Autism Care (UK) Limited

Autism Care Community Services (Milton Keynes)

Inspection report

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Date of inspection visit:
14 February 2022
15 February 2022
16 February 2022

Date of publication:
17 March 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Autism Care Community Services (Milton Keynes) is registered as a domiciliary care agency who provide care and support to people living in four supported living properties. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of inspection seven people received personal care support in supported living settings.

People's experience of using this service and what we found
Right support
● Improvements were required so everyone receiving support could develop, flourish and pursue their interests.
● Improvements in medicines management were needed so everyone receiving support could be supported with their medicines safely and in the way they preferred.
● Not everyone was supported to have the maximum possible choice and control over their lives.
● The staff team worked hard to provide person-centred care which was stimulating and followed people's preferences but they did not have sufficient management support to achieve this.
● Staff enabled people to access and follow up specialist health and social care support but not always in a timely manner.

Right care
● Improvements were required so people were always protected from abuse and avoidable harm. Management oversight of these processes was not effective.
● People were not always fully supported to communicate in the way they preferred. Not all staff were provided with the training to support people in this area.
● People's care and support plans were being refreshed but had been out of date and inaccurate for a long time. This raised the risk of people not receiving the right care.
● Not all people living in the services received care that supported their needs and aspirations, was focused on their quality of life, and followed best practice.
● Risks associated to people's care and choices were set out in their care records, but improvements were required to ensure all risks were assessed and regularly reviewed.
● Many of the staff team provided kind and compassionate care and wanted to see sustained improvements for the benefit of people receiving support. The team leaders worked over and above their responsibilities to

try to achieve this, but lacked management support.

Right culture
● Not everyone living in the services led inclusive and empowered lives because of the ethos, values, attitudes and behaviour of the registered manager and provider.
● People did not always receive good quality care, support and treatment as staff were not sufficiently trained or supported in their roles.
● Some staff had left recently and the remaining staff team were stretched to ensure sufficient staffing levels were maintained. The staff team worked together to achieve this.
● Some people and those important to them were not always involved in planning and reviewing their care.
● The registered manager had not promoted an open and welcoming culture in all locations. Many staff did not feel valued, supported and felt their attempts to raise concerns were not listened to.

Internal compliance audits in recent months had identified many of the issues we found on inspection but had not been acted on by the registered manager. They resigned shortly before the inspection. An interim management team supported the inspection openly and transparently. The provider was keen to develop an action plan and work at pace to make and embed improvements in all required areas.

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

Rating at last inspection
The last rating for this service was good (published 3 January 2020).

Why we inspected
We undertook this inspection to assess that the service is applying the principles of 'Right support right care right culture'.

The inspection was prompted in part due to concerns received about alleged neglect and poor care to some people. A decision was made for us to inspect and examine those risks.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to person centred care, management oversight of the service, safe care and treatment, protection from the risk of abuse. We also identified a breach in relation to complaints processes.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

For further details see our detailed findings below.

Is the service caring?

Requires Improvement

The service was not always safe.

For further details see our detailed findings below.

Is the service responsive?

Requires Improvement

The service was not always safe.

For further details see our detailed findings below.

Is the service well-led?

Inadequate

The service was not safe.

For further details see our detailed findings below.

Autism Care Community Services (Milton Keynes)

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
One inspector and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspector visited the three supported living properties where people received personal care and also visited the office to review records. The Expert by Experience made phone calls to relatives to gain their feedback.

Service and service type
This service is registered as a domiciliary care agency. It also provides care and support to people living in four 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The registered manager resigned shortly before the inspection took place. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced at the office. We then made arrangements to visit people in their homes and return to the office when staff would be there to support the inspection.

What we did before inspection

We reviewed information we had received since the last inspection. We received information from the local authority commissioning and safeguarding teams. The provider was not asked to complete the required Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report.

This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We communicated with six people who used the service and eight relatives about their experience of the care provided. Some people were unable to talk with us and used different ways to communicate including signs, gestures, vocalisations and body language. We also observed people and their interaction with staff and each other throughout the inspection visits.

We received feedback from 20 members of staff. This was in person, over the telephone and by email. This included the business support manager, a registered manager from another service, team leaders and support staff.

We used the Short Observational Framework for Inspection (SOFI) and spent time observing people. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and medication records. We looked at three staff files in relation to recruitment processes. A variety of records relating to the management of the service, including quality assurance audits, policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We received a range of records and updates including training and supervision information, updates on care processes and support plans.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- People were not always kept safe from avoidable harm. Not all staff were up to date with safeguarding training or knew what to do if they had any safeguarding concerns. One member of staff said, "We kind of know to go to the person 'on-call' but we usually can't get hold of them." Some staff also told us if they raised concerns no action was taken, so they did not have confidence in the systems in place.
- The registered manager had not kept clear records of safeguarding concerns, undertaken investigations when required or made all required safeguarding referrals. For example, when someone sustained unexplained bruising, or placed themselves in danger. During the inspection the interim management team reviewed records and made several referrals to the safeguarding team retrospectively.
- We did not see clear and up to date information on display in all locations giving guidance and information to staff about safeguarding and whistleblowing processes.

