Kodali Enterprise Limited

Woodside Care Home

Inspection report

Woodside Care Home
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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?	Requires Improvement

Summary of findings

Overall summary

We carried out this unannounced inspection on 11 September 2017.

Woodside Care Home can provide accommodation and personal care for 39 older people, people who live with dementia and people who have a physical disability. There were 29 people living in the service at the time of our inspection.

The service was run by a company who was the registered provider. There was a manager whom we registered to be in their post shortly before this inspection. 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. In this report when we speak both about the company and the registered manager we refer to them as being, 'the registered persons'.

At our inspection on 21 July 2016 we found that there were three breaches of the regulations. Two of the breaches had reduced the registered persons' ability to consistently provide people who lived in the service with safe care. In more detail, we found that there were shortfalls in the arrangements that had been made to promote good standards of hygiene and to maintain particular areas of the accommodation. As a result we rated our domain 'safe' as 'Requires Improvement'. The third breach referred to other developments that needed to be made to ensure that the service was well managed. Therefore, we also rated our domain 'well led' as 'Requires Improvement.' In addition to these concerns, we concluded that changes needed to be made to ensure that people consistently received effective care and so we rated our domain 'effective' as 'Requires Improvement'. As a result of these ratings we concluded that the summary rating for the service was 'Requires Improvement'.

Shortly after our inspection the registered persons told us that they had made the necessary improvements to address each of our concerns. We completed a further inspection on 26 January 2017 to check on the progress that had been made. We found that sufficient steps had been taken to address the breaches relating to the service's ability to ensure that people received safe care. We found that new and strengthened provision had been made to promote good standards of hygiene to reduce the risk of people acquiring avoidable infections. We also noted that improvements had been made to the accommodation, although more still needed to be done to provide people with a comfortable setting in which to live. We did not change the rating of our domain 'safe' which remained as 'Requires Improvement'. This was because we needed to see that the improvements which had been made would be sustained.

In relation to our domain 'well led', we found that the registered persons had not made enough progress to ensure that the service was robustly managed and so we concluded that the breach had not been met. Therefore, we repeated the breach and rated our domain 'well led' as 'Requires Improvement'. In line with our inspection methodology we did not review what improvements had been introduced to promote the

service's ability to provide people with effective care.

After our inspection the registered persons told us that they had made further improvements to address the concerns we had raised about the management of the service.

At the present inspection we found that a number of improvements had been made to the way in which the service was run. However, these had not resulted in people always receiving a high quality service. Therefore, we concluded that the service was still not fully being managed in the right way and we decided that the breach of the regulations relating to this matter had not been resolved. You can find out what action we have told the registered persons to take in relation to this breach at the end of the full version of this report.

In addition, we found further shortfalls in the arrangements that had been made to provide people with safe care. This was because people had not always been suitably protected from avoidable risks to their health and safety. In addition, we noted that medicines had not consistently been managed safely. We concluded that the shortfall in question was a breach of the regulations. You can find out what action we have told the registered persons to take in relation to this breach at the end of this report.

Our other findings at this inspection were as follows. There were not enough housekeeping and laundry staff on duty to meet the minimum level set by the registered persons. Some of the necessary background checks on new care staff had not been completed in the right way. However, care staff knew how to respond to any concerns that might arise so that people were kept safe from abuse.

Although some care staff had not received all of the training the registered persons said they needed, in practice they knew how to care for people in the right way. People enjoyed their meals and they were helped to eat and drink enough. Care staff had ensured that people received all of the healthcare they needed.

The Care Quality Commission is required by law to monitor how registered persons apply the Deprivation of Liberty Safeguards under the Mental Capacity Act 2005 and to report on what we find. These safeguards protect people when they are not able to make decisions for themselves and it is necessary to deprive them of their liberty in order to keep them safe. In relation to this, the registered persons had not fully ensured that one person only received lawful care. However and more generally, people were helped to make decisions for themselves whenever possible. When people lacked mental capacity the registered persons had ensured that decisions were taken in people's best interests.

