Voyage 1 Limited

177-179 Spring Grove Road

Inspection report

177-179 Spring Grove Road
Isleworth
Middlesex
TW7 4BA

Tel: 02085684428
Website: www.voyagecare.com

Date of inspection visit:
01 February 2016

Date of publication:
01 March 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**

Summary of findings

Overall summary

The inspection took place on 1 February 2016 and was unannounced. We conducted the inspection because we had received concerning information on three separate occasions about the service from two relatives of people who used the service and a social worker responsible for overseeing the care of one person. The concerns included a lack of management and organisation at the service, healthcare appointments being missed, changes in health needs not being addressed, the provider not taking appropriate action following accidents, limited social activities, out of date and inaccurate care plan records, poor communication with relatives, complaints not being responded to, medication errors and nutritional needs not being met.

The last inspection of the service was on 14 November 2014 when we found there were no breaches of Regulation.

177-179 Spring Grove Road is a care home for up to eight adults with a learning disability. At the time of the inspection seven people were living at the home. Some people also had physical disabilities, a range of complex health needs and were not able to communicate their needs verbally. Voyage 1 Limited is an organisation providing care and support to people with learning disabilities, autism and brain injury throughout the United Kingdom in residential, outreach and day services.

There was not a registered manager in post. The registered manager had left the service in 2015. The organisation had employed a new manager who had started work at the service one week before the inspection. They had applied to be registered with the Care Quality Commission. 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 and associated Regulations about how the service is run.

The staff did not always support people in a safe way to eat and drink and this put them at risk of choking.

People received their medicines as prescribed and in a safe way. However some of the protocols for administering medicines to individuals and records of stock medicine were not up to date or accurate.

People's health needs and how these had been treated were not always recorded. Some health needs had not been met. Improvements in this area were being made and the provider was taking action to make sure people's needs were met and properly recorded.

People received a varied and nutritious diet but the staff did not always keep accurate and contemporaneous records of the drinks they had given people who were at risk of dehydration. The staff had not always responded to changes in people's weight.

Some staff did not treat people with dignity and respect. They did not always consider people's feelings or

offer them opportunities to make decisions.

Some of the staff tended to focus on the task they were performing rather than the person they were caring for.

People were not always supported to take part in varied social activities which reflected their needs and preferences.

Records about people's planned care and the care they received were not always accurately maintained.

Incidents and accidents had not always been investigated and the provider had not mitigated risks to people because of this. The provider had not always notified the Care Quality Commission about these accidents and incidents.

The provider had investigated and taken action to improve the service following complaints they had received.

The provider had responded to the concerns about the service and had created an action plan. They had started to change systems and make improvements at the service.

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 staff did not always support people in a safe way to eat and drink and this put them at risk of choking.

People received their medicines as prescribed and in a safe way. However some of the protocols for administering medicines to individuals and records of stock medicine were not up to date or accurate.

Is the service effective?

Requires Improvement

The service was not always effective.

People's health needs and how these had been treated were not always recorded. Some health needs had not been met. Improvements in this area were being made and the provider was taking action to make sure people's needs were met and properly recorded.

People received a varied and nutritious diet but the staff did not always keep accurate and contemporaneous records of the drinks they had given people who were at risk of dehydration. The staff had not always responded to changes in people's weight.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff did not treat people with dignity and respect. They did not always consider people's feelings or offer them opportunities to make decisions.

Some of the staff tended to focus on the task they were performing rather than the person they were caring for.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always supported to take part in varied social activities which reflected their needs and preferences.

The provider had investigated and taken action to improve the service following complaints they had received.

Is the service well-led?

Requires Improvement

The service was not always well-led

Records about people's planned care and the care they received were not always accurately maintained.

Incidents and accidents had not always been investigated and the provider had not mitigated risks to people because of this. The provider had always not notified the Care Quality Commission about these accidents and incidents.

The provider had responded to the concerns about the service and had created an action plan. They had started to change systems and make improvements at the service.

177-179 Spring Grove Road

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 February 2016 and was unannounced.

The inspection team consisted of two inspectors. Before the inspection visit we looked at all the information we held on the provider, including notifications of significant events and the concerning information we had received.

During the inspection we spoke with the manager, deputy manager, senior support worker and support workers on duty. We also met the organisation's regional operations support manager who was spending some of their time at the service to help manage it. The manager had been in post for one week before the inspection. We met all seven people who lived at the service. However, because of their learning disability and level of communication we were not able to speak with them about their experiences of the service. Therefore we observed how people were being cared for and supported. We looked at the way in which medicines were managed. We looked at three support plans and associated records, the records staff used for communication and planning their work and records of care provided for three people.

