Teignbridge House Care Home Limited

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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

This comprehensive inspection took place on 5 July 2018 and was unannounced. We last inspected this service in May 2017 where it was rated 'Requires Improvement' overall and 'Requires Improvement' in the Effective and Well-led key questions. Following the previous inspection in May 2017 we identified two breaches of regulation, corresponding to regulation 11, need for consent, and regulation 17, good governance. During this inspection in July 2018 we found that sufficient action had been taken to improve on these areas. However, we identified some different concerns, relating to medicines.

Teignbridge House 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. Teignbridge House accommodates up to 24 people in one adapted building. At the time of our inspection there were 22 people living in the home.

The service had 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.'

Prior to our inspection an incident had occurred involving the lack of window restrictors on a bedroom window and a person had been injured. During this inspection we looked at the actions taken to minimise the risks of similar incidents taking place. We found the provider had taken steps to ensure other people living in Teignbridge House were protected from similar risks.

All the people living in the home needed help from staff to take their medicines. When reviewing people's medicines, we found a number of inconsistencies between the number of tablets people had in stock compared to the numbers recorded. This meant it was not possible to tell whether people had been taking their medicines as prescribed by their doctor.

We found records were not always accurate. For example, we found some falls people had experienced had not been recorded in the accident book or the falls diary. People's care plans were highly detailed however, and contained lots of clear guidance and information for staff on how best to support people.

Although action had been taken to implement improvements following our previous inspection in relation to the monitoring of the service, we found concerns remained as issues relating to medicines had not been identified. This meant the service was still in breach of regulation with regards to good governance.

We found the systems in place to manage the laundry in the home were not effective. People's clothes were regularly getting lost or mixed up with the laundry of others. Complaints had been made by people in the home and by relatives. The registered manager told us they were in the process of reviewing the systems in place to manage this and were going to be allocating specific hours for staff to oversee this and ensure these

issues were dealt with.

Action had been taken to ensure staff understood the Mental Capacity Act 2005, the principles of the Act and how to apply these. We found people were involved in all aspects of their care and their consent had been sought prior to any care being delivered.

Recruitment procedures were in place to help ensure only people of good character were employed by the home. Staff underwent Disclosure and Barring Service (police record) checks before they started work. Staff knew how to recognise possible signs of abuse in order to protect people. Staffing numbers at the home were sufficient to meet people's needs. Staff had the competencies and information they required in order to meet people's needs. Staff received sufficient training as well as regular supervision and appraisal.

The people who lived in Teignbridge House were provided with care which was person centred and met their individual needs. People and staff told us they were confident people living in Teignbridge House were receiving a good standard of care. Comments included; "You'd go a long way to find a better place than this, they're remarkably good here at taking care of you, at first I was sceptical, but I can't fault it, I am perfectly happy" and "On the whole when you get to this stage in life and come to live in a place like this it's very good."

We received some very positive feedback from everyone we spoke with about the caring nature of staff at Teignbridge House. People made comments including; "Yes it's very good, in fact it's excellent and the staff are all lovely", "The carers are very good, one of the best around I would say for everything" and "They're all very polite, they are human beings and they do a marvellous job and cope with so many situations, I feel very well cared for."

People were supported with their wellbeing when they were at risk of isolation. One person told us they had needed to stay in their room for a few weeks because of their health. We asked them if they ever felt lonely and they replied; "If I ring the call bell they come very quickly, even at night." They also said; "Someone usually pops in every half hour or so anyway, they all come in."

People, relatives, staff and healthcare professionals were asked for their feedback and suggestions in order to improve the service. People were provided with enough food and fluids to meet their needs. Care was taken to ensure people enjoyed their food and it met their personal preferences. Comments from people included; "The food is lovely. That's why I've put on a stone since being here" and "Yes, the food is very good, there's soup and two choices, if you don't like the choices you can have something else."

People had access to activities which met their needs. The home hired an activities coordinator who was continuously looking for ways to improve people's lives through activities and engagement. They told us about a project they had set up called the Penpal project alongside the local junior school and how much people enjoyed this.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to people not always being safe from risks relating to the management of medicines, records not always being accurately maintained and the systems in place to monitor the service not always being effective. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The systems in place to manage medicines did not ensure people had their medicines as prescribed.

People were protected from the risk of abuse as staff understood the signs of abuse and how to raise concerns.

Risks relating to people's health needs had been identified and action had been taken to minimise these.

Assessments of risk and risk management plans had been put in place.

Is the service effective?

Good

The service was effective.

People's rights were respected under the Mental Capacity Act 2005.

People's consent was sought prior to care being provided.

