such as dementia and Parkinson's Disease. The care home accommodates up to 35 people in one adapted building. At the time of the inspection, the service was supporting 33 people.

People's experience of using this service and what we found
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Although risks were managed due to staff knowing people well, risks were not always appropriately recorded or visible for staff to refer to. Medicine administration and recording practices were not always safe, leaving people at risk of not receiving their medicines correctly. Records were not always robust or contemporaneous, which meant the registered manager could not always demonstrate full management oversight in areas such as auditing and accident and incident mitigation.

Recruitment checks were not always thorough. We addressed this with the registered manager who has since ensured full employment history and references have been gathered. Individual staff supervision meetings were not always being completed throughout the year. However, staff informed us the registered manager was always available to speak to and they had attended group supervisions.

People, relatives and staff all praised the management of the service, commenting on its "family feel" and positive ethos of ensuring people received a high- quality life. People and relatives felt able to raise concerns and staff felt highly supported by the registered manager. Feedback was sought from people, relatives and staff through meetings and surveys.

There were a sufficient number of appropriately trained staff to meet people's needs. Staff knew people well,, and took time to engage them in activities that were personal and joyful to them. People and relatives felt staff were kind and compassionate towards them, and we observed interactions which confirmed this throughout our inspection. People were encouraged to maintain their independence where possible, and had their dignity and privacy respected.

People were supported to maintain their nutritional and hydration needs through staff support and adapted equipment. Referrals to healthcare professionals were completed where required, and a visiting healthcare professional commented on the high level of communication from staff as well as their willingness to follow any advice. This included working alongside outside organisations to ensure people received the care they needed, such as the local hospice during the end stages of people's lives. The environment was set up to meet the needs of people with cognitive impairments.

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

Rating at last inspection
The last rating for this service was Good (published 5 September 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to people's rights and liberties not being protected in line with the principles of MCA 2005, risks to people not always being recorded, medicine recording and administration not always being safe, and records not being completed in full at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We have made recommendations around recruitment checks for new staff. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

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Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Bolters Corner Nursing 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of three inspectors, one of whom acted as 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.

Service and service type
Bolters Corner Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at our inspection. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who lived at the service, seven relatives and seven members of staff including the registered manager. We also spoke with a visiting healthcare professional. We reviewed a range of documents including seven care plans, medicine administration records, accident and incidents records, policies and procedures and internal audits that had been completed.

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

After the inspection
Following the inspection, we reviewed additional information we requested from the inspection such as the service's staff training matrix and updated mental capacity assessments.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● Medicine administration and recording practices were not always safe. Protocols for as and when medicines (PRN) were not in place. PRN protocols inform staff of the signs that a person requires a PRN medicine administered, and what the maximum dosage of the medicine is within a 24-hour period. We raised this with the registered manager, who confirmed these had not been in place, but would be with the introduction of the new electronic medicine administration record (MAR) system.

● Body maps were not in place to inform staff of where they should apply pain patches. This left people at risk of the medicine being incorrectly placed and therefore compromising its effectiveness or causing skin irritation if placed on the same part of the body repeatedly. One relative told us they had found a pain patch in the family member's clothing. Staff were not able to identify what area of the body the patch had fallen away from.

● Some people were receiving their medicines covertly, with it being disguised in food or drink. Some covert medicine protocols had not been reviewed since 2016. These should be reviewed regularly to ensure people were still receiving medicines that were required and it was being administered in the correct way.

● MAR charts were not always being completed in full. This meant staff could not be certain that people had received their prescribed medicines.

Assessing risk, safety monitoring and management

● Risks to people were not always clearly recorded. For example, one person had a diagnosed health condition. Information on how to de-escalate any behaviours of anger or frustration were recorded in a document that was uploaded to the care planning system but was not included in the person's psychological and emotional care plan. We informed the registered manager of this who said they would ensure the information was transferred in to the person's care plan. Since the inspection, we have received evidence that this has been done. As staff knew the person well, there had been no impact to them.

●Personal emergency evacuation plans were in place. However, these were generic and did not state what individual help a person would require leaving the building in an event such as a fire. The registered manager informed us that these would be updated. Following the inspection, we received evidence from the registered manager that this had been done.

Learning lessons when things go wrong

● Accidents and incidents were recorded but did not always include information of action taken to prevent future risks. For example, one person had been falling frequently, with each occurrence documented. However, accident and incident forms did not record that a sensor mat and hourly observations had been put in place to mitigate the risk of occurring again. As action had been taken, the impact to the person was

low, but further work was required on documentation around this.