After the inspection visit we received feedback from two relatives of people who used the service and one social care professional who oversaw the care of one person.

Requires Improvement

Is the service safe?

Our findings

During our inspection visit we observed staff supporting some people to eat and drink. We also looked at the support plans and guidelines for three people who required some support in this area. The staff supporting one person with a drink initially gave them a drink which had not been thickened. They then added a small amount of thickening powder, which they had not measured, and gave the drink to the person. They added more powder changing the consistency of the drink, so that the person had been offered three different consistencies of the same drink. We asked this member of staff and another member of staff if there were guidelines regarding the consistency of food and drink the person required. One member of staff told us, ''(The person) has their food pureed because they have difficulty swallowing.'' They told us that they did not know of any guidelines, but if there were these would be in the person's support plan. The person's support plan did not contain guidelines about food and drink. The only reference to the consistency of drinks was a handwritten note by staff following a dietitian appointment in June 2015 which stated, ''Fluids to be thickened.'' The exact consistency of food and drink for a person who has swallowing difficulties is important because they may choke if they are given the wrong consistency for their needs. The staff supporting this person did not have an awareness of this and put them at risk by changing the consistency of their drink.

We also observed the staff pushing a wheelchair with a person in without using foot plates. This meant the person's feet were not properly supported and failure to use proper foot rests could lead to an injury.

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

The regional operations support manager told us they had been reviewing and updating the guidelines for each person regarding the consistency of food and drink. Following the inspection visit they told us they had made all the staff aware of these guidelines.

One social care professional told us that when they had visited the home the staff had not checked their identification or asked who they were before letting them into the service. We saw that the regional operations support manager had discussed security at a team meeting in December 2015, reminding the staff to check visitor's identification. However, on the day of the inspection visit, the member of staff answering the door to the inspection team did not ask to see our identification or verify who we were. We told the manager about this and they agreed to remind all staff about the importance of keeping the service safe and secure.

Some of the people who contacted the Care Quality Commission told us that they felt people did not always received the support they needed with medicines. In January 2016 there was an incident where some staff administered medicines which a person was no longer prescribed and another incident where staff had not administered prescribed medicines to the same person. The regional operations support manager had investigated these incidents and had taken appropriate action. They had also audited how medicines were

managed. Where they had found errors in recording or problems with storage they had taken action to address these. They had also investigated a medicine error which had occurred in December 2015 and taken appropriate action following this, which included sharing their findings with the local safeguarding authority.

We looked at the way in which medicines were managed at the service. All staff responsible for administering medicines had been trained and assessed as competent. Medicines were stored securely. People had received their medicines as prescribed. However, some of the administration records were not completed clearly and this meant the information about whether the person had received their medicines was sometimes difficult to see. The staff counted boxed medicines to make sure they held the correct stock. Some of the records of this were inaccurate and did not reflect the information on the administration records. This meant that there was the potential for errors as it was not always clear how much of each type of medicine was held at the service. People's doctors had signed agreement to protocols for administering some PRN (as required) medicines. However, these had last been reviewed in 2014 and some people's needs had changed since that time. In addition medicines which had been newly prescribed since 2014 had not been included in the PRN protocols. Therefore the staff did not have clear and up to date information about the circumstances of when they needed administer some medicines which were not required all the time.

The staff who worked the night of 25 January 2016 had recorded they had seen cockroaches in one bedroom in the staff communication book. No action had been taken in response to this information and the manager and regional operations support manager told us they were not aware of this. They told us they would investigate this and take action if necessary.

Requires Improvement

Is the service effective?

Our findings

In October 2015, November 2015 and January 2016 we received contact from three different people who expressed concerns that people's health needs were not always monitored or met. Relatives and a social care professional told us that changes in people's needs had not always been shared with them. However, following our inspection, one relative told us, ''They always ring me if (my relative) has seen the doctor or if anything is wrong.''

The social care professional who we spoke with following our inspection visit, told us the person they supported required regular input and support to manage their physical and health needs. They said that the staff had not given the support the person required and this had been detrimental to their health and wellbeing. They told us the staff had not followed guidance from healthcare professionals and were unaware of the guidance which had been shared with the service. They also told us that information about healthcare appointments had not been recorded. One person told us that their relative had not attended the healthcare appointments they needed to and they had needed to follow this up with staff to make sure it happened. They told us guidelines from healthcare professionals had not always been followed and they had ''lost faith'' in the provider at meeting their relative's needs.

