Leeds Autism Services

Ashlar House - Leeds

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Ashlar House is registered to provide accommodation for people who require personal care for up to eight people with autism. Care is provided on three floors in singly occupied rooms, some of which are very spacious. Each room is provided with all necessary aids and adaptations to suit a person's individual requirements. There are communal areas for dining and relaxation. At the time of our inspection seven people were using the service.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service received planned and co-ordinated person-centred support that was appropriate and inclusive for them.

The service was a large home, bigger than most domestic style properties. This is larger than current best practice guidance. However, the size of the service having a negative impact on people was mitigated by the building design fitting into the residential area and the other large domestic homes of a similar size. There were deliberately no intercom, cameras, industrial bins or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

People's experience of using this service and what we found
Even though the management team were not fully aware of Registering the Right Support, the service applied these principles and values and other best practice guidance. These ensured people who used the service could live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people who used the service reflected the principles and values of Registering the Right Support by promoting choice and control, independence and inclusion. People's support focused on them having as many opportunities as possible for them to gain new skills and become more independent.

The provider did not have effective systems in place to assess, monitor and improve the quality of service provided. Complete, accurate and contemporaneous records were not always kept. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, best interest's decisions had not always been recorded following a mental capacity assessment.

Individual risks to people's health and safety were assessed and mitigated. However, concerns were noted regarding fire safety risks and actions in the providers legionella risk assessment. The provider did not have

robust infection prevention and control systems in place. The home needed redecoration and refurbishment. Some records and minor issues suggested medicines management was not always safe.

Staff did not receive appropriate training necessary to enable them to deliver effective care and support. Staff had not received sufficient formal supervision as outlined in the providers procedure or an annual appraisal.

People said staff were kind and caring. Staff understood how individual people preferred their care and support delivered and the importance of treating people with dignity and respect. The service was not supporting anyone who was at the end of their life. Support plans were person-centred and contained sufficient information for people's care and support needs to be met. Staff involved healthcare professionals to support people's health needs where required. People received support with eating and drinking, when needed and were involved with weekly menu planning.

There were sufficient staff to meet people's support and care needs. Recruitment processes were robust, and an induction was completed by all staff. People felt safe in the home and with staff. Lessons had been learnt from incidents that had happened. People were asked for their views about the service and the provider worked in partnership with other services to support people's care and quality of life. There was a system in place to respond to any complaints.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (report published 6 July 2018) and there were multiple breaches of regulation. The rating at this inspection has remained the same. 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 although, some improvements had been made the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating. We have found evidence the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

Enforcement
We have identified three continued breaches of regulation in relation to environmental risks, infection control, staff training and supervisions and lack of governance systems. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

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?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was 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.

Ashlar House - Leeds

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
The inspection was carried out by one inspector and an assistant inspector.

Service and service type
Ashlar House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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. 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 announced. We gave a short period notice of the inspection because it is a small service and we needed to be sure the provider would be in the office to support the inspection and people are often out and we wanted to be sure there would be people at home to speak with us.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We requested feedback from stakeholders. These included the local authority safeguarding and commissioning team and Healthwatch England. Healthwatch England is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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 our inspection
We spoke with three people who used the service about their experience of the care provided. we spoke with the chief executive officer (CEO) who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the care operations manager, a deputy manager and two staff members.

We reviewed documents and records that related to the management of the service, including a range of policies, procedures and guidance used by staff in their role, records of safeguarding and complaints, audits and quality assurance reports. We reviewed four staff member's files and records associated with the management and administration of people's medicines. We looked at three people's support plans.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and further quality assurance records.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained 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.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess the risks relating to the health safety and welfare of people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, some improvement had been made with identifying individual risks for people, but further concerns were noted regarding fire safety risks and legionella risk assessment. The provider was still in breach of Regulation 12 (Safe care and treatment).