People's medicines were not always stored and managed in a safe way, and ongoing risks to people and how staff were mitigating them were not always appropriately recorded. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, medicine storage was safe. The clinical room where medicines were stored was clean and organised.
● Risks to people were appropriately managed. One person was nursed in bed and at high risk of pressure sores. Daily notes demonstrated staff were regularly repositioning the person to keep their skin intact.
● The registered manager checked accidents and incidents records for any trends. There was no formal documentation of this but due to there only being a small amount of accidents and incidents occurring, there was no impact to people.

Staffing and recruitment
● Safe recruitment checks had not always been completed. Staff member's' employment history had not always been gathered and recorded, meaning that unexplained breaks in employment could not be investigated further. References from previous employers had not been obtained and recorded to ensure the staff member was of good character. We advised the registered manager of this who has since sent us evidence that these had been completed.
● People and relatives felt there were enough staff to meet people's needs. One person said, "The staff are never rushed." A relative said, "Whenever I've been here there is enough staff."
● Staff sickness and annual leave was covered by permanent staff rather than agency workers. Staff members confirmed this, with one telling us, "We always work it out, [staff members] will always cover." Another staff member said, "They will call people on their day off if someone is sick. It's always covered." This allowed people to receive care from staff who were familiar to them.

We recommend that full employment history is gathered, and recruitment checks are thorough for any newly employed staff.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us they felt safe living at Bolters Corner. One person said, "The staff know how to keep me safe and the home is so secure." A relative told us, "I think [my family member] is safe here. As soon as he moved in he was well looked after and settled so quickly. He feels safe too."
● Staff were aware of their responsibility to safeguard people from abuse. One staff member told us, "I always look out for any issues or concerns and address or report them straight away if necessary." Another staff member said, "I'd report it to the registered manager, local authority, CQC or whistle blow. We have a lot of options, but I know the manager would act appropriately."
● There had been no safeguarding incidents for the local authority to be made aware of. However, the registered manager knew the type of issues or incidents which would need to be reported.

Preventing and controlling infection
● Staff adhered to infection control procedures. We observed staff washing their hands thoroughly and using personal protective equipment (PPE) where required.
● The service was clean and tidy with no malodours. Laundry was washed and stored correctly to prevent cross contamination.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 when this is in their best interests and legally authorised under the MCA.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Staff did not always follow the principles of the MCA. Decision specific capacity assessments had been completed for one person which had found them to have mental capacity. However, a DoLS application had been submitted to the local authority to deprive them of liberties, including access to their mobile phone and administering medicine covertly. A person cannot be deprived of their liberty if they have the mental capacity to make a decision; even it is unwise. Therefore, the registered manager had not applied the principles of the MCA.
- Another person had been found to have capacity to consent to personal care which was documented on a mental capacity assessment. However, a DoLS application has also been submitted stating they did not have capacity to consent to this.
- Best interest decisions had not been completed. These ensure the people involved in a person's care such as their family and GP discuss what is the least restrictive option for the person when depriving their liberty in some way. We raised this with the registered manager who informed us they would review the documentation around mental capacity. Since the inspection, we have received updated mental capacity assessments by email from the registered manager. However, these still did not fulfil the principles of the MCA 2005. Therefore, we have provided further feedback to the registered manager and will review this during our next inspection.

People's rights were not protected in line with the principles of the MCA 2005. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Pre-admission assessments were completed prior to people moving in to the service to ensure their needs could be met. A relative confirmed, "[The registered manager] came and did an assessment." These included details around the person's health, social and personal care needs."
● Nationally recognised standards were used to assess people's needs. For example, Waterlow scores were used to determine a person's risk of skin integrity breakdown.
● Staff were kept up to date with new and changes to existing best practice and national guidelines. One staff member told us, "The manager will always tell us of any new practices." Another staff member said, "The [registered] manager will tell us in handovers and staff meetings if there are any new guidelines we need to follow."

Staff support: induction, training, skills and experience
● Supervision records demonstrated that some staff had not received individual supervision meetings since early 2019. Two staff members had not received a formal supervision since 2014. However, staff told us the registered manager was available to speak to at all times so they felt there was no impact to them. The registered manager also held group supervisions if they had identified areas in the service for improvement.
● Staff were up to date with training. This included areas such as first aid, moving and handling and safeguarding. One staff member told us, "There is enough training. Last week was food safety training. We can ask for more training if we needed it."
● People and relatives felt staff were well trained. One person said, "They are very good at what they do, they are very well trained I think." A relative said, "Staff know what they are doing. They take care of the residents really well."

