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Elizabeth House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 November 2018 and was unannounced.

Elizabeth House Residential Care Home provides a service for up to 14 people in Mansfield Woodhouse Nottinghamshire, who have needs associated with ageing or are living with dementia. On the day of our inspection eight people were living at the service.

The service had a registered manager. 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

At our last inspection on 10 November 2016 we rated the service 'Requires Improvement'. Shortfalls in the fundamental care standards were identified in how people received their medicines, the cleanliness of the service, the choice of activities available and the systems in place to monitor quality and safety. At this inspection, we found ongoing concerns and some new shortfalls in the care and support people received. We also took account of the inspection history; the service had continued to not reach the minimum fundamental care standards people should expect.

Staffing levels and deployment of staff meant people did not consistently receive quality care. Staff had to multi-task and had limited time to spend with people, this compromised how people received care and support. Safe staff recruitment checks were completed before staff commenced their employment.

The management of medicines did not consistently follow best practice guidance. Hand written entries on medicine administration records did not always have two staff signatures, to ensure information recorded was accurate. Topical creams did not routinely have the date recorded of when they were opened and some prescribed creams were left in a communal area.

The recommendations made by the local commissioning group infection control audit in 2017 and 2018 had not been fully complied with.

There was no analysis of accidents and incidents to consider themes and patterns. Staff were aware of risks associated with people's needs, but these were not consistently recorded and may have impacted on people receiving inconsistent care and support.

Safeguarding procedures were in place to protect people from abuse and avoidable harm and discrimination. Staff received refresher training and opportunities to discuss their work and development needs.

People received a choice of meals. Where a pureed diet was required, there was no consideration in how

this was presented. Staff were aware of people's needs but information available for staff was not consistently up to date. People were supported with any health conditions

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. Staff were aware of the principles of the Mental Capacity Act 2005.

Staff were kind and caring, but people did not consistently experience dignity and respect in how their needs were met because staff were over stretched and task focused. People were seen to not have a positive lunchtime experience. Staff were seen to assist people with their eating needs standing up and were frequently interrupted to assist other people.

The social activities, stimulation and opportunities for people continued to be limited. The activity plan on display did not match the activities available. We have made a recommendation about the social activities and opportunities available for people.

People had access to the complaint procedure. Advocacy information leaflets available for people were out of date. Considerations of people's end of life care had been discussed with them.

As part of the provider's quality assurance process, people and their relatives received an opportunity to share their experience about the service via an annual questionnaire. People who used the service, relatives and staff were positive about the registered manager.

There were systems and processes in place to monitored quality and safety, but these required further development to provide sufficient assurance improvements would be made and sustained.

During this inspection we found one breach of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 consistently safe.

The staffing levels and deployment of staff required further review and monitoring.

Medicines management did not consistently follow best practice guidance. Infection control measures needed further improvement.

There was no analysis of accidents and incidents to consider themes and patterns.

Risks associated with people's needs were understood by staff but not consistently recorded.

People were protected from abuse because staff followed safeguarding procedures to protect people.

Is the service effective?

Good

The service was effective.

Staff received an induction and ongoing training and development.

People received a choice of meals and their dietary needs were known and monitored.

People's received support to access health care services and staff followed recommendations made by external healthcare professionals.

The principles of the Mental Capacity Act 2005 were understood by staff and people were appropriately supported in line with this legislation.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and caring, but the staff rota did not provide staff

with sufficient time and this impacted on the quality of care people received.

People's dignity and respect was not consistently upheld.

Independent advocacy information was out of date.

People and or their relatives, received opportunities to discuss their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People continued to receive limited opportunities of social and meaningful activities and stimulation.

People's needs were assessed and staff were knowledgeable about people's needs.

End of life care plans were discussed with people.

Is the service well-led?

Inadequate

The service was not well-led.

The service continued to not fully meet the fundamental care standards expected of providers. Further improvements were required in the systems and processes that monitored quality and safety.

People received opportunities to share their experience about the service.

Elizabeth House Residential 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 comprehensive inspection took place on the 20 November 2018 and was unannounced. The inspection team consisted of one inspector 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.

To assist us in the planning of the inspection, we used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information that we held about the service such as notifications. These are events that happen in the service that the provider is required to tell us about. We sought the views of the local authority and health commissioning teams, and Healthwatch Nottinghamshire, who are an independent organisation that represents people using health and social care services. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group.

During the inspection, we spoke in part, with eight people who used the service, two visiting relatives, two visiting health care professionals and a visiting hairdresser.