- Fire alarm, fire door tests and emergency lighting checks had not always been completed weekly. For example, fire doors had not been tested between 25 February and 13 March 2019 and 20 May and 6 June 2019. The care operations manager said these were now on an electronic calendar to remind staff, so they would not be missed.
- The provider's fire risk assessment had been completed in November 2018. Medium risk actions had been identified but these had not been completed. Following our inspection pictorial evidence was received from the provider showing these actions had now been completed.
- The staff training record showed nine out of 15 staff had not completed fire training and one staff member's training had expired. The CEO told us staff had received training but there was still information to be added to the training matrix.
- The provider's legionella risk assessment was dated 5 December 2011 and showed some actions had been rated as 'high' which meant these should be completed within one month. The CEO told us these had not been completed. Following our inspection, the CEO submitted an updated version of the risk assessment which was dated March 2018, to the CQC. We noted the identified actions remained the same as the 2011 version of the risk assessment. The CEO told us they would be following up these actions with the building owners immediately.

We found no evidence people had been harmed, however, systems were not robust to demonstrate some risks were effectively managed. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Gas and electrical safety certificates were in date.
- Staff understood where people required support to reduce the risk of avoidable harm. Support plans contained basic explanations of the control measures for staff to follow to keep people safe.

● The provider had completed general environmental risk assessments to evaluate and minimise risks to people's safety and well-being.
● Accidents and incidents were analysed in a way which enabled trends to be identified.

Preventing and controlling infection

At our last inspection the provider had failed to assess the risk of infection and how to prevent this. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection some improvement had been made. However, there were still some risks with the preventing and managing infections. The provider was still in in breach of Regulation 12.

● Cleaning and infection prevention and control practices were not robust.
● There was mouldy grout around the baths and toilets were discoloured around the base.
● The environment looked 'tired' and needed updating. The home would benefit from redecoration and new furniture. For example, a sofa in the dining room had stained arms. A staff member said, "The whole place could do with a lick of paint."
● Detailed cleaning schedules were in place, but these were not always completed, making it difficult to establish if all areas of the home were being cleaned effectively.

We found no evidence that people had been harmed, however, infection control systems were not effective. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had completed infection control training and hand washing posters were in place to remind people and staff about good hand washing techniques.

Using medicines safely
● Whilst there was no evidence to suggest there was any impact on people, some records and minor issues suggested that medicines management was not always safe. For example, there was a lack of instructions for staff on some handwritten medication administration records (MARs). The handwritten MARs had not been double signed to confirm prescription label information had been transcribed accurately.
● Most people received their medicines via a prepared dosage system and this was on time. However, one person did not receive a prescribed item for several days as this had ran out.
● Two people had non-prescribed medications stored in their medication cupboard. These items were not being managed in line with the providers non-prescribed medication policy.

We found no evidence that people had been harmed, however, medication management systems were not robust. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were happy with their medication arrangements. One person said, "I am happy with the tablets I take."
● Protocols were in place for 'as required' medicines and body maps showed were people's creams should be applied.
● Staff had received medication training and their competency had been assessed to ensure they were safe to administer medicines.

Systems and processes to safeguard people from the risk of abuse

● The provider had effective safeguarding systems in place and staff had a good understanding of what to do to make sure people were protected from harm or abuse.

● People told us they felt safe in the home and with staff.

● Staff said they had received appropriate safeguarding training.

Staffing and recruitment

● There were sufficient staff on duty to meet people's needs and enable people to participate in social activities.

● People we spoke with said there was enough staff to always support them.

● Some staff said there was not enough staff, but were aware a recruitment programme was in place. The care operations manager said they were continually recruiting new staff as the service used a number of agency or bank staff.

● The provider operated a safe recruitment process.

Learning lessons when things go wrong

● Lessons were learnt when things went wrong. For example, following a recent incident, one person now has daily body maps completed.

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 requires improvement. At this inspection this key question has remained 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

At our last inspection the provider had failed to ensure staff received appropriate supervision and appraisal. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not, enough improvement had been made and the provider was still in breach of Regulation 18.

● People were not always supported by staff who had ongoing training. For example, some staff had not completed training in specific subjects or refresher training had not been completed.
● Staff were not given opportunities to review their individual work and development needs consistently through supervision or appraisal. A staff member said, "I think I have had at least one supervision."

Staff did not receive appropriate training, supervision or appraisal to enable them to always deliver effective care and support. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff completed an induction programme prior to starting work. Staff new to care completed the Care Certificate. This is an agreed set of standards that sets out the knowledge, skills and behaviours expected of job roles in health and social care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Staff applied learning effectively in line with best practice, which led to good outcomes for people and supported a good quality of life.
● Staff worked closely with health and social care professionals, people and their families to ensure people's abilities, goals and preferences were recognised.
● The management team used nationally recognised sources for information and guidance.