Care staff were kind and people were treated with compassion and respect. People's right to privacy was promoted and there were arrangements to help them to access independent lay advocacy services if necessary. Confidential information was kept private.

People had been consulted about the care they wanted to receive and they had been given all of the help they needed. Care staff promoted positive outcomes for people who lived with dementia and people were supported to pursue their hobbies and interests. There were arrangements to fairly and quickly resolve complaints.

Good team working had been promoted and staff were encouraged to speak out if they had any concerns about the care people were receiving.

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.

People had not always been protected from avoidable risks to their health and safety.

Medicines were not always managed safely.

Background checks had not always been completed for new care staff in the right way.

The registered persons had not deployed enough housekeeping and laundry staff to meet the minimum level of cover they considered to be necessary.

Care staff knew how to keep people safe from the risk of abuse including financial mistreatment.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Care had not always been provided in an organised way to ensure that people's legal rights were reliably protected.

Although in practice care workers knew how to care for people in the right way, they had not received all of the training the registered persons considered to be necessary.

People enjoyed their meals and they had been helped to eat and drink enough.

People had been assisted to receive all the healthcare attention they needed.

Is the service caring?

Good

The service was caring.

People received kind and compassionate care.

People's right to privacy was respected and their dignity was promoted.

Arrangements had been made to enable people to be supported by lay advocates if necessary.

Confidential information was kept private.

Is the service responsive?

Good

The service was responsive.

People had been consulted about the care they wanted to receive and had been given all of the assistance they needed.

Care staff promoted positive outcomes for people who lived with dementia.

People were supported to pursue their hobbies and interests.

Complaints had been properly investigated and quickly resolved.

Is the service well-led?

Requires Improvement

The service was not well led.

People had not been fully involved in the development of the service.

Quality checks had not always been completed in right way.

There was good team work and care staff had been encouraged to speak out if they had any concerns.

Woodside 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 registered persons were 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.

Before the inspection, the registered persons completed a Provider Information Return (PIR). This is a form that asks them to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about. We also invited feedback from a local authority who contributed to the cost of some of the people who lived in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

We visited the service on 11 September 2017 and the inspection was unannounced. The inspection team consisted of an inspector, a special professional advisor and an expert by experience. The special professional advisor was a registered nurse. An expert by experience is a person who has personal experience of using this type of service.

During the inspection visit we spoke with 10 people who lived in the service and with two relatives. We also spoke with the care coordinator, a senior member of care staff, three care staff, one of the activities coordinators and the administrator. In addition, we spoke with the registered manager and with the managing director of the company. We also observed care that was provided in communal areas and looked at the care records for nine people who lived in the service. In addition, we looked at records that related to how the service was managed including staffing, training and quality assurance.

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

After our inspection visit we spoke by telephone with another five relatives.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living in the service. One of them said, "I'm okay here and the staff are helpful enough." Another person who lived with dementia and who had special communication needs smiled appreciatively when we pointed towards a member of care staff who was nearby. Relatives were confident that their family members were safe. One of them remarked, "Yes, I do think that the staff are trustworthy. They're kind but very rushed on most times I've been in the service."

However, we found that people had not been reliably protected from some avoidable risks to their health and safety. When we arrived in the service at 9.30am the central heating was switched off and both communal areas and bedrooms were uncomfortably cool. We raised this matter with the registered manager who said that the heating would be switched on as soon as possible but we noted that the radiators only started to become warm at 11.15am. By this time we had received a number of complaints from people who lived in the service. Summarising these, a person said, "It has been cold in here this morning and they really should have the heating set so that it comes on more quickly now that it's autumn." At the end of our inspection visit the registered manager assured us that they would carefully monitor how well the accommodation was heated in the future.