During the inspection we spoke with the registered manager, a senior care worker, a care worker and a staff member that had dual roles as care staff, domestic, cook and activity coordinator. We looked at the care records of three people who used the service. We checked that the care they received matched the information in their records. We also looked at a range of information to consider how the service ensured

the quality of the service; these included the management of medicines, staff training records, staff recruitment and support, audits and checks on the safety of the environment, policies and procedures, complaints and meeting records.

Requires Improvement

Is the service safe?

Our findings

Risks associated with people's needs and the environment were not consistently and effectively managed. Accident and incident records showed 30 events had occurred during 2018. The registered manager told us of the action taken in response, such as contacting the GP and informing people's relatives. They also gave examples of the reason for some falls occurring, such as people being unwell and this affecting their balance. However, there was no analysis completed to review for any themes and patterns. This lack of oversight meant it was difficult for the registered manager to fully know what risks people were exposed to and if further action was needed to reduce the risk of reoccurrence.

On the day of our inspection, we found a person's bedroom window restrictor was broken and the window was open. This was not a risk to the person whose room it was and was potentially a low risk to others, because other people did not go into this room. However, we were concerned that no action had been taken to fully mitigate this risk. We also found a large wooden board was propped against a bathroom door that was used by one person. The maintenance person told us they were aware of these issues and they took action to make the environment safe at our request. However, we were concerned these risks had not been responded to at the point they had been identified by staff.

We saw examples of risk assessments that provided staff with guidance of the action required to safely support people. This included risks associated with people's mobility and the use of equipment to support them such as a hoist. A visiting healthcare professional told us staff used equipment and followed recommendations in managing risks, such as in the care and prevention of pressure ulcers. People with diabetes had their needs assessed and staff were clear about the risks people were exposed to and the action required if a person experienced either high or low blood sugars. Staff were seen to use appropriate moving and handling techniques and equipment when supporting people with their mobility needs. Staff also provided explanation, reassurance and were unrushed.

Some people living with dementia experienced periods of heightened anxiety that affected their mood and behaviour. We found staff were knowledgeable about people's needs and the strategies used to support people. This included diversional techniques and we saw a staff member effectively support a person with an activity that relaxed them.

Staffing levels and the deployment of staff required reviewing, to ensure it was sufficient in meeting people's safety and individual needs. Visiting relatives and professionals told us they felt staff were, "Over stretched" and "Under staffed, the staff are very busy." A relative told us they were concerned that their relative had recently had a fall and sustained a fracture and this occurred in the communal lounge when no staff were present.

Staff did not raise any concerns about staffing levels. The registered manager told us whilst they did not use a dependency tool to inform them what staffing was required, they considered staffing levels to be sufficient. The registered manager worked Monday to Friday in the afternoon and evening and also worked additional times to support people to attend health appointments.

We saw on the day of our inspection, four people required additional staff support at times due to their anxiety and behaviour. Whilst staff provided this support, their attention was limited due to meeting the needs of others. We saw a person was feeling very frustrated about wanting to go to the toilet and had difficulty remembering where it was, due to no staff being around we pointed to where the toilet was situated. Three people required two staff to support them with their mobility needs. The registered manager was present on the morning due to our inspection and we saw how they also provided care and support to people. This included assistance with meals and drinks and they provided people with reassurance and attention. In normal circumstances the registered manager would not have been on shift. We were concerned how two care staff would have managed to support people without the assistance of the registered manager.

The registered manager told us the cook who had dual roles which included being a care staff member, housekeeper and the activity coordinator, they could be called upon if additional support or supervision was required. In addition, the registered manager told us the maintenance person could also provide supervision if required. However, we were concerned that neither of these staff could be relied upon to provide assistance when they were working in the kitchen or elsewhere in the building. We saw care staff were busy and task focussed and were unable to spend time with people other than to provide support when meeting people's needs. We therefore concluded, people's dependency needs and staffing levels required assessing and monitoring to ensure sufficient staff were deployed to meet people's assessed needs safely.

People were supported by staff who had been through the required recruitment checks as to their suitability to provide safe care and support. These included references and criminal record checks.

Medicines did not consistently follow best practice guidance. For example, two staff signatures were not always recorded for hand written entries on medicine administration records. This is important information to ensure no errors are made in transcribing. Topical creams were not always dated when opened, this needs to be recorded to check the expiry date. An open container was found on top of the medicines trolley with topical creams in the dining room. This meant prescribed medicines were not consistently stored correctly and safely.

