Care Quality Commission

Maria Mallaband Care Homes Limited

Willowdene Care Home

Inspection report

Lizard Lane
Stockton-on-Tees
TS21 3ET
Tel: 01388 606093
Website: http://www.mmcgcarehomes.co.uk/

Date of inspection visit: 31/10/2014 and 03/11/2014
Date of publication: 23/02/2015

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?	**Requires Improvement**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 31 October 2014 and 03 November 2014 and was unannounced. This meant the staff and provider did not know we would be visiting.

Willowdene Care Home provides care and accommodation for up to 48 people and includes a small, separate 12 bed unit for older people living with dementia. It also provides nursing care. On the day of our inspection there were 43 people using the service.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Willowdene Care Home was last inspected by CQC on 29 May 2013 and was meeting all the regulations inspected.

During our inspection visit we found there were insufficient numbers of staff on duty in order to meet the needs of people using the service. There was only one member of staff in the residential part of the home for the 12 residents, one of whom had nursing needs and required 2:1 care.

Summary of findings

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We saw evidence that thorough investigations had been carried out in response to safeguarding incidents or allegations and comprehensive medication audits were carried out regularly by the manager.

Training records were up to date and staff received regular supervisions and appraisals, which meant that staff were properly supported to provide care to people who used the service.

People had access to food and drink throughout the day and we saw staff supporting people in the dining room at lunch time when required.

We saw in the care records consent was obtained for photographs and the sharing of information, as well as end of life wishes. However, not all of these records were signed by the person using the service or a family member. This meant we could not be sure if the information contained in the record was a true reflection of people's wishes.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home, and the Maple Suite was suitably designed for people with dementia.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We discussed DoLS with the registered manager and looked at records. We found the provider was following the requirements in the DoLS.

People who used the service, and family members, were complimentary about the standard of care at Willowdene Care Home. They told us, "The care here is brilliant", "she loves it here, it's the healthiest she's been for years", "everything about the care home, I can't fault" and "happy with the care".

We saw staff supporting and helping to maintain people's independence. We saw staff treated people with dignity and respect and people were encouraged to care for themselves where possible.

On the first day of our inspection visit we saw that people's care records were left outside each room, tucked behind the hand rails. As care records contain personal information, we discussed this with the registered manager who told us that it was not normal practice and should not be happening. The registered manager rectified it straight away and care records were placed back in people's rooms. On the second day of our inspection visit, we did not see any care records in the corridors.

We saw that the home had a full programme of activities in place for people who used the service.

All the care records we looked at showed people's needs were assessed before they moved into Willowdene Care Home and we saw care plans were written in a person centred way.

Some care plans we looked at did not contain sufficient detail about people's needs and preferences and some risk assessments were missing important information. We also saw that risk assessments were not always up to date and some care plan reviews were overdue. This meant that care records were inconsistent.

We saw a copy of the provider's compliments, concerns and complaints procedure, and saw that complaints were fully investigated.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. There were insufficient numbers of staff on duty in order to meet the needs of people using the service.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Thorough investigations had been carried out in response to safeguarding incidents or allegations. All of the safeguarding incidents we looked at had been correctly reported to the local authority and to CQC.

We saw that safeguarding audits and medication audits were carried out regularly by the registered manager.

Is the service effective?

Good

The service was effective. People received effective care and support to meet their needs. People had access to food and drink throughout the day and we saw staff supporting people when required. We found that the provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

We saw in the care records that consent was obtained for photographs and the sharing of information, as well as end of life wishes. However, not all of these records were signed by the person using the service or a family member.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home, and the Maple Suite was suitably designed for people with dementia.

Is the service caring?

Good

The service was caring. Staff treated people with dignity and respect and people were encouraged to care for themselves where possible.

People we saw were well presented and well groomed and we saw staff talking to people in a polite and respectful manner.

On the first day of our inspection visit, poor practice was observed regarding the confidentiality of care records. The registered manager corrected this practice during our visit.

Is the service responsive?

Requires Improvement

The service was not always responsive. Some care plans we looked at did not contain sufficient detail about people's needs and preferences and some risk assessments were missing important information. We also saw that risk assessments were not always up to date and some care plan reviews were overdue. This meant that care records were not always accurate

Summary of findings

The home had a full programme of activities in place for people who used the service.