Supporting people to eat and drink enough to maintain a balanced diet
● People were helped to receive a healthy and balanced diet. People had a choice of and access to sufficient food and drink throughout the day. One person said, "I sometimes go out if I don't like what is on the menu."
● Menus were planned weekly in consultation with people based on their preferences. These were displayed

in pictorial format in the dining room. One person said, "I like shopping and sit in on the Sunday meeting to decide our meals."
● Staff encouraged people to help prepare food and drink to develop and support their independence.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff from across the provider's other locations worked at the home routinely and the provider used standardised paperwork, including support plans. If people attended one of the provider's services through the day their support plan was available to staff. This ensured people receive consistent, timely, coordinated, person-centred care and support.
● Staff attended handover meetings at the start of each shift where relevant information was shared; this helped to ensure people received continuity of care.
● The service supported people to maintain good health and supported people to access healthcare professionals such as GPs, opticians, dentist and psychiatrists.
● Advice and guidance from healthcare professionals was documented within support plans and staff followed their instructions.

Adapting service, design, decoration to meet people's needs
● The building was designed appropriately, to enable people to have as much independence and personal freedom as possible.
● There was no indication Ashlar House was a care home; as it blended in with neighbouring family properties.
● Communal areas were relaxed with a calm atmosphere and people had access to a garden area.
● People's bedrooms were decorated with photographs and pictures and people had items they were interested in and reflected their personal preferences. For example, one person had a range of videos they liked to watch.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People were involved in making every day decisions and choices about how they wanted to live their lives. Staff ensured people were involved in decisions about their care; and knew what they needed to do to make sure decisions were made in people's best interests. Although, best interest decisions had not always been recorded.
● Mental capacity assessments had been carried out when required and the provider had submitted DoLS applications appropriately to the local authority and where required.

Good

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 remained good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People received care and support from staff who were friendly and caring. Interactions between staff and people showed positive relationships had been developed. The atmosphere in the home was relaxed and warm.
- People provided consistently positive feedback about staff and living in the home. One person said, "They [staff] are really good, it is a good relationship."
- Compliments had been received by the home. These included, 'Thank you and your team for all the care and consideration you give to the wellbeing of my brother, [name of person], I am always so grateful to the staff at Ashlar House for making such a wonderful environment for him'.
- People were supported to access religious services of their choice and were able to visit chosen places of worship.
- Some staff had completed training in equality.

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

- Staff supported people to express their views and be involved in making decisions about their care and support. Staff knew how people communicated their needs.
- People and/or relatives had been consulted with and their wishes and preferences had been recorded.
- People had access to advocates where this was required. Advocates represent the interests of people who may find it difficult to be heard or speak out for themselves.

Respecting and promoting people's privacy, dignity and independence

- People were enabled to maintain and develop relationships with those close to them and to develop social networks and links within the local community. Relatives and friends could visit at any time.
- Staff encouraged people to be as independent as possible. This included assisting with cooking, cleaning and personal care. A person said, "They do not take my independence away."
- People's privacy and dignity was respected by staff. A staff member said, "I shut the door and close the curtains. I leave the room if it is appropriate and help with hand on hand washing if this support is needed."
- The provider's 'statement of purpose' showed what people could expect for privacy, dignity, and choice.

Good

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 requires improvement. At this inspection this key question has now improved to good. This meant people's needs were met through good organisation and delivery.

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

At our last inspection the provider had failed to ensure people were receiving support that consistently met their needs and preferences. This was a breach of Regulation 9 (Person-centres care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of Regulation 9.

- Support plans were person centred and reflected each person's individual needs.
- There was sufficient information in support plans to enable staff to meet people's needs. Support plans were mostly reviewed to make sure people's current needs were up to date.
- People had access to a good range of activities and social opportunities. People undertook any activities they wished to participate in. For example, horse riding, train journeys and meals out. People were supported to go on holidays or overnight stays with family.
- The service had developed good links with the local community with people actively participating in events in their surroundings.
- People were supported to maintain relationships with people who mattered to them. For example, one person spoke with their relative via the internet and some people spent time with their family at weekends.
- People's diverse needs were detailed in their support plans and met in practice. This included cultural needs and religious requirements.