Staff told us they had completed training in the management of medicines and records confirmed this. We saw a staff member administering people's medicines. A person initially refused their medicine, but the staff member was patient and provided reassurance and explanation, the person was seen to relax and take their medicines. Staff had guidance about people's medicines, this included their preference in how they took their medicines. A monthly medicine audit was completed to review how medicines were stored, administered and managed and staff had access a medicine policy that informed their practice.

The prevention and control measures to manage infection control and cleanliness were being improved and further action was required to ensure people were sufficiently protected from the risk of cross contamination. The local clinical commissioning group completed an infection control audit in 2017 and 2018. Recommendations were made to ensure best practice guidance was being followed. The registered manager had an action plan to make the required improvements and was working towards completing this work. We identified three people who used a hoist to support them to use the toilet, who shared a sling. The registered manager showed us additional slings were available for staff to use, however, staff did not use them. This meant people were at risk of infection due to cross contamination by sharing slings. We saw a person was eating their meal using a plate guard. A staff member identified they did not require this and removed it and put it on another person's plate without cleaning it, which was unhygienic and a cross contamination risk.

Cleaning schedules confirmed how cleanliness was maintained. Staff wore personal protective equipment to reduce the risk of cross contamination when required. Staff had completed training on infection control, including hand washing and food hygiene.

People told us they felt safe living at the service. A person said, "Yes, it's okay for that (safety)."

Staff were aware of their role and responsibility to protect people from avoidable harm including discrimination. A staff member said, "We've had training, I'm aware of what to report, people's safety is really important." Staff told us they had received training to support them in keeping people safe and training records confirmed this. The registered provider had safeguarding policies and procedures in place to guide practice.

Good

Is the service effective?

Our findings

Assessment of people's needs, included the protected characteristics under the Equality Act and these were considered in people's care plans. For example, people's needs in relation to their age, gender, religion and disability were identified. This helped to ensure people did not experience any discrimination. Staff were aware of people's needs and preferences, and provided care that reflected people's wishes.

Staff received an induction, training and ongoing support to develop their understanding and skills in best practice guidance. People told us they felt staff were competent and knowledgeable and understood their needs. A person told us about living at the service, "It's quite good." A relative said, "[Name of staff member] is absolutely brilliant, and [name of relation] likes the staff. My relation has been here years and staff are professional."

Staff told us they received opportunities to discuss their work with the registered manager and that they received refresher training. A staff member said, "We have one to one meetings with the manager and training is fairly regular, we have some face to face and workbooks to complete. It's good I have no concerns." New staff received an induction and shadowing opportunities. A staff member told us the registered manager observed their care and gave feedback to support their development. Staff training records confirmed staff received training the provider had identified as required, such as health and safety, moving and handling and first aid. External healthcare professionals had also delivered training such as diabetes awareness and urinary tract infections. Long distance learning included dementia awareness.

People received support with their nutrition and hydration needs. People did not raise any concerns about the choice of meals and drinks. A relative said, "Meals appear to be good, there's a choice."

We found staff to be knowledgeable about people's needs and preferences regarding their dietary requirements. We saw staff discussed the meal choice available with people, alternatives were offered and provided, if people did not want the choices available. Food stocks were stored and managed in accordance with best practice guidance. The local authority food agency inspected the service in 2017 and awarded a rating of five, this is the highest rating that can be awarded and confirmed what we found. People's independence was promoted with eating and drinking, for example some people used a plate guard to assist them to eat independently.

Staff recorded people's food and fluid intake and monitored this to ensure they received sufficient amounts. Any concerns were responded to such as reporting to the GP and specialist nurse.

People received support to access healthcare services and staff understood any health conditions. A visiting healthcare professional told us staff reported any concerns in a timely manner. They also reported people's health needs were managed well by competent and knowledgeable staff. Staff told us about some people's health conditions and how they supported people, it was clear they had a good understanding of people's needs. Records confirmed people had accessed health services such as opticians and chiropody and were supported to attend hospital outpatient appointments. Information about people's health and welfare

needs were shared with other organisations such as hospital staff to support people with their ongoing care needs.

The environment met people's needs. For example, a passenger lift was available, some signage was used to support people to orientate and raised toilet seats were in place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. A relative confirmed they were involved in the process of best interest decisions. Where authorisations had been granted, these had no conditions attached to them.

Staff were aware of the principles of the MCA. They told us how they encouraged and supported people as far as possible to make choices. Staff were aware of the decision-making process for important decisions that were made on behalf of people who lacked capacity to make certain decisions. We saw examples of assessments in areas such as medicines, and day to day decisions.

Requires Improvement

Is the service caring?

Our findings

Staff were kind and caring, but they had limited time available to spend with people and this at times, impacted on people receiving care that consistently respected their dignity.