When we first arrived in the service we also noted that a long length of the first floor main corridor did not have any working lights and so was quite dark. Again, we raised our concern with the registered manager who arranged for the maintenance manager to address the problem. However, this took several hours to achieve and during this time there was an increased risk that people using the corridor would fall because they could not see clearly where they were going.

A further problem was that the registered persons had not prepared suitably detailed written instructions to guide care staff about how best to assist some people to move to a safe place in the event of an emergency. Although care staff in practice knew what action to take, shortfalls in the provision of guidance had increased the risk that people would not consistently receive all of the assistance they needed. A further shortfall was a number of trip hazards. These resulted from changes in floor level in a corridor that were not highlighted and so were unexpected. They also involved an area of floor in another corridor that had been repaired and left as bare plywood. Although the plywood had been screwed to the subfloor, it had only been taped down at the seams and as a result the edges were uneven.

We also found that there were oversights in the arrangements used for storing medicines. Although they were kept securely records showed that care staff had not consistently checked that medicines were being stored at the right temperature. This is important because when some medicines are not stored at the right temperature they can lose some of their beneficial therapeutic effect. In addition, although senior care staff who administered medicines had received training, we saw that they had not always followed national guidance when managing medicines that are administered by placing patches on a person's skin. When this is done it is important to vary the location on which patches are placed so as to reduce the risk of people developing sore skin. At the time of our inspection visit one person was having one of their medicines administered in this way. We noted that there were a significant number of occasions when care staff had

not recorded where the patches had been placed which had reduced their ability to ensure that this was done in the correct way. We raised our concerns about both of these shortfalls with the registered manager who immediately took steps to rectify the mistakes in question. More generally, we saw senior care staff correctly following written guidance to make sure that people were given the right medicines at the right times.

Failure to provide safe care and treatment by not assessing risks to people's health and safety, by not doing all that is reasonably practical to mitigate such risks and by not consistently managing medicines in a safe way was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we found that suitable provision had been made to protect people from other risks to their health and safety. We found that hot water was temperature controlled and most radiators were guarded to reduce the risk of scalds and burns. In addition, people were provided with equipment such as walking frames and raised toilet seats to reduce the risk of falls. Windows were designed so that they did not open too wide and could be used safely. In addition, suitable arrangements had been made to ensure that the accommodation was kept secure. Furthermore, records showed that when accidents had occurred the registered manager had carefully established what had happened. This had been done so that steps could be taken to help prevent the same thing from happening again.

We examined records of the background checks that the registered persons had completed when appointing two new care staff. We found that in relation to each person the registered persons had not obtained a fully detailed account of their employment history. This oversight had reduced their ability to determine what background checks they needed to make. However, in practice a number of checks had been undertaken. These included checking with the Disclosure and Barring Service to show that the applicants did not have relevant criminal convictions and had not been guilty of professional misconduct. These measures had helped to establish the previous good conduct of the applicants and to ensure that they were suitable people to be employed in the service. Furthermore, the registered persons assured us that the service's recruitment system would be strengthened to ensure that suitably detailed employment histories were obtained in the future.

The registered persons told us that they had carefully established how many care staff and other members of staff needed to be on duty. They said that they had taken into account the number of people living in the service and the help each person needed to receive. Records showed that sufficient care staff had been deployed in the service during the two weeks preceding the date of our inspection visit to meet the minimum set by the registered persons. We also noted that during our inspection visit there were enough care staff on duty because people promptly received all of the care they requested. However, we also noted that the registered persons had not reliably arranged for all of the housekeeping staff they said were necessary to be on duty. We saw that this had resulted in both care staff and the activities coordinators having to occasionally complete other duties such as cleaning and working in the laundry. Although we found the service to be clean and the laundry to be organised, the arrangement reduced the registered persons' ability to ensure that this situation could be maintained.

