Grandcross Limited

Begbrook House Care Home

Inspection report

Sterncourt Road
Frenchay
Bristol
BS16 1LB

Tel: 01179568800
Website: www.brighterkind.com/begbrookhouse

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13 December 2016 and was unannounced. Since the previous inspection conducted in November 2015 the registration status of the service has changed to a new legal entity, but has remained with the same provider organisation.

Begbrook House Care Home is registered to provide personal or nursing care for up to 32 people. At the time of our inspection there were 30 people living in the service.

There was a registered manager in place on the day of our inspection. 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. □

People's records were not always completed consistently or correctly to monitor and manage their health conditions. Some people were having their food and fluid intake monitored because they had been assessed as being at risk of dehydration or malnutrition. Their food and fluid charts were not adequately completed.

The service was not consistently responsive to people's needs. The quality and content of care plans was variable. People were not consistently involved in the decision making process regarding their care plans or in the reviews.

People told us that the staff were kind, caring and respectful. Concerns were expressed regarding the communication levels of some staff where English was not their first language. Staff were knowledgeable about people's needs and were aware of their life histories and background. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for. Staff felt well supported by the deputy and registered manager.

Care plans contained risk assessments. These included risk assessments for falls, moving and handling, skin integrity and bed rails. The assessments had been reviewed monthly and when risks to people had been identified, there were generally comprehensive plans in for place for staff to follow in order to reduce the risks.

Records showed that a range of checks had been carried out on staff to determine their suitability for work. Staffing levels were maintained in accordance with the assessed dependency needs of the people who used the service. Staff demonstrated a good awareness and understood their responsibilities with regard to safeguarding people from abuse.

People's rights were in the main being upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal

framework to protect people who are unable to make certain decisions themselves. In people's support plans we saw information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty.

People spoke positively about the activities offered and told us the programme was varied and enjoyable. Relatives were welcomed to the service and could visit people at times that were convenient to them.

People and their relatives spoke highly of the deputy and registered manager. They found them to be very helpful and approachable. They acknowledged that they had made improvements to the service in the short time they had been in post. They felt the atmosphere at the service had improved and described it as a happy friendly place. A recent external report by a health professional team stated; 'At present the new home manager is making excellent progress. Her leadership is palpable and the staff are responding to her style and consistency.'

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Good

The service was safe.

Medicines were managed safely.

Risks to people using the service were managed appropriately so that people were protected from harm.

Records showed that a range of checks had been carried out on staff to determine their suitability for work.

Staffing levels were maintained in accordance with the assessed dependency needs of the people who used the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People's records were not always completed consistently or correctly to monitor and manage their health conditions.

Staff were not consistently supported through an adequate training and supervision programme.

People's rights were upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

Where appropriate Deprivation of Liberty Safeguards (DoLS) applications had been made. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty.

Is the service caring?

Good

The service was caring.

People told us that the staff were in the main kind, caring and respectful.

Staff were knowledgeable about people's needs and were aware of their life histories and background.

The registered manager told us they ensure that all special events for people are celebrated in a way they choose.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The quality and content of care plans was variable.

Care plans were not consistently written in conjunction with people or their representative.

People spoke positively about the activities offered.

The provider had systems in place to receive and monitor any complaints that were made.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service has failed to fully meet the regulations.

Staff felt well supported by the deputy and registered manager.

People were encouraged to provide feedback on their experience of the service.

Begbrook House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 13 December 2016 and was unannounced. The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people who used the service were able to tell us of their experience of living in the home. For those who were unable we made detailed observations of their interactions with staff in communal areas.

We spoke with 10 people that used the service, six relatives, six members of staff and two visiting health professionals. We also spoke with the registered and regional manager.

We reviewed the care plans and associated records of six people who used the service. We reviewed the medicines administration records (MAR's) of the people who lived at the home. We reviewed documents in relation to the quality and safety of the service, staff recruitment, training and supervision.

Good

Is the service safe?

Our findings

People felt safe living at the service. Comments included; "I am safe here, I do not worry about anything they know what they are doing, they make sure my oxygen is full, if I press my bell they come"; "I am alright here, I feel safer because I kept falling at home, here everything is to hand"; "This is definitely a safe place to be, it is reassuring to have a bell to call people if I need them"; and "I am happy and safe here because I am being looked after."

