Mr D & Mrs S Mayariya

Fairfield Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Fairfield Care Home is a residential care home providing personal care for up to 21 adults. There were 14 people living in the home during our inspection visits. Two of those people were in hospital.

People's experience of using this service and what we found
Medicines management was not consistently safe. We have made a recommendation about the management of some medicines.

Risks to people's safety and the environment were not always identified and mitigated and risk assessments did not always contain accurate information to help staff manage risk. A continuity plan was not in place to ensure people would receive safe, consistent care in the event of an emergency.

Governance systems to monitor the quality and safety of the service were inadequate. Completed audits and checks had not identified the concerns we found. This demonstrated lessons had not been learnt since our last inspection.

Enough staff were on duty to meet people's needs. However, the provider could not demonstrate their staff were always recruited safely. Staff enjoyed their jobs, but they had not been supported to develop their skills and knowledge to provide high quality, safe care. Also, staff with no experience of working in a social care did not receive an induction that reflected nationally recognised induction guidance.

There had been a lack of consistent management and leadership at the service since 2015. Frequent management changes had impacted negatively on the quality and safety of care people received.

Whist people felt safe and were happy living at the home the standards of care they received had declined since our last inspection. People's privacy and dignity was not maintained, and people's personal belongings were not treated with respect. Staff knew people well but the language they used when they spoke about people was not always respectful.

Care was not always provided in line with people's preferences and choices and care records did not consistently contain detailed information to help staff provide personalised care. Action was being taken to address this.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Information about the service was not provided in a format all people could understand and more needed to be done to ensure the environment was dementia friendly. Improvements had not been made to the

environment since our last inspection to make sure it was a nice place for people to live. Some areas of the home were not clean.

People had enough to eat and drink and had access to health professionals when needed to maintain their health and wellbeing. People had opportunities to feedback their views on the service they received. Recent feedback showed people were happy with how their home was run.

People were supported to practice their religions and people's end of life wishes were documented if they had chosen to share this information. People were satisfied with the social activities available. People and their relatives knew how to make a complaint. No formal complaints had been received since our last inspection.

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

Following our inspection, we notified the local authority commissioners about the areas of concern we identified.

We reported that the registered provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were:

Regulation 10 Regulated Activities Regulations 2014 – Dignity and respect
Regulation 12 Regulated Activities Regulations 2014 - Safe care and treatment
Regulation 15 Regulated Activities Regulations 2015 – Premises and equipment
Regulation 17 Regulated Activities Regulations 2014 - Good governance
Regulation 18 Regulated Activities Regulations 2014 – Staffing

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 20 September 2018) and there was one breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider remained in breach of regulation.

This service has been rated requires improvement for the last five consecutive inspections.

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

The overall rating for this service is inadequate and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not, enough improvement is made within this timeframe and a rating of inadequate remains for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

Follow up: We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care.

Enforcement: Full information about CQC's regulatory response to the more serious concerns found in inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led

Details are in our well-led findings below.

Fairfield Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Our first visit was carried out by two inspectors, an inspection manager 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. One inspector returned to complete the second visit.

Service and service type
Fairfield Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The previous registered manager had deregistered with us August 2019. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had started work at the home and they intended to register with us. They were present during our first inspection visit.

Notice of inspection
Unannounced inspection visits took place on 19 and 25 September 2019.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who lived at the home and two people's relatives about their experiences of the care provided. We spoke with the manager, the provider, the administrator, the senior team leader, two team leaders, the cook and three care assistants. We also spoke with one visiting health professional.

We observed the care people received. We reviewed six people's care records and six people's medicine records. We looked at a sample of records relating to the management of the service including quality audits, action plans, training data and people's feedback. We also reviewed three staff files to check staff had been recruited safely.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
• The management of people's medicine was not consistently safe and some previously demonstrated standards had not been maintained.
• Staff administered some people's medicines through patches applied directly to their skin. Records of patch application and removal sites were not clear which placed people at risk. Accurate completion of these records is extremely important to ensure application sites are rotated in line with manufacturer's guidelines to prevent harm. Action was taken to address this.
• The provider's medication policy did not include guidance on the administration of patch medicines in line with The National Institute for Health and Social Care Excellence (NICE) guidance.
• Information was not always recorded to inform staff where to apply prescribed creams to a person's skin. A medicine audit completed on 12 September 2019 had identified this shortfall, but corrective action had not been taken.