Records showed that care staff had completed training and had received guidance in how to keep people safe from situations in which they might experience abuse. We found that care staff knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. They were confident that people were treated with kindness and they had not seen anyone being placed at risk of harm. They knew how to contact external agencies such as the Care Quality Commission and said they would do so if they had any concerns that remained unresolved. In addition, we found that the registered

persons operated robust and transparent systems when assisting people to manage their personal spending money. This helped to ensure that they were suitably safeguarded from the risk of financial mistreatment.

Requires Improvement

Is the service effective?

Our findings

People told us that care staff knew what they were doing and had their best interests at heart. One of them remarked, "I get on quite well with the staff and they know me and how I like things done" Relatives were also confident about this matter. One of them said, "I think that the staff do a good enough job. Sometimes I have to raise issues but they're minor and overall I think that the care is good. It's a shame really because the building just looks so run down – it gives the wrong impression of the actual care people receive."

However, we found that there were shortfalls in the arrangements that had been made to safeguard people when it had been necessary to deprive them of their liberty in order to receive care and treatment. People can only be deprived of their liberty in this way when it is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Although the registered manager told us that necessary applications for DoLS authorisations had been made, we found the process to be poorly organised and recorded. In particular, the registered persons did not have an accurate understanding of which applications had been made and the status of each. In addition, we found that care staff had not been briefed about this matter and were not sure what steps they should take in relation to each person to ensure that they only provided lawful care. Although we were told that none of the people for whom applications had been made had expressed a wish to leave the service, the oversight had reduced the registered persons' ability to establish what other steps they may need to take if this were to occur.

In addition, we noted that the document detailing the authorisation that had been received for one person could not be found. As a result of this shortfall the registered persons could not robustly assure us that they were suitably protecting the person's legal rights by complying with any conditions that had been set in the authorisation.

We raised our concerns about these matters with the registered persons who assured us that immediate steps would be taken to address each of our concerns. In addition, the day after our inspection visit the registered manager confirmed that the necessary improvements had been made so that there was a clear system for ensuring that care was only provided in a way that respected people's legal rights. The developments included clarifying the status of each application that had been made and liaising with the relevant supervisory body about any that appeared to have become delayed. They also included making sure that care staff were fully informed about the details of the authorisation that had been received.

However, we found that the registered manager and care staff were following other parts of the Mental Capacity Act 2005 by supporting people to make decisions for themselves. They had consulted with people who lived in the service, explained information to them and sought their informed consent. An example of this occurred when we saw a member of care staff explaining to a person why it was advisable for them to take a particular medicine that supported them when they became anxious. This was necessary because the person was questioning how the medicine in question would help them. The member of staff quietly explained to the person how the medicine was designed to relieve their symptoms and make them more comfortable. This explanation reassured the person who then indicated that they were happy to continue to

accept the medicine.

Records showed that when people lacked mental capacity the registered persons had ensured that decisions were taken in people's best interests. An example of this was the registered manager liaising with relatives and healthcare professionals when it was necessary for a person to have rails fitted to the side of their bed. These were necessary to help the person rest comfortably in bed without the risk of rolling out, falling and injuring themselves.

People told us that they enjoyed their meals with one of them remarking, "The food is pretty good. It's basic, but we get enough and I've no complaints." Records also showed that people were offered a choice of dish at each meal time and when we were present at lunch we noted that if necessary people were offered individual assistance to eat their meal.

We found that people were being supported to have enough nutrition and hydration. People had been offered the opportunity to have their body weight regularly checked so that any significant changes could be brought to the attention of a healthcare professional. We also noted that care staff were making sure that people were eating and drinking enough to keep their strength up. This included assisting some people to eat their meals and gently encouraging others to have plenty of drinks. In addition, the registered manager had arranged for some people who were at risk of choking to have their food and drinks specially prepared so that they were easier to swallow.

Records confirmed that people had received all of the help they needed to see their doctor and other healthcare professionals such as dentists, opticians and dietitians.

Good

Is the service caring?