Medicines were generally managed safely. Medicine administration record (MAR) charts contained photographs of people that had been dated to indicate they were still a true likeness of people. Allergies were listed clearly. PRN (as required) protocols were in place so that staff could clearly see when and why people might require additional medicines, such as pain relief. When PRN medicines were administered staff had documented the reason why; this meant that staff could identify any trends. Stock checks of all medicines were undertaken and these had been clearly documented. When we spot checked some medicines, we found the balances to be accurate.

We observed part of a medicine round. The nurse administering the medicines knew people well, assisted them with drinks and ensured they had swallowed their medicines before signing the MAR chart. They did not rush people and asked people if they needed extra medicines, for example if they had any pain. When medicines had been transcribed (handwritten) onto the MAR chart the majority of these had been signed and countersigned. We did note one exception to this, but when we pointed it out to a nurse, this was immediately rectified.

Although the majority of bottles of medicines had been dated when opened, not all had. For example, we saw two bottles of medicines that had been dated when opened, but the expiry date had not been added. This meant there was a risk that staff could inadvertently administer liquid medicines that had expired.

Topical creams and ointments were signed for when they were applied. We looked at some topical administration records; they were fully completed. We looked at the latest pharmacist visit report from 5 October 2016. Nothing of concern had been noted.

Care plans contained risk assessments. These included risk assessments for falls, moving and handling, skin integrity and bed rails. The assessments had been reviewed monthly and when risks to people had been identified, there were generally comprehensive plans in for place for staff to follow in order to reduce the risks. For example, moving and handling care plans contained details about the hoist and sling that should be used. In addition, when people's risks changed, the plans had also been amended in order to reflect the changes. For example, one person had fallen despite them initially being assessed as a low risk. After the fall, the plan had been reviewed to reflect additional measures staff should take to reduce the risk of recurrence. We did note one person had been assessed as having a very high risk of choking. In the associated nutritional care plan staff had documented there should be 'a clear choking plan in place for all staff to follow', but there was no such plan in place. The registered manager agreed to look into this matter.

Records showed that a range of checks had been carried out on staff to determine their suitability for work. This included obtaining references and undertaking a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal background and whether they were barred from working with vulnerable adults.

Staffing levels were assessed by following the Care Home Equation for Safe Staffing (CHESS) dependency tool. Staffing rotas viewed demonstrated that staffing levels were maintained in accordance with the assessed dependency needs of the people who used the service. The service only used agency staff in exceptional circumstances and unexpected absences were in the main covered by existing staff. One member of staff told us; "If everyone turns up for the shift, there is enough staff." A visiting health professional commented; "Most of the time there are enough staff; if I need staff assistance when I see residents, staff will always come and help straight away." There were mixed comments from people and relatives about the levels of staff; not all felt there were enough on duty, especially at weekends, whilst others felt there had been an improvement in numbers since the new registered manager has been in post.

The staff we spoke with had a good awareness and understood their responsibilities with regard to safeguarding people from abuse. They were able to explain the actions they would take if they suspected a person was being abused. Staff also understood the term 'whistleblowing'. This is a process for staff to raise concerns about potential malpractice at work.

Appropriate arrangements were in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any particular trend or lessons to be learned. Accident and incident forms clearly identified the nature of the incident, immediate actions taken and whether any further actions were required. For one person who had experienced a number of falls in close succession actions taken included the need to install sensory equipment and increase observations.

Requires Improvement

Is the service effective?

Our findings

People's records were not always completed consistently or correctly to monitor and manage their health conditions. Some people were having their food and fluid intake monitored because they had been assessed as being at risk of dehydration or malnutrition. Associated charts in relation to food intake were completed in full. However, fluid intake monitoring was poor. In one person's care plan it had been documented; 'Staff to make sure [person's name] is eating and drinking well and vice versa to report to the nurse on duty.' However there was no guidance for staff on what 'drinking well' actually meant in relation to the volume of fluid they should be drinking each day. The fluid charts for this person showed that for the previous ten days their fluid intake had been less that one litre per day. Current government guidance on drinking enough to stay hydrated recommends people aim for 6 to 8 glasses of fluid each day (1500-2000mls). On 10 December 2016 the input was recorded as just 300mls and yet in the daily record nothing had been documented to indicate that staff had identified this amount as inadequate. This meant there was a risk that people were not having enough to drink.

An external health professional body also recently reported to the service that their food and fluid charts were poorly completed. They advised that their documentation required close monitoring regularly throughout the shifts, the daily totals of the fluid should be recorded and form part of the staff shift handover.