Staff felt supported and told us they received sufficient training to carry out their role. Staff understood people's needs and how to best meet them.

People had access to enough to eat and drink in a way that met their preferences.

Is the service caring?

Good

The service was caring.

Staff demonstrated respect for people's dignity and privacy.

We observed some positive interactions between people and staff.

People spoke very highly of the staff at the home and the care they provided.

Staff knew people well and knew how best to communicate with them.

Is the service responsive?

Good

The service was responsive.

People's needs had been identified and were regularly reviewed. Action was taken to respond to changing needs.

Care was person centred and people were included in the running of the service.

People were provided with sufficient activities and stimulation to meet their individual needs.

People were encouraged to make complaints should they have any and these were listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led.

Although improvements had been made, concerns relating to the effectiveness of the monitoring systems remained and therefore the service remained in breach of regulation.

There were systems in place to assess and monitor the safety and quality of the care provided but these had not always been effective in identifying concerns.

People spoke highly of the registered manager and the leadership team.

People were asked for their views and these were acted on to improve the service.

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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.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls from height. This inspection examined those risks.

This inspection took place on 5 July 2018 and was unannounced. One adult social care inspector and one expert by experience carried out this inspection. An expert by experience is a person who has personal experience of using services or caring for a person who uses services. In this case the expert by experience had experience in caring for a person living with dementia. Prior to the inspection, we reviewed the information we had about the home, including notifications of events the service is required by law to send us.

During the inspection we spoke with 12 people who lived in the home. On this occasion we did not conduct a SOFI (Short Observational Framework for Inspection). SOFI is a specific way of observing care to help us understand the experience of people who are unable to talk to us. However, we did use the principles of SOFI when conducting all our observations
around the home.

We spoke with the provider, who is also the registered manager, four members of staff and two visiting healthcare professionals. We looked at the ways in which medicines were recorded, stored and administered to people. We also looked at the way in which meals were prepared and served and reviewed in detail the care provided to four people, looking at their care files and other records. We reviewed the recruitment files for three staff members and other records relating to the operation of the service, such as

risk assessments, complaints, accidents and incidents, policies and procedures.

Requires Improvement

Is the service safe?

Our findings

We identified some risks to people relating to the management of medicines. We reviewed the medicines for three people who lived in Teignbridge House and found inconsistencies in the medicine stock levels. Each person's medicines were kept within a safe in their bedroom and staff told us they regularly conducted audits and checks to ensure medicines were recorded and administered correctly. However, we found, there were inconsistencies in the amount of medicines held for three people. The numbers of tablets recorded on people's individual medicine administration record sheets did not correspond to the numbers of tablets present within their personal safe. At times the numbers in the safe were too high and sometimes they were too low. This meant the provider could not assure themselves that people were receiving their medicines as prescribed by their doctor and could therefore place people at risk of harm. Following our inspection, the provider put in place new checking and auditing systems to ensure stocks matched records. They also ensured a full audit took place and spoke with staff about the importance of record keeping in relation to medicines.

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

Prior to our inspection an incident had taken place involving a person gaining access to the roof through an unrestricted window. This had resulted in the person sustaining significant injuries. Following this incident, the provider had taken action to install restrictors on all the windows which ensured people were protected from the risk of falling from a height. The provider had completed an environmental risk assessment which had also identified that some taps people had access to were not fitted with working temperature restrictors and therefore people had been placed at risk of scalding. The provider had ensured these were all fitted and the risks were minimised. We found these risks had been mitigated and found that risks to people's safety and welfare had been identified and acted upon. These included risks to people's skin integrity and risks relating to nutrition and hydration.

Some improvements were still needed with regards to the maintenance of the home. For example, there was a hole in a pane of glass in the staff toilet which could easily be accessed by people living in the home and could potentially place them at risk of cutting themselves. We raised this with the registered manager who told us they were in the process of working through a list of required maintenance tasks and this was already on the list. Regular environmental audits were being undertaken to ensure the premises and equipment were well maintained.

People who lived in Teignbridge House told us they felt safe. One person said; "I feel absolutely safe." Another person described to us how they felt safe in staff's hands when being transferred in a hoist. They said; "Yes they're always gentle, there's no trouble like that." During our inspection we spent time observing people's interactions with staff. We saw people spending time with staff, reaching out to them, smiling, chatting and looking comfortable in their presence. This indicated to us that people felt safe in staff's company.

Recruitment practices at the service ensured that, as far as possible, only suitable staff were employed. Staff files showed the relevant checks had been completed. This included a disclosure and barring service check (police record check). Proof of identity and references were obtained as well as full employment histories, this protected people from the risks associated with employing unsuitable staff.