The provider had a robust compliments, concerns and complaints procedure in place. None of the people, or family members, we spoke with had made a complaint but they knew how to and were aware of the complaints procedure.

Is the service well-led?

Good

The service was well led. The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

People who used the service, and their family members, told us, "It's well run" and "they work hard".

Staff we spoke with told us the registered manager was approachable and they felt supported in their role.

Care Quality Commission

Willowdene Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 31 October 2014 and 03 November 2014 and was unannounced. This meant the staff and provider did not know we would be visiting. The inspection was led by a single Adult Social Care inspector. The inspection also included a second Adult Social Care inspector.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. No concerns were raised by any of these professionals.

For this inspection, the provider was not asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with five people who used the service and six family members. We also spoke with the registered manager, one member of the nursing staff, four care workers and a cook.

We looked at the personal care or treatment records of four people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff.

Requires Improvement

Is the service safe?

Our findings

People who lived at Willowdene Care Home were not always safe because there were insufficient numbers of staff on duty in order to meet the needs of people using the service.

We saw there was one member of staff in the residential part of the home for the 12 residents, one of whom had nursing needs and required 2:1 care. Staff told us, "It's hard work sometimes", "if [name] needs anything, I have to ring for help upstairs" and "there are enough staff upstairs but two people downstairs need 2:1 care." Family members we spoke with expressed concern regarding the number of staff in this part of the home. They told us, "It's too much for one person", "they have to get help if [name] needs to go to the toilet", "could do with more staff" and "I've spoken with the manager before about staffing." This meant that there were insufficient numbers of staff on duty in order to meet the needs of people using the service.

During our tour of the building, staff did not raise any concerns with us about the number of staff in other parts of the home however on several occasions we heard call bells ringing on the first floor for long periods of time. On one occasion, three call bells were ringing at once and we observed the nurse in one of the rooms and other members of staff with other residents. On another occasion, a call bell was ringing for a long period of time and we observed two members of staff leave a person's room, ignore the call bell and enter another person's room who did not appear to require assistance. We mentioned this to a member of staff who then attended to the person whose call bell was ringing.

We discussed staffing levels with the registered manager. The registered manager told us, and members of staff confirmed, that any staff absences were covered in the first instance by existing home staff. The home also had their own bank staff if required, all who had experience of working at Willowdene Care Home. The registered manager told us that she also covered nursing shifts if required. We also saw a copy of the results of the most recent multi-disciplinary team (MDT) survey, carried out in November 2013, which stated, "More staff needed, difficult to find carers at times." We discussed with the registered manager our observations and comments received regarding staffing and recommended she reviewed staffing levels, particularly in the residential part of the home.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the recruitment records for four members of staff and saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS), formerly Criminal Records Bureau (CRB), checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passports, birth certificates and utility bills. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant that the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We saw a copy of the provider's safeguarding policy and procedure and a copy of the safeguarding statement, which stated, "All employees receive appropriate training at the induction stage in adult abuse." We checked training records for four members of staff and found that all had received and were up to date with safeguarding training.

We looked at the safeguarding alert file and saw that each safeguarding incident had a cover sheet which contained the date, names of the people involved, description of the incident, the outcome and a signature. We saw evidence that thorough investigations had been carried out in response to safeguarding incidents or allegations. The file contained records of interview notes, safeguarding meeting minutes, decision/outcome forms, incident report forms and outcomes of disciplinary hearings, including letters to the members of staff involved. We also saw copies of disciplinary records in individual members of staff's personal files, for example, when medication errors had occurred. All of the safeguarding incidents we looked at had been correctly reported to the local authority and to CQC.

We saw that safeguarding audits were carried out regularly by the manager. The last safeguarding audit had been carried out on 2 October 2014 and checked staff awareness of potential safeguarding issues, how to report concerns and a check of care plans and risk assessments. One action that came from the safeguarding audit was for planned staff safeguarding training.

Requires Improvement

Is the service safe?

Willowdene Care Home is a two storey, detached building set in its own grounds. We saw that entry to the premises was via a locked, key pad controlled door and all visitors were required to sign in.