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.

- The CEO and care operations manager were aware of the AIS. The service had an AIS policy in place and had identified, recorded, shared and met the information and communication needs of people with a disability or sensory loss, as required by the AIS. One person's support plan stated, 'Staff could support me by offering me written information or photos alongside verbal; I am far better equipped to make a choice using these techniques'.
- People have access to the internet, if needed, documents and information could be provided in adapted

formats, such as pictorial or large print.
● Where people required visual aids for communication, these had been provided. For example, the use of a 'tablet'.

Improving care quality in response to complaints or concerns
● People knew how to complain. The complaint procedure was in a pictorial format and people were able to raise any concerns during keyworker meetings. One person provided the management team with written suggestions, although, these, along with niggles were not always recorded.
● The provider had policies and procedures in place to guide staff in how to manage complaints. The service did not have any current ongoing complaints at the time of the inspection.

End of life care and support
● The management team spoke with people during the review process to explore their views and wishes.
● People's spiritual and cultural preferences were recorded in support plans.
● At the time of inspection there was no one receiving end of life care.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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.

At our last inspection the provider had failed to ensure effective systems had been established or operated to monitor the safety and quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not, enough improvement had been made and the provider was still in breach of Regulation 17.

● There was no provider oversight. The CEO initially believed the previous management team were doing a good job, but became aware of issues within the past six months.
● There was no robust quality management system in place which ensured the service was assessed or monitored for quality and safety in relation to people's care and support needs.
● Following the last inspection, the management team had failed to fully implement the action plan as concerns were still noted in some of these areas.
● Audits were carried out which provided an insight into the service, although, these did not identify and generate change and improvements that were needed. For example, an audit for October/November 2018 had not recorded any manager or organisational actions even though actions had been noted during the audit.
● The management team had created an overall action plan for 2018/2019 which had collated actions from monthly audits that had been completed. However, this was not effective, as some actions were still to be completed from February 2018 and some actions from May 2018 did not had any evidence of progress.
● Following a resident's survey in September 2018, one outcome recorded was, 'The process also includes better audits of our services, more transparent ways of working and listening to a wide range of views'. However, the audit process was still not robust.
● Records relating to people's health care needs had not always been updated. For example, one person's hospital passport had not been updated since April 2018 even though changes were noted.
● Cleaning schedules and medication weekly audits had not always completed, and these had not been checked or reviewed by the management team.
● The management team were clear about their responsibilities for reporting incidents or concerns to the

local authority or CQC as required by law. However, we noted they had failed to notify both the local authority and CQC regarding an incident in May 2019. This was retrospectively completed following our inspection.

The provider did not have effective systems in place to assess, monitor and improve the quality of service provided. Complete, accurate and contemporaneous records were not kept. This is a breach of the Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A staff member told us, "In the past it's been quite institutionalised. They have been doing what they can to drag it into the 21st century. It's having a positive effect. We are not there yet but it is a lot better than it was, it is moving in the right direction."
● The managers worked to develop the staff team so staff at all levels understood their roles and responsibilities.
● The management team displayed an open approach and listened to people and staff when things went wrong.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff spoke positively about the management team and the quality of care provided. One staff member told us, "[Name of care operations manager] is supportive and they are putting in methods to keep this place running."
● The management team demonstrated a commitment to provide person-centred support by engaging with people and stakeholders. Staff understood the provider's vision for the service and they worked as a team to deliver these.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Residents meetings provided an opportunity for people to be involved with the service and any planned changes. Although, the last meeting was in December 2018, the care operations manager said these were going to be recommenced.
● The provider used surveys to seek people's views about their support and the service. The last survey showed were positive responses.

Working in partnership with others
● The service had good links with the local community and key organisations, reflecting the needs and preferences of people they supported. For example, the local pub, charity shops and churches.

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 12 HSCA RA Regulations 2014 Safe care and treatment Not all risks were safely managed. Infection detection and control systems were not effective. The management of medicines was not always safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate training and supervision necessary to enable them to deliver effective care and support.

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 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality of service provided. Complete, accurate and contemporaneous records were not kept. The provider did not have effective systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people.

The enforcement action we took:

Warning notice issued