Systems and processes were not effective in ensuring all people using the service were protected from the risk of abuse and improper treatment. This placed people at risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

- Not all people, including those unable to make decisions for themselves, had freedom, choice and control over their lives because risks were not minimised safely. Staff did not always have access to positive behaviour support plans to understand how people expressed emotion and distress, and support strategies suited to each individual. This meant there was a higher risk of people not receiving consistent or safe care.
- Key risks to people's safety, for example the risk of choking, were not consistently and safely managed. Two people's support plans stated they were at risk of choking, but the speech and language team (SALT) assessment and guidance could not be found. Suitable monitoring of people's eating and drinking when they were at risk of choking was not always taking place or being recorded. Not all staff were aware who was at risk of choking. A member of staff told us they had received online training in how to use de-choker equipment but would not feel confident using it.
- People were not kept physically safe as safety checks had lapsed in some locations. This included checks of the smoke detectors and other safety equipment. Information was not readily available to give to the emergency services in the event of a building evacuation on what people's support needs were. Fire risk assessments were not up to date in all houses. The interim manager took immediate action when this was brought to their attention.
- The storage, administration and recording of medicines was not always safe. We found a range of issues

which included medicine administration records (MAR) not being completed in line with best practice and containing unexplained gaps. Key information such as allergies were not always accurate and not all medicines were stored safely. This place people at higher risk of physical harm.
● Not all 'as needed' medicines had protocols setting out when they should be offered or administered. Guidance in place for other medicines lacked detail and were not regularly reviewed. The interim manager took immediate action when this was brought to their attention, including arranging medicine reviews for people living in some locations.
● The registered manager had not always managed incidents, accidents and people's expressive emotions consistently or safely. They did not always take or record follow up action when staff reported incidents, and had not embedded good practice in staff completing behaviour charts. Records were disorganised. Staff told us they did not have confidence the registered manager took appropriate action when incidents occurred. This placed people at higher risk of receiving unsafe care or care which did not meet their needs.
● There was no system in place to learn lessons when things went wrong. Regular analysis of incidents, accidents and people's expressive emotions did not happen. This meant opportunities were missed to spot trends and themes and put in place measures to reduce the risk of recurrence.

Systems and processes were not effective in ensuring people received safe care and treatment. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the interim manager took swift action when issues were brought to their attention. This included following up on health and safety concerns, making referrals to the positive behaviour support team and SALT team. They initiated medicine reviews for people where required and put in place 'as needed' protocols. They also reviewed accidents and incident records and made referrals to the local authority safeguarding team retrospectively as needed.

Preventing and controlling infection
● Infection prevention and control measures required strengthening in some areas. Staff raised concern they had not been required to do regular PCR tests in line with government guidance. However, improvements were recently introduced so they were completing an LFD test before each shift. This reduced the risk of infection spread in the event of a positive COVID 19 result.
● We identified one of the cleaning products were not suitable or effective against COVID-19. The provider placed an order for cleaning products during the inspection. Cleaning schedules were not always signed to show tasks completed. Action was taken during the inspection to store cleaning equipment such as mops safely.
● The interim manager was taking action at the time of inspection to improve IPC records, for example re-doing staff risk assessments and hand hygiene competency checks.
● We saw staff wore masks and had access to personal protective equipment (PPE).
● The service prevented visitors from catching and spreading infections.
● The service followed shielding and social distancing rules.
● The service made sure that infection outbreaks could be effectively prevented or managed. It had plans to alert other agencies to concerns affecting people's health and wellbeing.
● The service's infection prevention and control policy was up to date.
● The service supported visits for people living in the home in line with current guidance.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment

● Although staff were stretched, there were usually enough staff available to ensure staffing levels were sufficient. Staff told us their concerns about short staffing and the staff team pulling together to ensure gaps in the rota were covered. Team leaders told us it was stressful trying to ensure shifts were covered but they did their best to achieve this.

● The provider followed safe recruitment practices for staff working in the service. This meant checks were carried out to make sure staff were suitable and had the right character and experience for their roles.