The home comprised of 36 en-suite bedrooms in the ground floor residential and first floor nursing units, and 12 bedrooms, which were not en-suite in the Maple Suite (dementia unit). We saw that the accommodation included a lounge, dining room and several bathrooms and communal toilets in each unit. There was also a conservatory on the ground floor. All were clean, spacious and suitable for the people who used the service.

We saw that comprehensive medicine audits were carried out regularly by the manager. The last medicine audit was carried out on 8 October 2014. This audit involved checking medicine records for three people and resulted in 10 actions. Actions mainly referred to documentation and included photocopies of charts as evidence. We saw that all the actions had been signed by the nurse on 9 October 2014 to say they had been completed. We also saw records relating to two safeguarding incidents where drug errors had been made by members of staff. For each one, we saw copies of investigation reports, records of meetings with the staff members concerned and the outcomes of the meetings. These records were kept in the staff members' personal files and we saw that the incidents had been appropriately reported to the local safeguarding team and to CQC. We saw medicine care plans were in place and contained evidence that people's preferences had been taken into consideration, for example, how people liked to take their medicine and with what drink.

We saw copies of 'Resident at risk' reports in people's care records. These were used when a risk had been identified, for example, pressure damage, weight loss/nutrition, infection control, mental capacity etc. Each report included the date, details of the risk, body maps and charts, equipment in use and actions taken. We saw these records were up to date.

Family members we spoke with told us they thought their relatives were safe at Willowdene Care Home. They told us, "Yes, feels safe" and "very safe."

Good

Is the service effective?

Our findings

People who lived at Willowdene Care Home received effective care and support from well trained and well supported staff. Family members told us, “The staff are great” and they were “happy with the care”.

We saw a copy of the provider’s annual training plan. Mandatory training included moving and handling, first aid, fire safety, medication awareness, adult protection (safeguarding), infection control, health and safety and food hygiene. We looked at the training records for four members of staff and saw certificates, which showed that mandatory training was up to date. The registered manager showed us the electronic training matrix, which was colour coded to show when training was due and also if training was overdue. The registered manager told us that staff would not be allowed to work at the home if any of their training was overdue.

The registered manager showed us a copy of the staff supervision plan for 2014. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Each member of staff had a supervision contract, which included six supervisions per year, each supervision to last a minimum of 30 minutes and each supervision record to be signed by the member of staff and the supervisor. We checked four members of staff’s records and saw supervisions had been carried out and recorded as per the contract. The registered manager also showed us a copy of the appraisals plan for 2014. Staff appraisals were carried out at different times of the year and for those that had been completed we saw they included comments by the member of staff and the supervisor on what has been achieved since the previous appraisal, what should be done next and a training needs analysis. For those members of staff who hadn’t had an appraisal yet in 2014, we saw records of appraisals from 2013. This meant that staff were properly supported to provide care to people who used the service.

People had access to food and drink throughout the day and we saw staff supporting people in the dining room at lunch time when required. People were allowed to eat in their own bedrooms if they preferred and we observed a good rapport between staff and people who used the service. We saw that there was a four week menu, which offered two main choices at lunch time, several light options at tea time and snacks throughout the day. An alternative ‘light bites’ menu was also available. People who used the service, and family members, told us they were happy with the food provided at the home. They told us, “The food is good”, “she’s eating well” and “it’s lovely, very happy”.

We saw in the care records that consent was obtained for photographs and the sharing of information, as well as end of life wishes. However, not all of these records were signed by the person using the service or a family member. This meant we could not be sure if the information contained in the record was a true reflection of people’s wishes. We asked people and family members whether they had been asked to provide consent to care and treatment. They told us, “Yes, they ask me”, “they ring me if they need to ask me anything”, “they went through everything with me” and “I signed the forms”.

We saw a copy of the “guide to our services” booklet, which provided information on decision making for people who lacked the capacity to make their own decisions and provided information about assistance and support from other professionals. In one of the care records we saw that a mental capacity assessment recorded the person was “unable to consent to care and treatment” however the person’s assessment of needs recorded the person was “able to make choices of day to day living and can communicate”. This was confusing and we brought it to the attention of the registered manager, who agreed to look into it.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We discussed DoLS with the registered manager, who told us she had considered the impact of the recent Supreme Court decision about how to judge whether a person might be deprived of their liberty and had contacted the local authority for guidance. The registered manager told us that she had identified those people who required their applications to be submitted more urgently. Two applications had been submitted and approved by the supervisory body and a further four applications were waiting approval. We saw records of

Good

Is the service effective?

these applications in people's care records and also saw that notifications of the applications had been submitted to CQC. This meant the provider was following the requirements in the DoLS.