Our findings

People were positive about the quality of care that they received. One of them said, "Most of the staff are pretty good here. They're can get very busy but they're kind to us all." Another person who lived with dementia and who had special communication needs gave a 'thumbs-up' sign when we pointed towards a member of care staff who was passing by. Relatives were also complimentary about this matter. One of them remarked, "I do find the staff to be caring. They vary of course and there's a high staff turnover, but the ones who stay are kind to the residents."

We saw that care staff were friendly, patient and discreet when caring for people. They took the time to speak with people and we witnessed a lot of positive conversations that promoted people's wellbeing. An example of this occurred when a person became upset because they thought they had missed their mid-morning drink. A member of care staff noticed this and quietly reassured them. The member of care staff then went to the kitchen to make the person a cup of tea while they waited for the drinks service to arrive in the part of the service where they were sitting.

Care staff were considerate. We noted that they made a special effort to welcome people when they first moved into the service so that the experience was positive and not too daunting. Other examples included care staff asking people how they wished to be addressed and establishing what times they would like to be assisted to get up and go to bed. Another example was care staff politely clarifying with people if they wanted to be checked during the course of the night.

We noted that care staff recognised the importance of not intruding into people's private space. Bathroom, toilet and bedroom doors could be locked when the rooms were in use. In addition, we saw care staff knocking and waiting for permission before going into rooms that were in use. We also noted that care staff closed doors behind them when they were assisting people with their personal care so this was undertaken in private.

Records showed that the registered manager had noticed that on some occasions members of staff spoke with each other in an informal way. The records showed that the registered manager had been concerned that the tone of these conversations may have been misunderstood by people who lived in the service and seen as being disrespectful to them. We saw that the registered manager had immediately taken action to address the matter. This included giving staff clear written guidance about how to speak with each other when in the company of people who lived in the service. The registered manager said that the action taken had resolved the problem and this was further confirmed by us only hearing appropriate conversations during the course of our inspection visit.

We found that people could speak with relatives and meet with health and social care professionals in the privacy of their bedroom if they wished. In addition, care staff assisted people to keep in touch with their relatives by telephone and by post. We also noted that the registered manager had established links with local lay advocacy resources. Lay advocates are independent of the service and they can help people to make their voices heard when expressing their needs and wishes.

Written paper records that contained private information were stored securely. In addition, computer records were password protected so that they could only be accessed by authorised staff. Care staff had been provided with written guidance about the importance of keeping confidential information private including the correct use of social media sites.

Good

Is the service responsive?

Our findings

People said that care staff provided them with all of the assistance they needed. One of them remarked, "The staff are very willing and they work here because they care about us and not for an easy life." Relatives were also positive about the assistance their family members received. One of them told us, "My family member has lived in the service for a long time and they need a great deal of care. Whenever I call to see them they're neatly dressed and they look well in themselves. This is quite an achievement and simply wouldn't happen if they weren't receiving pretty much constant care."

People told us that they had been consulted about the care they wanted to receive. This was so that care staff could prepare an accurate care plan that described the assistance to be provided. In addition, records showed that people had been reliably given all of the assistance they needed. This included help with washing and dressing, promoting their continence, keeping their skin healthy and managing routine medical conditions.

We saw that care staff promoted positive outcomes for people who lived with dementia. This included providing reassurance when they became distressed. We saw that when this occurred staff followed the guidance in the people's care plans so that they supported them in the right way. An example of this was a person who was becoming upset because they could not clearly recall how many grandchildren they had. A member of care staff gently pointed towards a photograph of the persons' family that was displayed on their bedroom wall. They then both counted the number of grandchildren on the photograph. After they had done this the person smiled and then chatted with the member of staff about where each grandchild lived and their individual personalities.

Care staff understood the importance of promoting equality and diversity. We noted that arrangements had been made for people to meet their spiritual needs by attending a religious service. In addition, the registered manager was aware of how to support people who had English as their second language, including being able to make use of translator services. We also found that suitable arrangements had been made to respect each person's wishes when they came to the end of their life. An example of this was care staff making relatives welcome so that they could stay with their family members during their last hours to provide comfort and reassurance.