People's mealtime experience was poor. For example, staff presented the food silently and did not make any comment or give any description about the food that was placed before people. Two staff assisted three people to eat their meal, and were seen to stand over them. This meant staff did not have eye contact with the person as they were supporting them and this was not respectful.

Staff frequently left the person they were assisting, to support other people. They moved from person to person in silence, not giving the person they were assisting any explanation when they left them. This impacted on people receiving their meal in a dignified manner without interruption.

During the mealtime a person became very agitated and started shouting threats to others. They hit out and knocked a bowl of food that a staff member was holding, it did not spill as it was pushed towards the staff members chest but there was a risk that it could have. The staff member had to stop assisting a person in order to address the needs of the person who was anxious. Another person attempted to remove some items of clothing, a staff member who was assisting another person had to leave them and support the other person. These examples show how people's dignity and respect was compromised due to staff being overstretched in their availability to support people effectively.

When we spoke with staff about how busy they were at lunchtime a staff member said, "It's like having six kids, it's a routine you get into." Whilst this was well meaning it was not respectful towards the people who lived at the service. Staff also acknowledged that the mealtime was not a positive experience for people and told us this was unusual. Whilst this may not have reflected people's everyday experience, it demonstrated how people's needs can be variable and how the staff rota did not fully consider people's needs.

One person required their meal to be pureed but no consideration had been given to how this was presented. For example, the individual food could have been pureed separately, to enhance the sensory experience of colour and taste.

A person was seen to be supported by staff to transfer using a hoist. Whilst on other occasions staff were seen to be supportive and respectful when providing this support, on this occasion, staff did not verbally communicate until the person began to shout, they then spoke in a kindly manner.

Whilst the mealtime was mostly silent, for example we did not hear staff refer at any point to the food that was being eaten. When staff did speak with people it was in a kind and friendly manner. Staff supported people to put an apron on before they received their meal and they spoke kindly and gave explanation as they supported people.

Feedback from people who used the service, relatives and visiting professionals were positive about the

approach of staff. A relative said, "The girls (staff) are brilliant, it's a lot of work, I think they find the writing frustrating, they work hard." Another relative said, "There is a lot of love here, [relation] doesn't go without anything." Visiting professionals described staff as, "They are friendly and welcoming, they have been very good with [name of person] in understanding their needs." "It's generally a calm and relaxed atmosphere and staff are very kind, I have no concerns about the care."

Relatives told us they received opportunities to discuss their relations care with the staff and the registered manager arranged meetings to review the care provided. Records confirmed what we were told. One person's care record showed how the person and their relative had met with the registered manager and actions were agreed to the care provided. These actions had been followed up as required.

Whilst information was available about an independent advocacy service, this was found to be out of date. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. The registered manager told us they would source up to date advocacy service information.

People's information was treated confidentially, the registered manager was aware of the new general data protection regulation, this is a new law that sets out how people's personal information should be managed. However, they had not updated their policies and procedures to reflect this change. This meant there was a risk that people's information may not have been fully protected because staff did not have up to date information and guidance.

There were no undue restrictions in place about people receiving visitors; relatives confirmed they could visit unannounced.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we identified that people received limited social activities, occupation and stimulation. At this inspection, we continued to have some concerns in the choices and opportunities people received. A relative told us they visited their relation at different times throughout the day, but had not seen activities provided and felt this was an area that could be improved upon.

An activity timetable on display advised what the expected activities for the day were, this included a quiz, board games and dominoes. These activities were not offered. Instead a staff member who was employed an hour a day to provide activities, spent time with people in the afternoon by showing a black-and-white calendar of photographs of "old Woodhouse". This was the area the service was situated in. The staff member was seen to reminisce about places in the photographs and this generated a conversation about people's pastimes and events. Whilst a couple of people were seen to enjoy this from their response, not all people were interested or able to engage in this activity.

A person who sat in another room had been given some knitted sensory resources and these looked attractive, but the person was not taking any interest in them, rather they were shouting and unsettled. Staff told us this was known behaviour and that the person responded best to being left alone. Earlier this person was seen having their hair set by a visiting hairdresser, they were seen to be relaxed and calm during this activity.

The registered manager told us they had external entertainers visit at particular times of the year to celebrate events such as Christmas. They also told us that people did not have any religious or cultural needs that they required support to pursue. The registered manager told us they were aware activities could to be improved upon, but told us people had showed limited interest in activities.

We recommend that the service seek advice and guidance from a reputable source about activities, occupation and stimulation for people living with dementia.