Staff numbers were sufficient to ensure people were safe from risks and meet their needs. One person said; "There are enough staff. I don't have to wait. I ring the bell and they come down straight away." During our inspection we saw staff supporting people at their own pace in a relaxed way. Staff responded to call bells promptly and we saw staff spending time with people one on one. Staffing numbers and deployment changed depending on people's needs. At the time of our inspection there were five members of care staff working in the mornings, three in the afternoons and two waking staff at night. These numbers did not include management staff and activities staff.

People were protected by staff who knew how to recognise signs of potential abuse. Staff confirmed they knew how to identify and report any concerns. Staff had received training in how to recognise signs of harm or abuse and knew where to access the information if they needed it. Safeguarding information and relevant contact numbers were displayed within the home for them to use.

Good infection control practices were in use and there were specific infection control measures used in the kitchen and in the delivery of people's personal care. The home had fire extinguishers, fire protection equipment and clearly signposted fire exits to assist people in the event of a fire. Each person had a completed personal emergency evacuation plan which detailed how they needed to be supported in the event of an emergency evacuation from the building.

Good

Is the service effective?

Our findings

Following our previous inspection this key question had been rated as Requires Improvement. A breach of regulation had been identified with regards to a lack of understanding of the Mental Capacity Act 2005 (MCA). Following our inspection staff had received training in this area and displayed an understanding of the Act and its principles. Some people who lived in Teignbridge House had been diagnosed with dementia. This condition sometimes affected people's abilities to make specific decisions at specific times. 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.

Following our inspection in February 2017, people's care plans had all been reviewed to ensure they all contained information about their ability to make decisions and how to best support people to make these where they could. We did find one person's care plan did not contain an individual mental capacity assessments or evidence of best interests decisions being made with regards to a sensor mat and bed rails. We raised this with the registered manager and they took action with regards to this immediately.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). If a person is under continuous supervision and control, is not free to leave to live elsewhere and does not have the mental capacity to consent to these arrangements, they are being deprived of their liberty. An application must be made to the local authority for legal authorisation. Some people who lived in Teignbridge House were under constant supervision and control and were deprived of their liberty in that they were unable to leave the home on their own. We saw the registered provider had made applications to the local authority where these were required.

People spoke highly of the care they received at Teignbridge House. People made comments including; "For me, it's great" and "We have a laugh. I love it."

People were supported by staff who knew them well and had the skills to meet their needs. Staff had undertaken training in areas which included the Mental Capacity Act 2005, safeguarding adults, medicine management, health and safety, infection control, food hygiene, first aid and fire safety. Staff also undertook training specific to their role and the people they cared for. This included; challenging behaviour, coping with aggression, dementia, pressure sores, communication, diabetes, stroke awareness and malnutrition. Staff training needs were regularly reviewed. Staff confirmed they received adequate amounts of training to carry out their roles and told us they could always ask for more if they wanted. One member of staff said; "They're really good here at giving training."

Staff received regular supervisions and appraisals. During supervisions staff had the opportunity to sit down in a one to one session with their line manager to talk about their job role and discuss any issues they may have. These sessions were also used as an opportunity for the manager to check staff's knowledge and

identify any gaps and training needs. One member of staff said "I feel supported. The managers are good and they check what you know."

People were supported to attend medical appointments when necessary. Medical advice and treatment was sought promptly. Records of medical appointments contained evidence of treatment and advice. Community nursing records for each person were stored in people's rooms with their care plans and this ensured good communication systems between community nurses and care staff. The provider told us they had recently purchased a new vehicle that transported wheelchairs. They told us this had helped with accompanying people to appointments and taking people out for activities. One member of staff said; "It's made such a difference having the van, we can take everyone to their appointments, we've only had it for six months but we're making good use of it." We spoke with two visiting healthcare professionals. They told us staff knew people well, listened to any guidance provided and acted on it.

There was a strong emphasis on the importance of people eating and drinking well. People spoke highly of the food and commented; "The food is lovely. That's why I've put on a stone since being here" and "Yes, the food is very good, there's soup and two choices, if you don't like the choices you can have something else, we get the menu the day before." We observed the lunchtime meal and saw people enjoyed the food and the social atmosphere. One person commented on the meal they had eaten by saying; "It was delicious, and the meat just fell apart."

Where people had specific needs relating to their food, such as a different texture due to swallowing difficulties, we found this had been identified and catered for. The cook and staff were clear on what type of food people liked and the texture they required to keep them safe. We spoke with the cook at the home who told us; "We have pureed, soft, and cut up diets here, I know what sizes of portions everyone likes from extra-large to small. They're like family to me now, I make sure they have a choice."