Supporting people to eat and drink enough to maintain a balanced diet
● People and their relatives were complimentary about the food. One person told us, "The food is very good, I always get choice and it tastes very nice." A relative said, "The food is very good."
● People were supported with their nutritional and hydration needs. Those requiring assistance to cut their food or eat were given it during meal times. Pureed and soft meals were available for those who required a modified texture diet.
● People at risk of malnutrition were monitored closely. People assessed as high risk were weighed weekly and were given high calorie snacks to encourage weight gain or maintenance.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Relatives felt that staff kept them up to date with important information around their loved ones. One relative said, "Staff keep me updated. They will phone me if the GP is coming in." A visiting healthcare professional echoed this, saying, "Staff follow instructions well. Communication is key, they do it very well. They are very proactive about talking to patients and family members and communicating messages back to me."
● There was an effective communication system in place for staff. The electronic care system front screen included a communication area where the registered manager could update staff on important information.

● Referrals to healthcare professionals had been completed where required. Care plans evidenced input from a variety of professionals such as chiropodists, podiatrists, opticians and GPs.

Adapting service, design, decoration to meet people's needs

● The environment was set up to meet the needs of the people living at the service. Chairs were arranged in clusters to promote social interaction. Corridors were wide enough to allow for wheelchairs use.

● People's rooms were personalised to suit their own interests and taste. This included pictures of loved ones and their own personal duvet covers.

● Adapted equipment was in use to aid the support being provided to people. For example, we observed the use of ceiling hoists, toilet seat raisers and profiling beds for people who required them.

Good

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.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People and relatives informed us that staff were kind and caring towards them. One person said, "Staff are very supportive and respectful. They are all very nice and very good at their job." A relative told us, "I can't speak highly enough about the care. They are a very caring family (running the service). I am very fortunate to have found this place."
- Staff greeted people with smiles, hugs and affection. We observed staff singing Happy Birthday to a person several times throughout the day. Staff told us that the person was likely to forget it was her birthday due to a cognitive impairment, so they did it to remind her but also make her feel special throughout the day.
- Staff spoke equally as warmly about the people they cared for. One staff member said, "I just always treat people how I would want my mum treated if she was living here." Another staff member told us, "The people here are all beautiful souls in their own way."

Supporting people to express their views and be involved in making decisions about their care

- People were involved in decisions around their care, with their families taking part if the person had been unable to. One relative said, "They encourage [my family member] where they can, even though he can't really make many decisions anymore." Another relative told us, "I was fully involved. They always give dad a choice too. They talk to him and tell him what they are going to do. They're very respectful." Another relative said, "They always discuss things with me." Care plans recorded where people and their relatives had been involved in reviews of their care.
- Staff involved people in making day to day decisions around their care and support. One staff member told us, "I'm always asking people to make day to day choices and then encourage them to make choices and decisions about their care." Care plans demonstrated people and their relatives had been involved in reviews and their opinions were welcomed and recorded.

Respecting and promoting people's privacy, dignity and independence

- People's dignity and privacy was respected. One person said, "Staff are very supportive and respectful." People and other relatives echoed this. People's bedroom doors included a clear glass pane that could lead to people's dignity being compromised as it allowed people to look in to their room during personal care. However, the registered manager had recognised this and installed a slide panel to allow dignity to be respected during personal care and when people requested it to be utilised.
- Staff encouraged people to maintain their independence as long as possible. A staff member told us, "I always encourage people to do little things such as mobilising more frequently to keep everyone moving." People were given adapted equipment to aid this. For example, one person was given a plate guard for their

lunchtime meal. This allowed them to eat their meal without staff input and maintain their independence with meal times.

Good

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- There were a variety of activities available for people to take part in. One person told us. "Some of the activities are fun, there's quite a variety." A relative said, "They always have the music man once a week. [My family member] loves that and starts tapping his feet."
- Staff had time to sit with people and spend time engaging in conversations and activities that were important to them. We observed one staff member sitting with a person and looking through a magazine about motorbikes. The person was clearly engaged and enjoying the conversation. A staff member told us, "With the people that spend a lot of time in their room I'll try to spend time with them. Whether it's reading, or just having a chat about things that they were interested in in the past."
- There was an open visiting policy. People's family and friends were able to visit at any time without making an appointment. One person told us, "My wife can visit me whenever she wants." A staff member told us, "[Relatives and friends] can visit whenever they like. We encourage it."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Care plans included information around how to communicate with people individually. These included if people had visual or hearing impairments that staff needed to be aware of.
- A staff member introduced us to a person and respectfully explained to us they were blind. They then informed the person we were sitting on their left-hand side. This allowed the person to be aware of our presence and engage in a conversation.