We recommend the provider reviews their medicines policy to ensure it reflects best practice guidance and current legislation.

Systems were not sufficient to ensure safe use of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

• People told us they received their medicines when they needed them.
• Medicines were stored securely and staff administering medicines had received training in safe medicines management.

Assessing risk, safety monitoring and management
• Risks to people's safety were not always identified. One person known to be at high risk of falls had to walk down five steps in a dimly lit corridor to get to their bedroom. However, this potential risk had not been assessed. An assessment was completed when we raised this the provider.
• Risk assessments did not always contain accurate information to help staff manage risk. One person's risk assessment stated they needed to wear a special boot on their foot whilst they recovered from an injury. However, staff told us the person had not needed to wear the boot since July 2019. When we raised this with the senior team leader the risk assessment was updated.
• Environmental risks were not always identified and mitigated. For example, the patio slabs in the rear garden were uneven which posed a potential tripping and falls risk .

• The provider confirmed a continuity plan was not in place. This meant they could not demonstrate how people would receive safe, consistent care in the event of an emergency.
• During our second visit the provider informed us of their plans to improve risk management. We acknowledged some improvement had been made between our visits in response to our feedback.

Systems were not sufficient to demonstrate risk was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• At our last inspection areas of the home required refurbishment to ensure it was a pleasant environment for people to live. At this inspection sufficient improvement had not been made.
• Systems to monitor cleanliness were ineffective because areas of the home were dirty. For example, skirting boards in the dining room were covered in a thick layer of dust. A relative commented, "The whole place needs a good scrub." A health professional also shared concerns in relation to cleanliness.
• Paintwork on door frames throughout the home was chipped which meant it was difficult to clean.
• Previously, people had found it difficult to access the rear garden area. At this inspection access had not improved. Therefore, the outside space did not meet the needs of some people. One person commented, "The ramp is too steep."

The premises were not clean or properly maintained. This placed people at risk of harm. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• During our first visit, pedal bins in two toilets were broken and toilet rolls were stacked on top of toilet cisterns. This increased the potential risk of cross infection. The provider acknowledged our findings and took action to address this.
• Staff had access to and wore personal protective equipment, such as gloves and aprons, when necessary in line with good infection prevention and control practice.

Learning lessons when things go wrong
• The overview of accidents and incidents needed to be improved to ensure patterns and trends were identified. This meant opportunities to prevent a reoccurrence could have been missed. The new manager was addressing this.
• Sufficient improvement had not been made since our last inspection to demonstrate compliance with regulations. This showed lessons had not been learnt.

Staffing and recruitment
• The provider had failed to take the action needed to demonstrate staff were recruited safely. Recruitment files were disorganised, and the provider's recruitment policy was not consistently followed .
• Enough staff were on duty to meet people's needs in a timely way during our visits.

Systems and processes to safeguard people from the risk of abuse
• Despite the issues identified above, people felt safe living at Fairfield Care Home. One person said, "I feel safe here, here there is someone else around."
• The provider's safeguarding policy did not reflect current best practice guidance and regulations. The provider told us action was being taken to address this.
• Staff knew to report any suspected or witnessed abuse to their managers and whilst confident these would be addressed understood how to escalate their concerns if they were not.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

Staff support: induction, training, skills and experience
• The provider had not ensured staff had been supported to develop their skills and knowledge to provide high quality, safe care. For example, some people lived with dementia, but staff caring for them had not received training in dementia care.
• Training staff completed to help them understand the Mental Capacity Act continued to be ineffective. For example, some staff did not understand how to ensure decisions were made in people's best interests.
• The provider did not have a clear overview of the training staff had completed or when it needed to be refreshed. Action was being taken to address this.
• Management observations and checks of staff practice did not take place. Therefore, the provider could not assure themselves staff were competent in their roles.
• The provider had not ensured their induction for staff with no experience of working in a social care reflected nationally recognised guidance for induction.

The failure to ensure staff had been provided with appropriate training and were competent in their roles potentially placed people and staff at risk. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

• New staff, however, told us they felt supported when they started work at the home. One new staff member said, "I read care plans and worked alongside the other staff. It was helpful."
• Staff received individual support through regular one to one meetings with their managers.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on

people's liberty had been authorised and whether any conditions on such authorisations were being met.