Steps had been taken to make Teignbridge House comfortable and decorated in a way that encouraged people's independence and met the needs of people living with dementia. The design and decoration of the premises promoted people's wellbeing and their wishes were taken into account. Efforts had been made to enable people with dementia to be less likely to get confused or disorientated. There was some signage available to help people find their way around. The dining room had recently been re-decorated and people had given positive feedback about this. Further improvements were in the process of being made.

Good

Is the service caring?

Our findings

We received some very positive feedback from everyone we spoke with about the caring nature of staff at Teignbridge House. People made comments including; "Yes it's very good, in fact it's excellent and the staff are all lovely", "The carers are very good, one of the best around I would say for everything" and "They're all very polite, they are human beings and they do a marvellous job and cope with so many situations, I feel very well cared for."

People were involved in all aspects of their care and support. Staff encouraged people to make choices in as many areas as possible. During our inspection we saw people making choices with regards to their food, their drinks and the activities they participated in.

People were encouraged to remain as independent as possible with regards to everyday skills and freedom of movement. Where people were able they were encouraged to go out into town and take part in groups and activities outside the home. People commented; "I've got no concerns or complaints about the place, I am very independent but they (carers) always help me to do as much as I can, and they always keep an eye on me." People's care plans highlighted what they were able to do for themselves and how staff should support and encourage them to maintain these for as long as possible. For example, where people were able to take part in their own personal care, staff were instructed on how to support this.

During our inspection, staff demonstrated they cared deeply about people's wellbeing and their self-esteem. Staff spoke to us in ways which demonstrated their respect and care for the people they supported. Comments included; "I love the residents. They make it a lovely place to work." People were encouraged to take part in activities which increased their wellbeing and self-esteem. One person told us how staff supported them to continue to take part in an amateur dramatics society they were a member of. They told us they truly enjoyed this and staff encouraged them.

The atmosphere in the home was warm and welcoming. During our inspection we saw and heard people chatting pleasantly with staff and sharing jokes with them. We saw people sharing names of endearment and physical affection with staff. All the interactions we observed were positive and encouraged people to feel comfortable and cared for.

People were supported with their wellbeing when they were at risk of isolation. One person told us they had needed to stay in their room for a few weeks because of their health. We asked them if they ever felt lonely and they replied; "If I ring the call bell they come very quickly, even at night." They also said; "Someone usually pops in every half hour or so anyway, they all come in."

Staff ensured people maintained relationships with their friends and relatives and helped them celebrate important occasions. The registered manager told us about a member of staff who had supported a person to reconnect with their loved one by supporting them to go and see them on a number of occasions and engaging with their passion for horses. Another member of staff told us; "Last Wednesday (Name of person) celebrated her birthday at the London Inn and we had fish and chips, presents and a sparkly cheesecake

with ice cream." This person had enjoyed this celebration.

Where people had religious or spiritual needs these were supported. For example, on the day of our inspection two representatives of the local church came to the home to provide a service and some religious singing. People were supported by staff to attend the event and people clearly enjoyed the experience and participated in the singing.

The registered manager felt people's privacy and respect was paramount and these views were shared by staff. During our inspection we observed staff ensuring they were out of earshot of others before talking about people's individual needs. This demonstrated respect for their privacy.

Good

Is the service responsive?

Our findings

People and staff told us they were confident people living in Teignbridge House were receiving a good standard of care. Comments included; "You'd go a long way to find a better place than this, they're remarkably good here at taking care of you, at first I was sceptical, but I can't fault it, I am perfectly happy" and "On the whole when you get to this stage in life and come to live in a place like this it's very good."

People who lived in the home had a variety of needs and required varying levels of care and support. With some people being more independent and others requiring significant input from staff. Staff knew people well and could tell us about people's specific needs, their histories, interests and the support they required.

People's needs had been assessed and from these, care plans had been created for each person. People and their relatives had been involved in the creation and the reviews of these. Each person's care plan was regularly reviewed and updated to reflect their changing needs. When people's needs changed action was taken to ensure the care provided was up to date and met their new needs. For example, one person had recently experienced hallucinations. Staff had sought guidance about this person's care from the mental health team and had contacted the GP to complete a medicine review for them. The person's care plan had then been updated with specific guidance for staff to follow in the instances when the person experienced these hallucinations.