During our inspection visit we looked at the healthcare records for three people. These indicated that people had not had regular or recent healthcare appointments. Some of the information about healthcare needs was missing. For example, the last recorded annual optician's appointment for one person was in July 2014. Records showed that the most recent contact with the dentist for the person had been in March 2015 with a note stating, ''the dentist is still off sick – call in one month.'' There was no evidence of consultation or contact with the dentist since. A record of physiotherapy for this person in August 2015 said that specific equipment had been ordered. There was no update after this to state whether the equipment had arrived or how it was to be used.

The healthcare action plan for a second person included actions for an annual flu injection and six monthly dentist appointments. There had been a year and two month gap between dental appointments in 2014 and 2015. The person's last flu injection had been in 2014. The person's plan stated that they had been discharged from the chiropodist in 2014 and that staff should follow guidance to support the person with nail care. There was no guidance in place or evidence the staff had attended to the person's nail care.

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

The regional operations support manager told us they were in the process of reviewing people's healthcare needs. They told us they had contacted people's GPs for information and were making sure everyone had access to the healthcare professionals they required. They showed us that they had updated some people's health support plans but they had not managed to complete all of these. We saw that a number of actions had been identified in the service improvement plan. The manager had also arranged for a physiotherapist

to visit the service and train the staff so they could offer the right support to people who needed this. The regional operations support manager had made referrals to specific healthcare professionals, such as a speech and language therapist and occupational therapist for people where their needs indicated they needed this support.

The regional operations support manager had arranged for additional training and information for the staff to help them understand the specific healthcare needs of one person. They told us a nurse was visiting the service to help them plan this training and make sure the staff had the information and skills they needed.

Before the inspection relatives had raised concerns with the provider that changes in health were not always identified and acted upon. The regional operations support manager had implemented a new protocol for staff to follow if people became unwell or an incident occurred. This was displayed on the staff notice board and had been discussed with all the staff. The regional operations support manager had also created a file of information for new and temporary staff which included profiles about people's needs and information about what to do in different emergency situations.

Before the inspection some of the concerning information we received stated that people's fluid intake was not always monitored and that they were not always given nutritious food.

The social care professional we spoke with following our visit told us that the person they supported required regular fluids and that the staff needed to monitor these. They said that this had not happened and this had resulted in the person becoming dehydrated in the past.

During the inspection we saw evidence that people had received a variety of home cooked and freshly prepared food. Daily care notes indicated that their diet was varied. We saw the staff preparing lunch for people on the day of the visit. However, we noted that they plated up four people's cooked meals and left these uncovered until people were ready to eat these. Some of the plated food was left for over 15 minutes. The staff did not reheat the food before serving.

The record for one person indicated that they had not been weighed regularly despite significant weight loss. For example, the person, who was not on a diet, lost 8.3kg between January and July 2015. However, they were not weighed in September, October or December 2015 and there was no evidence their weight loss had been reported to the dietitian or GP.

The record for another person showed they had not been weighed since August 2015. The person's health plan had an entry in December 2014 stating that the dietitian had given verbal guidelines for a high protein and high fat diet to increase weight. There was no record of this in the person's support plan for eating and drinking. There was no other information about this or what the person's ideal weight should be. The health plan for a third person stated that the dietitian had recommended a high fat and high protein diet in December 2014. There were no guidelines in place and the person did not have a support plan for eating and drinking. There was no information on the person's ideal weight.

There were no fluid monitoring charts in use on the day of the inspection visit. The guidelines for some people stated that maintaining these was important because people were at risk of dehydration. At 1pm we asked one member of staff about the fluid intake chart for one person. They were not aware that charts were required for any people. Another member of staff told us they did not know where the fluid charts for that day were. We asked staff how they had recorded the amount that people had already drunk that day and they were not able to tell us how this had been monitored or recorded. Therefore the staff could not accurately tell how much each person had drunk and whether they were at risk of dehydration because they

had not maintained a contemporaneous record of this aspect of their care.

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

The regional operations support manager told us that concerns about maintaining fluid charts had been identified and as part of the service improvement plan they were checking fluid charts and sending copies of these to the relevant local authorities as evidence of the support some people had received. They did not know why there were no charts in place on the day of our visit and agreed to speak with the staff about this.

Requires Improvement

Is the service caring?

Our findings

One of the relatives we spoke with told us, ''(My relative) is very happy, I cannot fault the place, the staff are caring.''

