HC-One No.1 Limited

Ridgeway Lodge Care Home

Inspection report

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27 October 2022

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Ridgeway Lodge is a care home providing personal care up to 61 people. The service provides support to adults with long term conditions, most people were living with some form of dementia. At the time of our inspection there were 52 people using the service.

People's experience of using this service and what we found
We found there were issues with how the registered manager, the provider, and staff supported people who lived with dementia and who expressed forms of distress. Staff training, knowledge and skills in this area was limited. People did not have meaningful reviews of their care to try and find solutions to this distress. There was a lack of dementia expertise to promote a safe and personalised care experience for people.

There was a lack of stimulation and access to the safe spaces outside, in the grounds of the home, for people living with dementia. Risks associated with dementia were not always explored and captured in risk assessments and care plans, to promote the individuals and others safety and mental well-being.

When people needed sensor equipment to reduce the risks of falls, this equipment was not always working or positioned correctly.

There were shortages of staff at night and poor processes to guide staff about what to do if there was reduced staffing, because of staff sickness for example. When evening shifts operated with less staff managers did not investigate these situations to look at what went wrong.

Staff did not have effective training and competency checks in place. Key training such as dementia training was not embedded into staff practice.

People's social experience living at the home was not always personalised to reflect their current interests and previous interests. Staff did not routinely chat and spend time with people, their interactions were task focused. Some people commented on how they had got to know the staff but they also said they had had to work at these relationships. For people who could not do this, some people felt they had a more distant relationship with staff.

Managers and the provider did not always investigate events when there was a need to, in order to see what had happened and learn lessons from these. Audits and reviews into people's social experiences at the home were limited.

People spoke with confidence about feeling safe at the home. One person told us, "Yes, I feel safe, I say that because I feel that we are well looked after." Another person told us, "Do I feel safe? Yes I do."

People's relatives were less confident. One person's relative said, "On the whole [name of relative] is safe,

but they [staff] don't always follow [name of relative's] care plan." Another person's relative told us, "Yes and no. Up until recently I would have said yes. There are moments when they are short staffed, and [name of relative] may not get enough attention."

People received health input from a GP or nurse as needed. People received effective care in terms skin management, and the management of their medicines.

People were supported to have choices and some 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.

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 requires improvement (published 21 March 2020). 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 the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of dementia care and staffing levels. This inspection examined those risks.

You can see what action we have asked the provider to take at the end of this full report.

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 safety management, staffing, person centred care and the leadership of the home at this inspection.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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.

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?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Ridgeway Lodge Care Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team was made up of three inspectors, a specialist advisor who was a nurse with knowledge of dementia care and two Experts 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.

Service and service type
Ridgeway Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ridgeway Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 13 October 2022 and ended on 10

November 2022. We visited the home on 13, 18, and 27 October 2022.

What we did before the inspection
We spoke with the local authority to gain their views of the home and looked at the information we held about the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent time at the home over three days so we could see how people were treated and supported by the staff and managers of the home. We completed a check to see people had received their medicines. During the inspection process we reviewed 11 people's care records, assessments, and care plans. We also reviewed staff rotas for the last three months, staff employment checks, medicine care plans, incident reports for the last six months, staff meetings minutes, and managers daily check records. We spoke with 12 people, 11 staff, 13 relatives, the registered manager, deputy manager and the area director. We also requested information to be sent to us via secure e-mail, in relation to risk assessments, care plans, handover notes, additional incident reports, fire and building safety checks.

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 requires improvement. The rating for 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.

Staffing and recruitment

At our last inspection the provider had failed to ensure there was enough staff to meet people's needs. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- The provider had recently temporarily increased staffing levels during the day and night to support staff following an incident at the home. We found this increase level during the day was suitable to meet people's needs now and the previous level was not.
- There had been times at night, over the last three months when there was less staff than the number the provider had defined as being safe, but no action had been taken about this. This could put people at risk of harm, especially those who needed more support at night.
- There was not clear guidance for senior staff to follow if staff did not turn up for the night shift.
- When the provider assessed people's needs to work out how much staff were needed they had not considered when people expressed distress either on a frequent or nonfrequent basis. When senior staff assessed how much support individuals needed, they did not always effectively consider if people became distressed, how often this happened, and how much support these people needed at these times.