● Some people were negatively affected by the availability and willingness of staff to drive people's cars to support them access a range of activities. In one location there was only one member of permanent staff who did this task. The interim manager confirmed they hoped to recruit more staff who could drive as part of their support role.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, care for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care

- People were not always involved in their care and encouraged to make choices. Documentation about care reviews, and the involvement of people and those important to them, could not be found. This heightened the likelihood of people receiving care which was not in line with their views or preferences.
- People were not always enabled to make choices for themselves and did not always have the information they needed to do so. For example, activity planners were not used in all locations, which meant people did not have support to plan how they wished to spend their time so staff could respect their wishes and choices. Weekly menus were not used in all locations so people may not have had sufficient opportunities to contribute their views on what they wanted to eat and drink.
- Care plans showed people's routines and preferences and they were able to make choices according to their mood and preference. For example, in one house during a mid afternoon visit one person had gone to bed for a nap and another person decided they wanted a bath, which they were supported with. In another house a person decided to have a shower just before lunch.
- Staff supported people to maintain links with those that are important to them.

Respecting and promoting people's privacy, dignity and independence

- The registered manager did not support people and those important to them with reviewing and setting goals and aspirations on a regular basis. This increased the likelihood of people not being encouraged with skills and learning development, or encouraged towards agreed independence goals.
- People were not always supported in a way which protected their privacy and dignity. One person frequently went outside the front of one of the houses and refused to come inside. Sometimes they removed some clothes, placed themselves in danger on the road, or at risk of illness due to being outside in the rain. This was in view of members of the public, and remained an ongoing concern at the time of inspection.

Ensuring people are well treated and supported; respecting equality and diversity

- Relatives and staff provided mixed feedback about the care and support people received. Some were satisfied with day to day care. One relative summed up the views of most of the feedback by saying, "We experienced how good it could be with the last manager so we can see how bad it is now. There is no involvement from the manager. The care staff need congratulating for keeping things going in the circumstances." Another relative said, "[Team leader] is an absolute star. Without them and the regular members of staff, it would be a really bad situation."
- Members of the staff team spoke very warmly about people living in the services and wanted people to receive better care and support. Staff were willing to share their concerns as they hoped positive

improvements could be made. One staff member said, "I just hope something happens, I want it to get better." Another said, "I hope most of us do stay as we do care."

● During the inspection we saw some warm and positive interactions between people and staff. One person was being supported to cook dinner and clearly enjoyed this, another was discussing their sore neck with staff and what they should do about this. We saw staff laughing and joking with people in one house and one person went through to the kitchen to continue the conversation when staff began food preparation.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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; 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; Meeting people's communication needs; End of life care and support

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.

● Staff tried hard to provide personalised care and work as a team but had felt unsupported by the registered manager and provider. Morale in the staff team was low and staff lacked confidence in supporting people's range of needs. This meant people did not always receive high quality and person-centred care. For example, people received funding for one to one, or two to one support, but often they spent extended periods of time indoors without stimulating or engaging activities to enjoy or participate in.
● Care and support plans were in the process of being updated by the interim management team but had not contained up to date, accurate or relevant information for a long time. For people who could not share detailed information themselves this meant important aspects of their care and health needs were overlooked. Staff told us, and records confirmed, support plans contained references to other people, other services and inaccurate information about people. In some locations team leaders had recently refreshed care plans with involvement from people and their relatives. One relative told us, "[Family member's] care plan was not worth the paper it was written on. It was obviously copied and pasted."
● Turnover in the staff team, with some experienced staff leaving, had an impact on some people living in the services. One relative said, "The problem is staff turnover, I don't think they get to know [people] well enough, there are lots of behaviours to look out for and staff not knowing them means low level incidents occur a lot and [family member] gets distressed. Last year has been particularly bad."
● People using the service had a range of communication abilities and ways of communicating their needs, wishes and feelings. Care plans included information about people's individual communication needs and preferences but these were not always followed. Some people used Makaton sign language but staff had not received training in this area. Some people used pictorial aids but we did not see any in use during the inspection in one of the houses. People were not able to always communicate effectively in the way they preferred.
● We received mixed feedback about people being able to spend time pursuing the leisure activities they wanted to, both inside their home and out and about. One relative said, "I think they should go out more and do more." A person told us they could do all the activities they wanted to, and told us they had been

bowling the day before which they had thoroughly enjoyed. Another relative said, "Recently [family member] was singing and dancing in the living room with staff and the manager came round and told them to be quiet and to stop and not to do it again, [family member] was quite upset because it's their house not the manager's."

● The provider had an end of life policy but people and those important to them had not been offered opportunities to share their views as part of end of life care planning, in the event this type of care was required.

People did not always receive person-centred care which was appropriate, met their needs and reflected their preferences. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People who lived in the services were supported to regularly speak and spend time with people who were important to them.

Improving care quality in response to complaints or concerns

● A complaints policy was in place but the complaints folder in the office for 2021 was empty. During the inspection we found evidence of two complaints which had been made but not followed up in line with the provider's policy.