People told us that there were enough activities for them to enjoy. One of them said, "There's something going on most days and there's quite a lively atmosphere here." Records showed that people were being offered the opportunity to enjoy a wide range of social events including arts and crafts, quizzes, gentle exercises and games such as carpet bowls. During the course of our inspection visit, an entertainer called to the service and we saw a number of people sitting in the main lounge where they enjoyed singing along to their favourite tunes.

People told us that they had not needed to make a complaint about the service. However, they were confident that if there was a problem it would be addressed quickly. We noted that there was a complaints procedure that described how the registered persons intended to respond to concerns. Records showed

that in the 12 months preceding our inspection visit the registered persons had received five formal complaints. Records also showed that the registered persons had correctly followed their own procedure and had quickly resolved each of these matters to the complainants' satisfaction.

Requires Improvement

Is the service well-led?

Our findings

People told us that the service was well run. One of them said, "I think that Woodside is run okay. It's certainly not posh but I get the help I need and the meals are sorted." Most relatives were also complimentary about the management of the service. One of them remarked, "It's quite well run I suppose and the new manager is definitely a step in the right direction." Another relative commented, "Yes, it's pretty good and I wouldn't move my family member to anywhere else."

However, we found that the registered persons had not always taken prompt action to respond to improvements suggested by people who lived in the service. Records showed that people had raised a number of concerns during the course of a residents' meeting that had been held just before our inspection visit. Two of these referred to defects in the accommodation that people felt increase the risk of them falling. However, we were told that the member of staff who had attended the meeting had not informed the registered manager about this feedback. This oversight had resulted in no action had been taken to address the concerns. We raised this shortfall with the registered manager who assured us that they would immediately establish what steps needed to be taken to address the concerns that had been raised.

Records showed that the registered persons had regularly completed a number of quality checks. We were told that these were designed to ensure that that people were reliably offered all of the care and facilities they needed. However, we noted that these checks had not been effective in quickly addressing the shortfalls we have already described in our report. These included the concerns we have noted in relation to the prevention of avoidable accidents, the safe management of medicines, the deployment of staff, the completion of recruitment checks, the delivery of on-going training and the management of deprivation of liberty authorisations. In addition, we noted that there were further shortfalls in the checks that had been completed of fire safety equipment and fire safety procedures.

We had further concerns in that a number of defects in the accommodation and its fixtures and fittings had not been quickly addressed. On the outside of the building the painted pebble dash finish was damaged, cracked and discoloured. On the inside, defects included a toilet seat that was completely broken off from the water closet, misplaced and missing ceiling tiles and scuffed and marked decorative finishes. We also noted that some of the furniture in bedrooms was damaged and mismatched. In addition, in the dining room one of the curtains was hanging off its rail and table clothes were torn, stained and looked very unsightly.

We also noted that the registered persons had not established a robust system to ensure that they quickly told us about all significant events that had occurred in the service. This shortfall had resulted in us not being informed about the registered persons' receipt of the deprivation of liberty authorisation we have mentioned earlier in our report. This oversight had reduced our ability to promptly establish that the person concerned was continuing to receive safe and lawful care.

Failure to assess, monitor and improve the quality and safety of the services provided was a breach of regulation 17 (1) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

However, care staff had been provided with the leadership they needed to develop good team working practices. We found that there were handover meetings at the beginning and end of each shift when developments in each person's needs for care were noted and reviewed. In addition, there was an open and inclusive approach to running the service. Staff were confident that they could speak to the registered persons if they had any concerns about people not receiving safe care.

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 The registered persons had not consistently provided safe care and treatment. They had not suitably assessed risks to people's health and safety, had not done all that is reasonably practical to mitigate such risks and had not consistently managed medicines safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had not adopted robust arrangements to assess, monitor and improve the quality of the service to ensure that people consistently received safe care.