We saw people who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including GPs, continence nurse, community psychiatric nurse, district nurses and chiropodists.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home. We looked at the design of the Maple Suite for people who had dementia. The bedroom doors had door knockers, letter boxes and large numbers on them. Some of the bedrooms had memory boxes placed on the wall beside the door to help people identify their own rooms. We saw that toilet and bathroom doors were painted in bright colours so people could identify them more easily. The corridor was well lit and clear from obstructions.

Good

Is the service caring?

Our findings

People who used the service, and family members, were complimentary about the standard of care at Willowdene Care Home. They told us, "The care here is brilliant", "she loves it here, it's the healthiest she's been for years", "everything about the care home, I can't fault" and "happy with the care".

People we saw were well presented and well groomed. We saw staff talking to people in a polite and respectful manner. Staff called people by their preferred name and interacted with them at every opportunity, for example, saying hello and having conversations with people in the corridor or asking if people were okay when passing their bedroom doors. We saw staff in the lounges bend or kneel down to talk to people so that people could see who was talking to them and hear what they were saying.

We saw staff supporting and helping to maintain people's independence. For example, one person told us he wanted to go to the toilet and we asked a member of staff to assist. The member of staff told us the person was able to go to the toilet on his own, which helped to maintain his independence. We observed the person walk to the toilet unaided. We also observed staff assisting people to the dining room for lunch and this was done in a re-assuring, encouraging and unhurried manner. Family members we spoke with told us the staff encouraged people to be independent. One family member told us, "She's very independent, they let her get on with it." This meant that staff supported people to be independent and people were encouraged to care for themselves where possible.

We asked people and family members whether staff respected the dignity and privacy of people who used the service. They told us, "No issues with dignity, staff know what they are doing" and "no concerns with dignity". We observed staff closing bedroom doors when carrying out personal care. We looked at the care records of four people who used the service and saw 'Safety in transfer' care plans, which documented the measures staff should implement to ensure the person's privacy and dignity during transfers. Staff told us they maintained people's dignity by carrying out personal care in private, closing bedroom doors and assisting people who needed help to mobilise around the home, for example, to go to the toilet. This meant that staff treated people with dignity and respect.

We saw a copy of the "guide to our services" booklet, which described advocacy, how the home could assist with choosing an advocate and details of the local advocacy service.

The "guide to our services" booklet also described how the home was committed to delivering a first class confidential service. However, when we arrived at the home on the first day of our inspection visit we saw that people's care records were left outside each room, tucked behind the hand rails. We asked staff why this was and we were told it was because people who were on regular observations did not like to be disturbed so the care records were kept outside the rooms so staff could access them without disturbing the person. This meant anybody accessing the home was able to read the care plans that had been left in the corridor. As care records contain personal information, we discussed this with the registered manager who told us it was not normal practice and should not be happening. The registered manager rectified it straight away and care records were placed back in people's rooms. On the second day of our inspection visit, we did not see any care records in the corridors.

We saw copies of relatives' communication records, which showed staff had involved family members in reviewing care plans and assessments. However, one communication record referred to a medicines error on 1 September 2014 and there was no evidence of any further contact with family members after this date to provide them with an update.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive because care records were inconsistent and not always up to date.

Some care plans we looked at did not contain sufficient detail about people's needs and preferences. For example, a moving and handling care plan lacked detail about the handling aids and methods required to ensure safe transfers. We also saw that some risk assessments were missing important information. For example, a member of staff advised us that a person had suspected diverticulitis however there was no reference to diverticulitis in either the nutrition care plan or risk assessment. The person did have an assessment of need however this referred to a nut allergy.