• The provider and staff had limited knowledge of the MCA. This indicated the service was not working in line with the requirements of the Act.
• The provider did not have a clear oversight of whether any people had restrictions placed on their care to keep them safe. They were taking action to address this.
• Staff did not know when a mental capacity assessment would need to be completed. This meant capacity assessments may not be completed for people when required .
• People confirmed, and we saw staff sought their consent before they provided them with assistance.

Adapting service, design, decoration to meet people's needs
• There was some signage throughout the home to assist people who were living with dementia to orientate themselves. However, more needed to be done to make the environment dementia friendly.

Supporting people to eat and drink enough to maintain a balanced diet
• People told us they had enough to eat and drink and liked the food. Staff were attentive at mealtimes which helped people to enjoy their meals.
• Staff including the cook knew what people liked to eat and drink. People's dietary preferences, including vegetarian diets were catered for.
• People's care records documented risks associated with eating and drinking. However, records relating to the monitoring of food and fluid intake were not always accurate. During our second inspection visit action had been taken to address this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
• Assessments of people's needs were carried out prior to them living at the home to determine if their needs could be met. Information gathered during assessments was used to develop care plans.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People confirmed they had access to health professionals when needed to maintain their health and wellbeing. District nurses and a chiropodist visited people to provide care and treatment during our visits.
• Staff felt they had good working relationships with health and social care professionals.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff attitudes had shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

• The provider did not ensure that people received good care. The multiple breaches of the regulations we identified confirmed this.

• Language used by staff when they spoke about people was not always respectful. For example, they used the term 'toileting' when they provided personal care. The provider was aware of this poor practice but had failed to address it.

• People's privacy and dignity was not maintained. A lock was not fitted to a toilet door that opened directly onto a communal area. Also, the door did not close properly. We saw this toilet was in regular use during our inspection.

• People's personal belongings were not treated with respect. For example, care was not always taken with people's items of their clothing. A relative explained how on many occasions items of clothing had gone missing and had been damaged during laundry processes.

• People's wishes were not always respected. For example, we found two people had not had showers for a long period of time, despite their care plans clearly stating that they enjoyed a shower. For one of these people their care records informed us they had only been offered one shower between 3 August and 11 September 2019. The person commented, "I used to have a shower but now I have a rub down, I don't have a shower anymore as they don't have one." When we discussed this with the provider they told us there was no reason why this person was not having a shower.

People were not always treated with dignity and respect. Poor practice was accepted. This placed people at risk of harm. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• The provider accepted our findings and had started to take action to address the concerns we identified.

• Despite our findings people were happy with the care they received. One person said, "I am happy, and I do like it, the carers are all very nice." Another told us, "I am well looked after."

• Individual staff members showed people kindness. For example, a staff member had gone shopping in their own time to purchase food items a person enjoyed eating. When they gave the items to the person they said, "Oh lovely, you are wonderfully kind."

• Staff described how they supported people to be as independent. For example, encouraging and supporting people to brush their teeth and wash their face themselves.

Supporting people to express their views and be involved in making decisions about their care
• People had been involved in planning their care. Where possible people had signed their care plans.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• Care and support was not always provided in line with people's preferences and choices.

• One person spent a lot of time in their bedroom watching television. However, they did not have a remote control to change the television channels and they had to wait for staff to do this for them. During our first visit we asked the provider to take action to address this. When we returned six days later a remote control had not been provided.

• People's care plans did not always contain detailed information. Staff told us they followed the advice of a health professional to wash one person's legs in a certain way to maintain their health. However, this information was not documented. The senior team leader was in the process of adding further detail to people's care plans to ensure records were accurate and informative.

• Other care plans had recently been re written and provided staff with information about people's likes, dislikes, personal preferences, care needs and medical history. However, a system was not in place to ensure people's care plans were updated on a continuous basis to help staff provide personalised care.

• People confirmed they received care from staff who knew them well. Discussion with staff confirmed they understood people's care needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• People were satisfied with the social activities available. One person said, "One of the girls [staff] does our nails. I have my hair done once a week." Another commented, "I am happy here we get up to all sorts we play games, and someone comes in to entertain."

• During our first visit some people went to a local pub for a meal. On their return people told us they had enjoyed themselves.

• People continued to be supported to maintain relationships with those that mattered to them and people's friends and family were welcome to visit at any time.