During our inspection we observed interactions which were not caring and did not show people respect. For example, throughout the morning the radio in the kitchen and television in the lounge were tuned to popular music stations. The television was showing music videos. Both the television and radio were loud. None of the people who used the service were given a choice or radio or television stations. They did not show any interest in these and the support plans we looked at did not record an interest in this type of music. However, the staff on duty sang and hummed along to the music and twice a staff member sat down to watch the television when no one else was in the room. One staff member was watching the television whilst they were supporting someone to put their coat on. They were not looking at the person they were supporting or speaking with them.

One member of staff was supporting a person to eat their breakfast. They did not communicate with the person, apart from telling the person to swallow or to open their mouth. When the person coughed on several occasions the staff member tapped them on the back and wiped their mouth with a paper towel, they did not speak with the person or reassure them. At one point the staff member wiped the table and then the person's face with a paper towel. On another occasion they used a spoon to scrape food off the person's chin and back into their mouth. The staff member left the table on several occasions and returned to supporting the person without telling them what they were doing. Another member of staff sat near the person to eat their own breakfast without speaking with or acknowledging the person. The staff member supporting another person with their lunch also did not communicate what they were doing. The staff placed paper aprons on people who were about to eat, without asking if they wanted this or explaining what they were doing. One person's support plan stated that they did not like to wear an apron at meal times, however the staff placed an apron on this person. The staff member supporting one person with their lunch picked a piece of food which had fallen on the person's lap with their fingers and placed it back on their plate. They then served the person this. These interactions did not indicate the staff respected the people they were supporting. The staff appeared focussed on the task they were performing rather than the person they were carrying for.

With the exception of one member of staff, the staff who entered rooms where people were seated did not acknowledge them or speak with them. One member of staff took someone who was in a wheelchair into the lounge. They left the person there without any communication and walked out of the room. Another member of staff moved people's wheelchairs around so they could get to a different part of the room, without asking the person or informing them what they were doing. At one point the staff told people they were getting them ready to take them out for a drive. They then started to put their coats on and move them out of the house towards the car. They gave no other explanation as to what they were about to do. When they spoke with people they did not bend down to their eye level or stand still. They said things as they walked past them, or when they were behind them. These interactions indicated the staff were not

considering people's need for information or offering them choices. They did not give people the opportunity to express themselves. One person, who was told to stand up because they were going out, remained seated. Instead of considering this may have been their way of expressing they did not wish to go out, the staff laughed at them, told them to ''come on'' and that they could stand up on their own.

A visiting reflexologist offered support to some of the people during the afternoon. They and a member of staff talked about the person they were supporting. They both teased the person about their feelings for another person who lived at the home. This showed that the professional and member of staff were not considering the impact of their conversation on the person's feelings.

These were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We described the interactions we had seen to the manager and regional operations support manager. They told us that there had been some concerns with the way in which some staff interacted with people in the past but they had tried to improve this. They told us they had received feedback from a visiting relative who had said that staff interactions with people had improved recently.

Requires Improvement

Is the service responsive?

Our findings

Two relatives and one social care professional who contacted us before the inspection told us there were not enough social activities or things for people to do. The social care professional who spoke with us as part of the inspection told us that people did not regularly go out of the house except to access the provider's resource centre which was next door.

One relative we spoke with told us they did not feel there were enough social activities for people to take part in. The other relative told us they were happy with the amount of social activities offered, although they told us about events their relative had been to in the past (2014) which they were not supported to do any longer.

During the inspection visit four people spent the morning at the neighbouring resource centre. The other three people were taken out in the mini bus for a drive for approximately one hour. For the rest of the morning two people were seated in the lounge where the television was playing a popular music station. The staff did not offer people other activities. People received individual support from a reflexologist for half an hour each in the afternoon.

The records the staff had kept to explain the activities people had taken part in each day indicated they did not have much variety. The record for one person for January 2016 showed that they had participated in one outing to a garden centre and three walks. They had a weekly reflexology session. The other days and remaining time spent on the days of these activities they had spent at the resource centre or listening to music in the lounge. For one period of six days the only activity recorded was listening to music in the lounge.

The record for another person in January 2016 indicated that they had taken part in one trip to a garden centre, one walk and one drive. There were two recorded reflexology sessions and the records indicated they had attended the day centre for two to three sessions (a morning or afternoon) each week. The other recorded activities were listening to music or relaxing in the lounge. The record for a third person in January 2016 showed that they had spent the majority of their time ''relaxing on the sofa'' or ''listening to music in the lounge.''

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

The regional operations support manager told us that there had been some organised activities which the staff had not recorded on people's individual log of activities.