There were low staffing levels and systems were not in place to ensure this was monitored, assessed and managed in a safe way. This placed people at potential risk of harm. This was a continued breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our feedback during the inspection a new process was implemented to guide senior care staff about what to do if not all the night staff arrived on shift.

Assessing risk, safety monitoring and management

- We found for people living with dementia who could become distressed the managers and provider were not monitoring and managing this risk in a safe way. This posed a potential risk to the individuals themselves and others.
- Staff did not follow care plans for a person who could express physical distress which potentially caused people harm. Managers were not monitoring how this new plan was being implemented.

● We raised two safeguarding referrals to the local authority because of what we found regarding distress management at the home, we believed people were at risk of experiencing harm.
● Sensory equipment to manage the risk of falls and injuries had been sourced but was not always in place, plugged in, and working. The registered manager had identified this issue before, but there were no ongoing checks and audits to monitor this safety issue.
● Some people who were assessed as being at risk of falling were wearing trousers which were too loose for them. Staff needed to pull them up, but they did not report this to the managers, so action could be taken, placing people at an increased risk of falls and injury as a result.

Learning lessons when things go wrong
● Incident reports were completed when a person had become physically and verbally aggressive towards staff. However, these reports did not represent what happened. This practice undermined lessons to be learnt and improvements to be made when people expressed distress.
● Investigations did not take place with lessons learnt when the managers identified issues with the use of sensory equipment.

Systems and practices had not been established to always assess, monitor and mitigate risks to the health, safety and welfare of people living at the home. This placed people at potential risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe living at the home. One person said, "Oh God I feel safe, safe as houses as they say." Another person said, "I feel perfectly safe living here."

Systems and processes to safeguard people from the risk of abuse
● Staff were knowledgeable about what potential abuse could look like and how they must report any concerns to a team leader or manager. However, staff were not aware of other agencies they could also report their concerns to outside of the home, such as the local authority.
● Staff received safeguarding competency checks. But these did not always show what staff had said in answer to the competency questions to support the assessor's judgement to demonstrate the assessment was robust.
● One assessor had recorded what staff had said, this had highlighted staff lacked knowledge and understanding about abuse and harm. But no action was taken, and these staff members were signed off as being competent. This could put people at risk of unsafe care.

Using medicines safely
● We found people had received their medicines as prescribed.
● We checked a sample of people who received mood controlling medicines and found these people were not being overly medicated. They also had regular reviews of these medicines by professionals to check if they still needed them and at the prescribed dose.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

People's relatives told us they were supported to visit their relatives when they wanted to.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff received training on dementia care. However, there were examples when people who had dementia did not receive effective support from staff and managers.
- When people became agitated towards staff they did not receive effective support from staff. Staff were also not supported to manage these incidents to help them perform well in their work after these incidents.
- The registered managers and the provider had not further developed the dementia training they provided so it became embedded into staff practice.
- Staff completed all the training the provider asked them to, but they were not able to tell us what was good about the training or how it helped them in their work. Staff told us there was too much training, meaning it was difficult to remember what they had learnt.
- Staff received regular supervisions, but again they struggled to tell us when they roughly had supervision last and what was good about it or how it helped them in their work.

Supporting people to eat and drink enough to maintain a balanced diet

- Food specialists were referred to and their advice was followed.
- Kitchen staff had the current dietary needs as directed by professionals to support people to gain weight and help prevent them from choking. However, when one person who was on a food plan to increase their weight, asked a member of staff for a snack. The member of staff said "No" and told us the person had just had their breakfast. Another person whose care plan said they should be supervised when eating because of a risk of choking, was left for five minutes alone when eating their lunch.
- When people expressed distress, this was not considered as part of their food risk assessments and care plans to see what potential impact this might have to maintain or increase their weight and keep them hydrated.
- When one person took a medicine and the side effect was a low appetite this was not considered as part of the risk assessment and care plan about maintaining a healthy weight. When another person experienced nausea the impact of this regarding their weight and hydration was also not considered as part of their risk assessment. These issues could prevent staff from helping people to maintain a healthy weight, posing a risk to their health.
- People did not feel they had a say on what they ate and drank. They said menus regularly changed at the last minute and they were not asked what their favourite foods and drinks were.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People had initial risk assessments completed when they moved to the home. But people did not have