We also saw that risk assessments were not always up to date and some care plan reviews were overdue. For example, a safety in transfer care plan had not been reviewed since 24 July 2014 and a self-medication review was due on 02 October 2014 and had not yet been completed. We also saw a nutrition risk assessment was due for review on 17 October 2014 and had not yet been completed. We saw this was last reviewed on 24 September 2014 but did not record the person's weight or body mass index (BMI) and the previous review on 24 August 2014 also did not record the person's weight. This meant that care records were inconsistent and not always up to date therefore health concerns could be missed.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All the care records we looked at showed that people's needs were assessed before they moved into Willowdene Care Home. We also saw "Me and my life" records in each person's care record which provided a personal history of the person using the service and information about what was important to the person. This helped staff in getting to know the person and to plan their care and activities.

We saw care plans were written in a person centred way and we saw evidence that plans had been developed with people using the service and their family members. Care plans included nutrition, safety in transfer, medication, communication and pressure care. We saw a care plan for communication, which described a person's ability to communicate. This meant that staff were provided with information on how to communicate with the person and promote engagement.

Family members told us they were kept informed about the health and well-being of their relatives. They told us, "They ring us if they think we need to know anything", "they always ring" and "all we have to do is ask if we want to know anything".

We saw the home had a full programme of activities, including excursions, games, film nights and music. During our visit we saw people sat in a circle playing a game where they had to throw a beanbag on to a letter and say a person's name beginning with the letter. We observed how staff encouraged participation and helped those people who required assistance. We saw this game encouraged people to be active and to use their memory to remember people's names.

We saw a copy of the provider's compliments, concerns and complaints procedure, which provided details of how to make a complaint, the complaints process and who to contact if your complaint was not dealt with appropriately. We saw the complaints file, which included completed complaints forms, a monthly summary of complaints, copies of letters sent to complainants, notes and minutes from investigative meetings and photocopies of evidence. We saw that a complaint was made in July about the attitude of a member of staff. We saw that it had been fully investigated and the complainant had signed to say they were happy with the outcome. None of the people, or family members, we spoke with had made a complaint but they told us they knew how to and were aware of the complaints procedure.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service.

We saw that the registered manager worked alongside staff, covered nursing shifts when required and provided guidance and support. People who used the service, and their family members, told us, “It’s well run” and “they work hard”.

Staff we spoke with told us the registered manager was approachable and they felt supported in their role. One member of staff told us, “We work as a team.” We saw the results of the 2013 staff survey, and saw that “approachability of managers” and “recognition and feeling valued” had both scored very highly.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. We saw the registered manager or nurse in charge completed a daily audit, which included checks of the home, whether residents were suitably dressed and presented, documentation, whether staff were wearing the correct uniform and a reflection on actions from the previous day. We saw these audits were carried out daily and were up to date.

We saw a copy of the quality audit schedule, which included a list of all the audits to be carried out and the frequency. For example, care plan audit every month, medication audit every two months, infection control audit every four months, health and safety audit every four months and a quarterly safeguarding audit. We saw copies of the most recent audits. All were up to date and included action plans for any identified issues. For example, an audit of a care plan had identified that a best interests decision form was missing. We saw this had been actioned by a senior care worker two days later.

We saw that the most recent quality assurance visit on behalf of the provider had taken place on 08 September 2014 and included discussions with people who used the service, relatives/visitors and staff, a review of notifiable events, a check of the premises and a review of complaints, records and documentation. We saw that actions were put in place, for example, “Each wheelchair should have foot plates in place at all times.”

We saw maintenance records for the home were up to date and included monthly checks of hot water/legionella, window restrictors, call bells and wheelchairs. Weekly checks included fire safety and equipment, fire alarm and emergency drill, emergency lighting and checks of bed rails and hoists. We also saw the monthly service and maintenance schedule, which showed that gas safety, control of substances hazardous to health (COSHH), portable appliance testing (PAT), lifts, hoists and fixed electrical equipment services and checks were all up to date.

We saw the results of the quality assurance survey from July 2014. This survey asked people who used the service, and their family members, questions about the quality of the service provided at Willowdene Care Home. For example, what they do well, what they could do to improve and what they have done from people’s comments e.g. “Speak individually with people who have requested a follow up to their comments or concerns” and “make minutes of meetings available in the home”. This meant that the provider gathered information about the quality of their service from a variety of sources.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: There were insufficient numbers of staff on duty in order to meet the needs of people using the service. Regulation 22.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: Care records were inconsistent and not always up to date. Regulation 20 (1) (a).