People's care plans were detailed and contained clear information about people's specific needs, their personal preferences, routines and how staff should best support them to live happy, contented lives. People told us they were supported by staff in the ways that met their needs. One person said; "I woke up at 2am, they (carers) are absolutely fantastic and brought me a cup of tea, the whole atmosphere is lovely, and there is nobody here I don't like, they make you realise you can do things." Step by step guidance was provided for staff where needed which helped ensure staff fully understood people's needs and ensured people were supported in a consistent manner. This was particularly important for the people who had communication difficulties.

People's communication needs were met. The home was complying with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Each person's initial assessment identified their communication needs, while determining if the service could meet their needs. Each person's support plan contained details of how they communicated and how staff should communicate with them. Staff demonstrated they knew how best to communicate with people.

The registered manager explained how they listened to people's choices and had regular meetings with people receiving support. These meetings enabled people to voice their wishes and discuss activities they would like to undertake. We reviewed the most recent meeting minutes and saw people had been asked to share their views and opinions.

People had access to activities which met their social care needs. Staff spent time looking for ways to develop meaningful activities for people and develop and maintain their skills. On the day of our inspection we saw people take part in arts and crafts, reading books and magazines, watching television, listening to the radio, enjoying a sermon and taking part in singing. People made comments including; "We get lots of entertainment, I love a sing along." People were supported to leave the home on organised trips out, in groups, alone or with staff support. One person said; "They take me out to the garden if I want and to Morrison's for a fry up."

The activities co-ordinator continuously looked for ways to improve people's lives through activities. They told us about a project they had set up called the Penpal project. This involved children from the local junior school visiting the home every week during term-time to socialise with the people who lived in Teignbridge House. Each person who wanted to participate was paired up with a child and they wrote to each other and got to know each other. A recent activity had involved children and people drawing each other's faces. This had created a lot of laughing and enjoyment. Staff told us people really enjoyed this project.

A complaints policy was in place at the home. People had access to the complaints procedure and were encouraged to make complaints should they wish to. People confirmed they felt comfortable to raise complaints and where they had made some, these had been listened to. Comments included; "I am very happy here, if I have any worries I ask (Name of registered manager), he deals with complaints."

Staff had received training in how to provide high quality end of life care to people in a respectful and compassionate way.

Requires Improvement

Is the service well-led?

Our findings

Following our previous inspection this key question had been rated 'Requires Improvement' and we had identified a breach of regulation. This was relating to the systems in place not being effective in monitoring the service provided.

At this inspection we found that action had been taken to respond to some of the concerns we raised in our previous inspection. This included ensuring staff had a clear understanding of the Mental Capacity Act 2005 and how to apply it. However, we found the provider had been reactive and not pro-active in ensuring people lived in a safe environment and we found the systems in place to monitor the management of medicines had not been effective. We therefore found the provider was still in breach of the regulation relating to good governance.

We found a clear programme of audits and checks in place, but these had not identified our concerns relating to medicines.

People's records were not always accurate. For example, we found instances where people had experienced falls which were recorded within their daily notes but had not been recorded in the accident book or the falls diary. This meant the registered manager could not assure themselves the information they were acting on was accurate and that appropriate action was being taken.

The systems in place to manage the laundry in the home were not effective. People's clothes were regularly getting lost or mixed up with the laundry of others. Complaints had been made by people in the home and by relatives. The registered manager told us they were in the process of reviewing the systems in place to manage this and were going to be allocating specific hours for staff to oversee this and ensure these issues were dealt with

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

The leadership of Teignbridge House consisted of the registered manager, who was also the provider, and two deputy managers. People spoke highly of the registered manager and the deputies. Comments included; "I get on very well with the managers and (name of one of the deputy managers) is very nice." Staff told us they felt well supported and made comments including; "The managers are really good and so supportive. It's a good place to work." In a recent survey, relatives gave good feedback about the management at the home and had written; "The management are very approachable and respond to requests and concerns."

The registered manager was always looking to improve and regularly sought ideas from staff and people who used the service. One of the deputy managers commented; "The manager is very good and he listens to suggestions." The registered manager regularly sought feedback from staff, relatives and people who used the service. They sent out yearly surveys, held regular meetings where people were encouraged to share

their views and visited people in their rooms to discuss any wants, needs or feedback they may have.

The culture of the service was caring and focused on ensuring people received person-centred care. Staff told us they were supervised and any poor practice was picked up and discussed. The registered manager told us they ensured their ethos and values relating to providing people with person centred care which promoted independence was demonstrated by the deputy managers and by the wider staff team.

The registered manager and the manager were aware of their responsibilities in ensuring the Care Quality Commission (CQC) and other agencies were made aware of incidents, which affected the safety and welfare of people who used the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely. 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had failed to adequately assess, monitor and improve the quality and safety of people. Records were not always accurate. 17(1)(2)(a)(b)(c)