dementia care plans as a starting point to plan their care needs and to define and explain what type of dementia they had.
● People living with other cognitive conditions such as Parkinson's did have care plans about their conditions, but these lacked details and how it impacted on the individuals.
● Managers had created 'behavioural support plans' for people who expressed distress who had dementia. These are often used to support people to reflect on their actions when people can't do this independently. These plans were generic and not suitable for people with memory problems.

Adapting service, design, decoration to meet people's needs
● The provider and managers had not taken advice from experts in dementia care to promote a 'dementia friendly' environment.
● Techniques used to support people to find their bedrooms were not used as the provider and registered manager had not considered this, which could cause upset to people who had forgotten where their room was, or equally upset others if people accidently came into their room.
● People living with dementia did not have access to outside spaces even in good weather and even though the home had safe spaces outside, which could have a negative impact on their mental health and well-being.
● The provider and the registered manager had not considered if these aspects of people's dementia care needed reviewing.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People we spoke with were confident about staff seeking GP's input if there was a need to. One person told us, "The doctors came this morning to sort out the options, so in that regard all is very good."
● Professionals were referred to when people needed support with their health. However, we found with one person where staff had sought professional input, this had not been managed in an effective way.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● Staff told us how they promoted choices for people with aspects of their daily care.
● Managers and staff had followed the correct guidance in assessing people's mental capacity for specific decisions about their lives.

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 were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
- Limited attention had been given to how people who expressed distress, were being supported by staff when they were agitated.
- This included a lack of thought and attention to those people who were living close to those who became distressed frequently.
- The lack of meaningful dementia planning, reviewing of care, and understanding, undermined the caring culture of the home.
- People told us the staff were kind, one person said, "The staff are nice, we have a good rapport." A relative told us, "[Staff] are kind and caring." We also saw staff treating people in a kind way.

Supporting people to express their views and be involved in making decisions about their care
- People who talked with us told us they were not consulted with as part of their care planning.
- We found people were not asked in a meaningful way about their care experiences, including the social aspect of their care.

Respecting and promoting people's privacy, dignity and independence
- People told us staff did not always knock on their door and wait to come in. We also saw staff did this when we were chatting to one person. One person said, "Some knock my door before coming in and some do not."
- We also saw and was told by one professional some people's trousers were loose which caused the trousers to fall down. We also found staff pulling or holding some people's trousers up, which is not promoting people's dignity. These staff also did not take action to address this issue in the long term.
- Those people who were independent were encouraged to do as much as they could independently. One person said, "I can go out and make myself a cup of tea when I want one."

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 requires improvement. The rating for this key question has remained 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

- There was a lack of personalised care for those who had dementia and expressed upset and agitation.
- One person called out frequently. The provider and the registered manager had not looked at ways to manage this other than a medicine review. They had not completed a person-centred review, involving staff, other managers, and professionals. They had not sought the input of dementia experts.
- Nor had they considered and assessed the impact this distress could have on the people near to them who spent most or all their time in their bedrooms. One person no longer could verbally communicate, and another would also regularly shout out in response to this agitation.
- Despite how powerful vocally this distress was, it did not prompt staff and managers to review all these people's needs. Staff and managers had become accustomed to this distress and were not looking at other ways to reduce it for all those concerned.
- People did have distress care plans but these sometimes lacked personalised details for staff to use to manage this.
- Staff were asked to record when people were upset, but staff did not always fill these records out and staff reviewing people's needs did not show they had looked at these as part of these reviews.
- One person had come to stay at the home on respite. But they had been given a tired room with marks on the walls, when there were nicer rooms available. When we asked the registered manager about this, they later supported this person to move.