Improving care quality in response to complaints or concerns

- The service had not received any complaints since our last inspection. However, people and their relatives felt able to raise a complaint if they needed. One person said, "I would be comfortable to (raise concerns) but I haven't yet had to." A relative told us, "If I want to talk to someone I always can." A staff member said, "We take it very seriously. I make notes and as soon as possible speak to the manager if someone has a complaint."
- People and their relatives were provided with satisfaction surveys to gather their feedback. Responses received were positive, with one saying, "As a family we are very happy and glad that our father is at Bolters Corner. They are excellent, and they became a family for our father and to us." Another read, "I would like to

say that you do a very good job, and there is nothing that concerns us."

End of life care and support

● Care plans included information around people's end of life wishes. This included if they wanted to be resuscitated and who they would want to be called if their health deteriorated. This meant people's wishes could be known by staff and respected.

● Relevant healthcare professionals were involved in people's end of life care. This was to ensure people were pain free and comfortable. For example, we observed one person was having input from the local hospice to manage their pain.

Requires Improvement

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Areas of documentation had not been completed in full. As reported in the Safe and Effective domains, even though risks were managed appropriately, information around people's risks were not always recorded. Further improvement was also required in documentation around MCA and accidents and incidents.
- Furthermore, care plans did not include personalised care information around people's life history, likes and dislikes. However, as staff had worked at the service a long time and knew people well, there was no impact to people. We did raise this with the registered manager as new and agency staff members would require information around this. The registered manager informed us this would be addressed. We will review this during our next inspection.
- Although the registered manager told us they were completing regular audits, he confirmed these were not being recorded. For example, checks on MARs and medicine storage were being completed regularly but the registered manager was not documenting his findings, but said "We don't mess about. If something needs to be done, it's done straight away." We raised the need for improvement of documentation with the registered manager. He told us, "I'd rather our people were well looked after and cared for than the records being perfect, but I also completely understand they're important too."

Documentation was not always completed in full or contemporaneous, and audits were not always recorded. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- However, other audits were being completed and recorded. For example, a maintenance audit had identified that new flooring was needed in areas of the home. We observed this had been completed.
- The registered manager was aware of their responsibilities in ensuring that CQC were notified of significant events which had occurred within the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service was a family run business, with the registered manager having been involved with the service since he was 11 years old. People, relatives and staff felt this had created a warm environment and that the

registered manager was approachable. One person said, "[The registered manager] is really nice and always here." A relative told us, "[The registered manager] is very good. They're a family business and very family orientated. I can talk to anyone about anything." Another relative told us, "[The registered manager] is great, they're all friendly. He's always smiling and gives you hope. He always says to tell him if I'm worried about anything."

● A healthcare visitor echoed this, telling us, "[The registered manager] has a good grip of all staff members and residents here. It makes it work very well."

● There was a shared ethos within the service amongst the staff. The registered manager said, "We are a home for life. Once people move here, they never need to move out." When we asked a staff member what the ethos of the service was, they explained, "Just to provide the best care as possible to give the people living here the best quality of life." Another staff member said, "People were always put first."

● Staff members were valued and supported by the registered manager. Some staff had been signed up to English courses to help build their skills and other staff had received financial help where needed. The registered manager told us, "I don't have anyone on minimum wage. Firstly, they'll stay and not want to leave their job here, and if they're going home and can't buy a pint of milk it's not right. It makes them more reliable and feel valued."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were involved in the running of the service. One person told us, "They're always asking if I'm happy with various parts of the home, ask if I have any improvements to suggest." Relatives also confirmed they were able to provide feedback through meetings.

● Staff meetings were held twice a year. Minutes of the meetings demonstrated a range of topics were discussed, such as findings from recent audits, communication and infection control. Staff who were not able to attend the meeting were asked to sign to confirm they had read the minutes. A staff member confirmed, "I know what is expected of me through staff meetings."

Continuous learning and improving care; Working in partnership with others

● There were plans in place to improve the running of the service. The registered manager told us, "We're starting to use the new electronic MAR system in March. I'm also supposed to hear today if permission has been granted for a building at the end of the garden for staff to live in if required."

● There were strong working partnerships with outside organisations. The registered manager attended forums with the local Clinical Commissioning Group (CCG) and worked in close partnership with a local mental health hospital.

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 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure people's rights were protected in line with the principles of MCA 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider to ensure people's received safe care and treatment at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure records were completed in full and contemporaneous.