• People were supported to practice their religions and representatives from faith groups visited the home.

Meeting people's communication needs

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

• Some people were provided with information about their home in a format they could understand.

However, information was not available in easy read or picture format. This was important as some people at the home lived with dementia.
• The homes 'service user guide' contained some incorrect information about the management team which could be confusing for people. Action was taken to address this.

Improving care quality in response to complaints or concerns
• People and their relatives knew how to make a complaint.
• A copy of the provider's complaints procedure was displayed within the home.
• No formal complaints had been received since our last inspection.

End of life care and support
• Some staff had received training to support people as they neared the end of their lives.
• People's end of life wishes were documented if they had chosen to share this information.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

Since 2015 the provider has failed to meet their regulatory requirements. They have continually been in breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection required improvements had not been made and the provider remained in breach of regulation 17. This demonstrates a failure to make and sustain improvements to benefit people.

• The service has been rated as Requires Improvement at the last five CQC inspections and the standard of care people received has declined since our last inspection.
• Governance systems to monitor the quality and safety of the service were inadequate. The provider continued not to complete any quality assurance checks. That meant they did not have oversight of the service to ensure people received care and support that promoted their wellbeing and protected them from possible harm.
• Audits and checks completed by staff were ineffective and had not identified the concerns we found. For example, cleaning schedules had been completed but the home was dirty.
• The provider had submitted an action plan following our last inspection which had set out the actions they planned to take to address our concerns by December 2018. We found actions taken had not been sufficient. Furthermore, new breaches in regulations were identified at this inspection.
• There had been a lack of consistent management and leadership at the service since 2015. Since our last inspection three different managers had worked at the home. During our first visit a new manager had been in post for four days. They told us they planned to apply to register with us. The previous registered manager had not worked at the home for several months before they had deregistered with us in August 2019.
• The provider explained frequent management changes had impacted negatively on the quality and safety of care people received. This showed the provider continued to be heavily reliant on their managers to ensure the service was running effectively. Therefore, lessons had not been learnt.
• The provider demonstrated commitment to providing good quality care, but they had failed to recognise how their lack of oversight and knowledge of regulation impacted on people and staff.
• The provider's policies and procedures did not include to best practice guidance and the provider did not

always follow their recruitment policy. This demonstrated the provider lacked knowledge and understanding about best practice guidance and legal requirements.
• The provider accepted poor care practice occurred and they had not ensured staff were adequately supported to be effective in their roles.
• Improvements were required in promoting person-centred care and ensuring people were treated with dignity and respected.
• People's confidential information was not stored securely in line with requirements. The cupboard in a communal area used to store people's care plans was unlocked during both of our visits so anyone visiting the home could be able to access these. Also, staffs personal telephone numbers were on display in a communal area. This information was removed on our request.

The above issues demonstrate a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Between our visits some reactive action had been taken to make some improvements.
• The latest CQC inspection rating was on display in the home. The display of the rating is a legal requirement, to inform people seeking information about the service of our judgments.

At our last inspection the provider had not met their regulatory responsibility to inform us of significant events that had happened at the home. This was a breach of regulation 18 of the Care Quality Commission Registration regulations 2009. (Notifications of other incidents).

At this inspection we found the provider was no longer in breach of regulation 18 because we had received statutory notifications as required by the regulations.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• People had opportunities to feedback their views on the service they received. Recent feedback showed people were happy with their care and how their home was run.
• Staff enjoyed their jobs. They told us they felt listened to and were supported by the provider. For example, they attended regular team meetings.
• Local authority commissioners had been supporting the provider to make improvements since our last inspection.
• The provider planned to develop partnership working with other organisations to support care provision and service development.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

The enforcement action we took:

NOP to restrict admissions and impose a positive condition around governance

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way to service users

The enforcement action we took:

NOP to restrict admissions and impose a positive condition around governance

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People were not always treated with dignity and respect.

The enforcement action we took:

NOP to restrict admissions and impose a positive condition around governance

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and process were not established and operated effectively to ensure compliance with requirements.

The enforcement action we took:

NOP to restrict admissions and impose a positive condition around governance

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	Staff had not been supported to develop their skills and knowledge to provide high quality, safe care.

The enforcement action we took:

NOP to restrict admissions and impose a positive condition around governance