Complaints were not acknowledged, investigated and acted upon in a timely manner. This was a breach of regulation 16(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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; Continuous learning and improving care

- The registered manager had failed to assess, monitor and improve the quality of the service. Processes to maintain oversight of people's care and support, including support plans and risk assessments, care records, medicines, accidents, incidents and expressions of emotional distress, restrictions on people's liberty and mental capacity assessments/best interest decision making were ineffective. This meant people were at risk of receiving unsafe care which did not meet their needs and of this not being identified and remedied.
- The provider had failed to ensure the service was consistently well-run. People's quality of care and support had deteriorated. Audits in recent months had identified concerns about how the service was run but it was early days in improvements being implemented and embedded.
- The systems in place to monitor the safe use of medicines was not effective. There was scant evidence available of monthly audits completed by the registered manager. The range of issues we found during the inspection, some of which were identified repeatedly by team leaders, had not been addressed or remedied by the registered manager. People were at higher risk of physical harm because of this.
- The system to review daily records with people and those important to them and support goal and aspiration setting had lapsed, which meant oversight and monitoring of their care and support was ineffective. This placed people at higher risk of receiving support which did not meet their needs or align with the preferences.
- There were ineffective systems in place to ensure appropriate follow up to incidents, accidents and expressions of emotional distress. The registered manager and provider had not taken action when required to keep people and staff physically and emotionally safe. Charts were not kept to monitor when people showed expressive emotions, or to support analysis for patterns or trends. Oversight of staff training needs in this area was not effective. Opportunities to put in place measures to reduce the risk of recurrence were missed, along with opportunities to learn lessons.
- The majority of staff did not feel supported, valued or respected by the registered manager and provider. Morale and confidence in the staff team were low. Staff supervision and team meetings did not take place regularly so staff were not given opportunities to receive key updates, share information and discuss their development. One staff member said, "Everyone feels deflated," and another said, "I can't say anything is working well at the moment."

● The registered manager and provider had not promoted an open and supportive culture for all people living in the service. There were signs of a closed culture in which staff were raising concerns and not feeling listened to, people were restricted in how they could spend their time and staff were not provided with sufficient support to enable people to live the way they preferred and which safely met their needs. Although there were a variety of systems in place for staff to share their views, concerns or seek support, these required further embedding into staff awareness and practice to be effective.
● The service had not been well-led. All of the feedback from relatives was negative in this area. Some feedback included, "Management is shambolic," "The [registered] manager is just awful and useless," "I think the [registered] manager is the problem and so many good staff have left because of them," "Everything's gotten worse with this [registered] manager. They are not available or approachable," and, "I don't know if the manager would recognise my [relative] in the street." A person using the service told us, "Management need to step up, but if not they shouldn't be a manager. My mum and keyworker are frustrated. I'm frustrated."
● The registered manager and provider had not met their regulatory responsibilities and requirements. Not all safeguarding concerns had been followed up appropriately.
● Oversight of health and safety checks, and maintenance issues, was not effective. Follow up action was not taken promptly when issues were identified. The interim management team started work immediately addressing the issues found.

Systems and processes to see the effective running of the service were inadequate. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives, staff and people we spoke to talked very highly of the team leaders and the support they provided to everyone.

The provider had acted upon concerns about the running of the service and recently put an interim management team in place. The registered manager resigned shortly before the inspection. The interim team supported the inspection openly and transparently. They were working hard to identify the full range of improvements needed and start the implementation of these.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Regular house and key worker one to one sessions did not take place for everyone who received care and support. This meant people did not always have opportunities to share their views and contribute to the running of their house
● The staff team worked in partnership with health and social care professionals but had lacked the support and oversight from the registered manager. This meant there was potential for delays with people's health and social care needs being met.
● The majority of relatives we spoke to had received feedback surveys and provided mixed comments on their experiences. Those who had submitted responses had not received any feedback on the results. One relative said, "I had one, but I didn't fill it in as what's the point."
● The service supported people with a range of abilities and equality characteristics. Team leaders and many of the support staff worked over and beyond their contracted duties to ensure people and their families were involved and kept up to date.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People using the service did not always receive safe care and treatment. Risks were not always assessed and reviewed, safety checks had lapsed in some areas, medicines practices required improvements. Systems to manage incidents, accidents and people's expressive emotions were not robust.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems to ensure people were protected from harm and the risk of abuse were not always effective. Processes were not followed and records were disorganised. Safeguarding information was not easily accessible for staff.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The complaints process was not always followed. Systems required strengthening.

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
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always received care, support and treatment which was appropriate, met their needs and reflected their preferences.

The enforcement action we took:

We issued a warning notice and gave the provider a short time scale to make improvements.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of management oversight of all key areas of the service. Issues identified were not acted upon in a timely manner. There were inadequate systems in place to monitor the quality of care and drive improvements of the service.

The enforcement action we took:

We issued a warning notice and gave the provider a short time scale to make improvements.