People's care plans provided staff with guidance about how to meet their individual needs. Staff told us they had sufficient information and through discussion, demonstrated an understanding of what was important to people. Care plans were regularly reviewed to ensure they reflected people's current needs. A relative confirmed they had been involved in the development of their relations care plans. They told us they were asked by the registered manager to review any amendments to ensure they agreed with any changes.

Care plans included guidance on people's communication and sensory needs. The PIR advised that information could be provided in large print where required. This meant the provider had considered the requirements of the Accessible Information Standard. This standard expects providers to have assessed and met people's communication needs, relating to a person's disability, impairment or sensory loss.

We noted that consideration had been given to how people may experience pain. However, there was no guidance to support staff of how people living with dementia may communicate this, which could have

impacted on the care they received.

People had access to the provider's complaint procedure, Relatives told us if they had any concerns, they felt able to raise them with the registered manager who was described as, "Responsive." A relative told us how they had been concerned that their relations false teeth had become misplaced, and that the registered manager arranged for a dentist to visit.

Where complaints had been made, the registered manager had taken action to review and resolve issues as per the complaint policy and procedure.

People's end of life wishes regarding how they would like to be cared for at the end of their life had been discussed with them. Some people had advance decisions that were recorded, this provided staff with important information about their wishes. Staff had received training in end of life care. This meant people could be assured staff had received appropriate training in end of life care and knew what their personal preferences were for care at this time of their life.

Inadequate

Is the service well-led?

Our findings

In our last three inspections, the provider was rated 'Requires Improvement'. Prior to this, inspections completed found the provider had been non- compliant in the fundamental care standards we reviewed. This shows the provider was not making the required improvements expected of them, to reach a minimum standard of 'Good'.

We were concerned that the systems and processes in place that assessed risk and monitor quality, were insufficient and ineffective in driving forward improvements.

There was a lack of clear oversight of the service. Accidents and incidents were not effectively reviewed and analysed to consider what lessons could be learnt to reduce further reoccurrence. There was no robust system in place to review staffing levels and deployment of staff, to ensure this met people's individual dependency needs. The current deployment of staff impacted on how care was provided, people's dignity and respect was compromised at times.

Social activities and opportunities available to people continued to be limited. Whilst the registered manager told us people showed little interest to participate in activities, people were not given sufficient choice to make an informed decision.

Audits and checks were limited and in some instances informal. For example, the registered manager told us they completed a daily walk around the service, but they did not always record their findings. However, the PIR stated this was recorded on the cleaning schedules, but we did not see any examples of this. A monthly medicine check was up to date and had not identified any of the issues that we found during this inspection. An infection control audit was completed. However, we were aware that the infection control audit completed by the local clinical commissioning group in 2017 and repeated in 2018, continued to show shortfalls and actions remained outstanding. Some improvements were being made to the environment such as walls being plastered, but there was no recorded plan in place for these improvements. Some areas of the service were tired and needed some redecoration and refurbishment, such as flooring being replaced. However, there was no ongoing improvement plan to show if and when, this work was planned. A lack of clear planning meant it was difficult to know, understand and be sufficiently assured, that the provider was taking action to make required improvements.

Information kept in the kitchen about what people's dietary needs were was found to be out of date. People's personal fire evacuation plans were also out of date and information included people no longer living at the service. This could potentially cause staff and the fire and rescue service confusion, in an event that required people to be evacuated from the building. The service user guide and statement of purpose used to provide people with information about what they could expect from the service, was not fully up to date. Whilst there were a lot of leaflets and information available to people and their relatives, this was not all up to date and therefore misleading to people.

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

2014.

Relatives were positive that the registered manager was approachable and kept them informed and involved in their relation's care. Staff told us they felt supported by the registered manager. There were communication systems in place for staff to share information with each other about people's needs. The registered manager gave people and their relatives opportunities to share their experience and views about the service by an annual questionnaire. Feedback received from the last questionnaire in 2017, showed people had requested more staff were provided at busy times. The registered manager told us they had increased staffing when a person was unwell or was at the end stage of their life.

The registered manager worked positively with external health and social care professionals. External professionals were pleased in how the registered manager was meeting people's needs and the communication they had with staff. The registered manager told us they kept up to date with best practice guidance by receiving alerts from CQC and the local authority.

We checked our records, which showed the provider had notified us of events at the service. A notification is information about important events, which the provider is required to send us by law, such as serious injuries and allegations of abuse. This helps us monitor the service. It is a legal requirement that a providers latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed their most recent rating in the service and did not have a website.

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 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality and safety of the service were not effective. 17 (1)