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

When people had been assessed as having complex nutritional needs, relevant support and advice was sought. Care plans showed people had been referred to the speech and language therapy team (SALT) and the guidance was filed within the care plans. In addition, care plans contained people's personal preferences, what they liked to eat and what they didn't like.

The chef was not on duty on the day of our inspection. The staff member undertaking the cooking duties for the day demonstrated a good understanding of people's needs and specific dietary requirements. We received mixed comments about the food. Comments included; "Food is very nice, I get a choice and there is always something I like"; "I do not like the food, it is not what I am used to"; "Food is alright, but I am not interested in it"; and "I have a good appetite and I enjoy all the food, there is a choice every time." We observed that food was served at the correct consistency and temperature, according to the people's needs. If people did not like the menu choices of the day alternatives were offered.

Staff were not consistently supported through an adequate training and supervision programme. Supervision is where staff meet one to one with their line manager. We reviewed staff records which demonstrated that regular staff supervision had not been conducted. This meant that staff had not received effective support on an on-going basis and development needs were potentially not acted on. Recent group supervisions were held and they covered infection prevention and accurate completion of supporting documents. One member of staff told us: "The group supervisions work well. The one-to-ones are not

necessarily as regular as they should be."

New staff undertook an induction and mandatory training programme before starting to care for people on their own. Training covered a variety of subjects such as moving and handling, infection prevention, health and safety, food hygiene and safe handling of medication. The training records demonstrated that some staff mandatory training modules required up-dating. These included fire safety, food hygiene and health and safety. This had been noted in the Regional Manager's November 2016 report alongside the requirement that supervisions need to be up-dated. An improvement plan was in place to ensure these actions were going to be taken forward by the registered manager by their year-end (March 2017). The planned training matrix provided by the service demonstrated that training plans were in place to take forward the refresher training within their set deadline. The service had access to in-house trainers who had the responsibility of taking forward the training plan.

People's rights were in the main being upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In people's support plans we saw information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely.

Consent to care was generally sought in line with legislation and guidance. Although staff told us they had received training the level of knowledge they demonstrated in relation to the MCA was variable. Capacity assessments had been completed; these were decision specific and had been completed for people who had capacity as well as those that had been assessed as not having capacity. The service had adopted a blanket approach for all, regardless of whether the person needed a capacity assessment or not. One member of staff said "It's a bit confusing, there's so much paperwork. We're having training on best interest decision making soon".

People had access to on-going healthcare services. Care plans contained notes from when people were reviewed by visiting health professionals such as the GP, speech and language therapy team, foot care professionals, the dementia care team and physiotherapists. There were two visiting health professionals on the day of our inspection to assess people's needs. One health professional told us; "My impression of Begbrook currently is that it is functioning very well. The nurse in charge has all the information I need to hand including changes in patients conditions and all relevant observations. I am very happy with competency levels currently. My advice is invariably followed correctly."

Good

Is the service caring?

Our findings

People told us that the staff were kind, caring and respectful. Concerns were expressed regarding the communication levels of some staff where English was not their first language. The language barrier proved frustrating to some people. Comments from people and relatives included, "I like all the carers and nurses, they are kind and compassionate, they know their job; however, there are problems with language and communication can be difficult"; "They are looking after me well but some staff do not understand English"; "All carers are lovely, cannot fault them, we have plenty of laughs"; "I know [person's name] is getting good care because they are so happy"; and "There are lots of caring staff here, everyone walks around with a smile."

We observed the lunchtime service in the dining room. We noted a number of positive interactions between staff and people. People were offered choices of food and drink. People were asked if they were comfortable and staff assisted with people's requests, such as providing a cup of tea instead of water. Where people were being served food in their room the tray was presented with a small vase of flowers. People were discussing their families and activities they liked to engage in. People felt comfortable with the staff and they were having a laugh with them. The dining room was decorated with Christmas decorations and a tree. One person was getting upset and they were comforted by a staff member. The person told the staff member they were "wonderful." People we spoke with knew all the staff and also spoke highly of the domestic staff. One person told us; "The cleaners come into my room every day. We're on good terms, they're lovely."

We did note some notable exceptions. We observed two members of staff assisting people to eat in their rooms. In both cases there was no verbal encouragement or interaction. However, the carers did not rush the meal and allowed the residents to eat at their own pace.

One person told us they were due to have minor surgery at a local hospital next week. They told us the deputy manager had been meticulous in organising the arrangements and this had put their mind at ease. A relative told us staff had suggested their loved one might like to move to another room when they were becoming distressed by the noises made by other residents in nearby rooms, they were taken and shown a more suitable room which they have since moved into and have found it to be a great improvement.