The manager told us they had tried to improve the social activities at the home and had recruited more staff who could drive the minibus to enable people to go out of the home on trips.

Before the inspection some people told us the complaints they had raised with the provider had not been responded to. During the inspection we found that the service's record of concerns and complaints was not kept up to date. However, the provider was able to evidence they had responded to complaints they had received. They had investigated specific incidents and taken appropriate action where necessary, including disciplining staff. They had also updated and reviewed procedures and protocols in response to concerns to minimise the likelihood of them reoccurring. The regional operations support manager had created an action plan which addressed different concerns, action that had been taken and proposed action and improvements.

Requires Improvement

Is the service well-led?

Our findings

In October 2015, November 2015 and January 2016 we received concerning information from three different people about the way in which the service was managed and organised. The registered manager left the service in November 2015. The provider recruited a new manager who started work at the service one week before our inspection visit. The regional operations support manager started their role in December 2015 and had spent some of their time managing the service since then. The concerns indicated that the staff at the service had not always communicated clearly with relatives about changes in people's needs or when responding to complaints or questions.

The relatives we spoke with told us they felt unsettled by changes in the management of the service and lack of management. One relative said, ''There have been a lot of different people and it is hard for the residents and us to get used to them, it's like dealing with strangers.'' One relative told us they had been in regular contact with the service over a number of concerns and needs not being met. They told us they had not received an appropriate response from managers at the service or senior managers.

The manager told us that they would be contacting relatives and other stakeholders to introduce themselves and give them the opportunity to discuss people's care.

The people who contacted us before and since the inspection told us that care plans and associated records were not always up to date. During our inspection visit we found this was the case. Information about people's health needs had not always been recorded or followed up. The fluid intake records for some people had not been completed contemporaneously. Some of the support plans did not contain important information about people's needs, for example guidelines regarding the consistency of their diet. The regional operations support manager told us that the daily log of activities had not been accurately completed.

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

In October 2015 we received concerning information from a relative of someone who used the service which included information about an accident which was not reported to the next of kin and where the person had not been given immediate medical help. The provider investigated these concerns and upheld them. In January 2016 we received further concerns from a social worker who care managed one of the people who used the service. They told us that not all incidents and accidents were recorded and some of these had not been dealt with or followed up. We looked at the service's record of accidents and incidents. Some of these included accidents where people had injured their head or face. Others included admissions to hospital. The provider is required by law to notify the Care Quality Commission of serious injuries. They had not done this and therefore we had not been aware of these incidents at the time they occurred.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009

One incident in October 2015 stated that a person had tripped and injured their head whilst staff were escorting them into a room. There was no evidence that this incident had been investigated or followed up by managers or the provider. This could have been an accident but may also have been preventable, the result of neglect or abuse and without investigation into the incident the provider was not able to assure themselves that they had adequately protected the person and mitigated risk. Another incident in October 2015 stated that a person was found with white powder around their mouth and it was assumed they had eaten some washing powder. This incident had not been investigated despite the fact that the provider's procedures and Control Of Substances Hazardous to Health Regulations state that chemical cleaning products should be stored securely to avoid this type of incident.

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

We discussed these with the regional operations support manager (who had not been in post at the time of the incidents). They agreed that this type of incident would normally have resulted in an investigation. We noted that an incident where medicines were mismanaged in January 2016 was investigated by the regional operations support manager. The incident was also reported to the Care Quality Commission and local safeguarding authority. Appropriate action was taken as a result of the investigation to mitigate further risks.

The provider had received some concerns about the service from relatives and other stakeholders before the inspection visit. They had responded to these by investigating individual concerns. The regional operations support manager had spent time at the service managing the staff and updating records and systems. They had also created an action plan which they had shared with the local authority. They discussed the action plan with us and we could see that they had clear objectives for improvement. Some of the changes that had taken place had improved the service already. Further improvements were needed and the provider was aware of these. At the end of the inspection visit we fed back out findings to the manager and regional operations support manager. They told us they were aware of the breaches we had identified and were able to demonstrate that they had started taking action to address these.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified The Care Quality Commission of incidents as described in this Regulation. Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure that care and treatment of service users was appropriate, met their needs or reflected their preferences. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure the safe

	care and treatment of service users because they had not done all that was reasonably practicable to mitigate any risks. Regulation 12 (2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not operate a system which effectively assessed, monitored and mitigated risks to the health, safety and welfare of service users. Regulation 17(2)(b) The registered person did not maintain an accurate, complete and contemporaneous record in respect of each service user. Regulation 17(2)(c)