End of life care and support

- People had end of life care plans which had involved people's relatives, one of whom complimented the staff how they cared for their loved one during this time, but these plans were not always person centred.
- Two people lived next to a person who expressed distress frequently, they were at end of life, their plans asked for peace and quiet. But staff and managers had not considered the impact of this person's frequent distress on these people and no alternative plans had been made.
- Practical details to enable staff to support one person's spiritual needs had not been obtained as part of their end of life plan. Other considerations in terms of people's sensory needs at this time had not been made.

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

- There were planned activities in place and an activity coordinator at the home daily. Activities included watching films and balloon exercises which people said they enjoyed. But there was a lack of prompting people's personal interests and former interests before they become unwell and developed dementia.

● Some people had been asked about going out to do something fun. But there was no follow up to check people had gone out and was this happening routinely. When we prompted the manager to check, this hadn't happened, and no further plans had been made to make this happen, which could undermine people's well-being.
● Staff did not routinely chat with people and spend social time with them. When staff did engage with people it was not in a familiar or personalised way. One person said, "I always have to walk with one of them [staff] but they don't really have time to chat with us". A relative said, "Sometimes [name of relative] looks a bit down, I feel [name of relative] is left to their own devices, I think engagement could be a bit better."
● For people who spent a lot of time in their bedrooms the TV was playing on a loop. Those who had not formed friendships with other people in the home said the day could be boring. One person said, "I feel safe, just a bit bored."
● The dining experience, whether in the dining room or if people were supported to eat by staff in their bedrooms, lacked a social atmosphere.

People were not being consistently treated in a person-centred way which promoted their quality of life. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● Managers responded to complaints raised in a timely way. When mistakes happened, they apologised and if the complaint was not upheld they explained why.
● The investigating manager wrote and explained the outcomes to the complainant. But they did not guide them as to what they can do if they did not agree with the outcome or how it had been managed.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● Staff did communicate with people in ways which promoted them to understand what staff were asking them.

Requires Improvement

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 requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to effectively assess the quality of the care provided. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

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

- The provider and registered manager had not identified shortfalls in dementia care at the home.
- Staff knowledge and understanding with dementia care was limited. The planning and reviewing of dementia care was not person-centred. Incidents of distress were not managed effectively with lessons being learnt. The associated risks to people were not always identified and explored.
- There were some shortages of staff in the evenings which did not prompt managers to investigate this, to prevent this from happening again.
- When people's sensory equipment was not in place or working this did not prompt investigations, an action plan, and regular auditing into this issue.
- We found audits into the food and dining experiences were not effective.

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

- There was not a positive culture in terms of understanding dementia and working together to try and solve problems for those living with dementia.
- Managers and staff no longer saw verbal expressions of distress as something they should try to resolve, or that could have an impact on those around individuals expressing agitation.
- A culture had also developed where processes were followed rather than looking at what was happening for the person and if managers and staff needed to do something different.
- There was not a culture of continuous learning, with training in key areas being embedded into staff practice and the culture of the home.

Continuous learning and improving care; Working in partnership with others

- Incidents reports did not always factually capture what happened, which could undermine improvements being made. Reviews into people's care did not always go to the heart of the issue.

● Professionals were called upon but there were missed opportunities in ensuring they had all the correct information when reviewing people who expressed distress.
● Dementia specialists were not involved to assess the service from a dementia perspective to improve these people's experience of care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People did have regular reviews of their care, these often-involved people's relatives. But we found people were not fully happy with aspects of living at the home, the meal options, dining experience, and the social life at the home. These issues had not been identified through people's regular reviews, which questioned how effective they were.
● The provider had produced questionnaires for people and relatives asking key aspects of their care. But there was a gap of some months before this information was looked at and an action plan devised.

There were key shortfalls with how the provider and managers assessed the quality of the care provided. This placed people at potential risk of harm. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● Following the recent significant incident at the home the provider and managers worked with the police, local authority and safeguarding team.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not being consistently treated in a person-centred way which promoted their quality of life with managers, staff, and the provider advocating for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems and practices had not been established to always assess, monitor and mitigate risks to the health, safety and welfare of people living at the home. This placed people at potential risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were key shortfalls with how the provider and managers assessed the quality of the care provided. This placed people at potential risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were low staffing levels and systems were not in place to ensure this was monitored, assessed and managed in a safe way. This placed people at potential risk of harm.