People's personal space was respected. Most bedroom doors were open, although this was the person's choice; we observed staff calling out to people and announcing themselves and asking if they could enter. The majority of people were positive about the care they received and confirmed that they are treated with dignity and respect. They confirmed that doors are closed and curtains drawn before personal care is undertaken.

Staff were knowledgeable about people's needs and were aware of their life histories and background. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for. One member of staff told us; "[Person's name] refuses personal care. You make appointments to see her. If she's not feeling good she will tell you when she wants you. She doesn't like a full wash, she gets anxious. If she's getting anxious you listen to her as she thinks she's the boss and you follow her lead."

The registered manager told us that they ensure that all special events for people are celebrated in a way they choose. They recently enabled one person to go to the local pub with their family. It had been the first time they had left the service for a year. Since then the person has ventured out many times. The staff also arranged flowers and gifts for their relative on their birthday and a small party was held for them at the service.

Requires Improvement

Is the service responsive?

Our findings

The service was not consistently responsive to people's needs. The quality and content of care plans was variable. Although some were well written, with clear guidance for staff to follow, this was not consistent. For example, we looked at the plan for one person with complex needs. They had an underlying medical condition and the plan was very detailed and explained the reasons why staff should undertake certain procedures. The service had received recent feedback from the local acute hospital and wound care service on their provision of good management and wound care treatment which has resulted in improved wound care for people. It had previously been identified by them that when viewing the care plan documentation it was difficult to recognise which person required a dressing and when.

Care plans for people with sensory disabilities were person centred. For example, in one of the plans we looked at staff had documented how the person preferred the staff to communicate with them. It had been documented "Responds positively to kindness. It calms her when spoken to with affection". The plan also showed that specialist support and advice from RNIB had been offered to the person.

Other care plans we looked at were not as detailed. One person who had a catheter in place and was prone to urinary tract infections was having their fluid intake monitored. Ensuring an adequate fluid intake can contribute to the prevention of urine infections. The person's care records showed that the catheter had been blocking every two to three weeks and needed replacing more regularly than the manufacturer's guidance. We looked at the fluid charts for this person and saw that the recorded fluid intake was variable. On 7 December 2016 the input was recorded as 580mls in a 24 hour period and on 8 December 2016 it was recorded as 450mls. There was no target input recorded on the chart and it was unclear if staff had identified the low intake or whether they had escalated it to a senior member of staff, because no reference was made to it in the daily record. For example on 8 December 2016, staff had documented "no concerns". There was a risk that the low recorded fluid intake could exacerbate the risk of the person acquiring urine infections. Their care plan also did not provide any guidance for staff on how to prevent blockages occurring, despite records showing the catheter blocked regularly.

When people had been assessed as being at risk of skin breakdown, care plans were in place and contained details of the type of pressure relieving mattress that was being used and how often staff should change people's position. However, it was not clear from the care plans what the correct mattress setting was because the information had not been documented. Some of the mattresses in use needed to be set according to people's weight. Positional change charts in people's rooms also did not have the information in relation to the required mattress setting written on them, although they did show that people had their positions changed in accordance with the care plan. There was no formal checking process of the mattress settings. Therefore, the nurse in charge could assure not themselves that all of the pressure relieving mattresses were set correctly without making further checks. This posed a potential risk of not meeting the person's specific needs.

People were not consistently involved in the decision making process regarding their care plans or in the reviews. Only one person was aware of their care plan and had been involved in compiling it. Another person

told us that despite making numerous requests to see their care plan they had not seen it. The plans we looked at had all been reviewed regularly. However, there was no evidence to show whether people had been asked if they felt the plan met their needs. There was also nothing to indicate if relatives had been invited to be involved in formal care plan reviews. This meant that care plans potentially did not reflect people's individualised needs. However, it was clear from care records that relatives were kept well informed about people's care. This was confirmed by the people we spoke with.

The registered manager told us that the service has introduced a resident of the day system which will focus on a particular person on a rotational basis. It is their intention that the person and their family will be more formally involved in the care planning process.

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

People spoke positively about the activities offered and told us the programme was varied and enjoyable. Activities included cooking, flower arranging, music therapy, visiting the local pub, films, arts and crafts. On the day of our inspection children from a local school came and sang carols. This was thoroughly enjoyed by all, particularly the interaction with the children following the carols. There was also a Holy Communion service with members of a local church presiding. People were encouraged to join in activities. For those who chose to remain in their rooms the activities coordinator spent time one-to-one time with them. One member of staff told us; "It's not about the activity, it's about the interaction."

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

The provider had systems in place to receive and monitor any complaints that were made. We reviewed the complaints file. In 2016 three complaints had been received. Where issues of concern were identified they were taken forward and actioned. People and their relatives told us they knew how to make a complaint. Some people expressed a few concerns about having to ask staff to undertake tasks, rather than them being undertaken as a matter of course. We were told by people these issues tended to be taken forward to their satisfaction.

The service had received a number of compliments. A family member recently commented; "We would like to thank you all profusely for the excellent care you provided for our Mum, during her time at Begbrook. She was very happy in her surroundings and during her final weeks we were extremely impressed with everybody's caring attitude and the attention given which ensure that Mum was made as comfortable as possible." A health care professional recently commented; "Begbrook always has a lovely atmosphere with happy and helpful staff."

Requires Improvement

Is the service well-led?

Our findings

The service has failed to fully meet the regulations and we identified two breaches of regulations. Our inspection identified similar concerns to a recent external health professional report regarding the need to improve their food and fluid chart documentation. Further work was also required relating to person-centred planning and ensuring that the person or their representative were fully involved in the process. Although improvements had been made the registered manager acknowledged that these areas of their work were still 'work in progress.' The issues that required further work had also been identified though their internal auditing processes. Where appropriate they sought guidance from health professionals on how to address the concerns.

The regional manager also visited the home regularly and compiled a monthly visit report. The visits were used as an opportunity for the regional manager and registered manager to discuss issues related to the quality of the service and welfare of people that used the service. Clear action plans were evident and timescales given to areas in need of attention, such as up-dating the training programme.

Recent compliments had been received from health professionals regarding improvements made in the management of medicines and their accuracy of recording MUST scores. 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop a care plan. They stated; "I was really impressed with the recording of weights/MUST. It was a pleasure to go through the care plans as everything was so tidy and accurate." A visiting professional told us; "I've seen this home during the peaks and the troughs, but with the new manager here it's much better. There is good leadership here and that is key. I think the staff respect the manager's positive attitude".

Staff felt well supported by the deputy and registered manager. Comments included; "We have regular staff meetings. We are asked for our opinion. We are listened to. Since [registered manager's name] has been here staffing levels have increased and nursing levels"; "She's lovely. She's really good and you don't feel scared to talk to her"; ""We are included in improving the service. The nurses attend clinical governance meetings where we discuss issues or concerns, and go through audit feedback"; and "The deputy manager is one of us. He always asks how you are. He's supportive." Regular staff meetings were held to discuss clinical governance and operational issues. This meant staff were kept fully informed of service issues including required staff actions, such as the need to adhere to the provider's sickness protocol.

People and their relatives spoke highly of the deputy and registered manager. They found them to be very helpful and approachable. They acknowledged that they had made improvements to the service in the short time they had been in post. They felt the atmosphere at the service had improved and described it as a happy friendly place. A recent external report by a health professional team stated; "At present the new home manager is making excellent progress. Her leadership is palpable and the staff are responding to her style and consistency." The report stated that improvements needed to be made and this will not happen unless the staffing level is maintained at two nurses during the day. The staffing rota identified that the service had acted on this recommendation. In the main the staffing level is now two nurses during the day,

or one nurse and one senior care assistant.

The provider sought feedback from people so that they could evaluate the service and drive improvement. A recent resident and relatives meeting had been held which enabled an open forum for discussion and enabled people to express their opinions. Item agendas included; refurbishment plans; survey feedback; nutrition and activity plans. One person told us they attend every meeting saying "I want to know what is happening; at the last one [the deputy manager's name] had answered everyone's questions and explained what they plan to do". The 2016 satisfaction survey received nine responses which represented a 31% response rate. People felt they were treated with kindness, dignity and respect and they had access to the registered manager. Where improvements were suggested the service has implemented an action plan. An example of this has included increased outdoor activities for people.

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 9 HSCA RA Regulations 2014 Person-centred care The service was not consistently responsive to people's needs. The quality and content of care plans was variable. Although some were well written, with clear guidance for staff to follow, this was not consistent. People were not consistently involved in the decision making process regarding their care plans or in the reviews.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's records were not always completed consistently or correctly to monitor and manage their health conditions.