Pooltown Care Limited

Acorn Manor Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Acorn Manor is a residential care home providing accommodation and personal care to 29 people aged 65 and over at the time of the inspection. The service can support up to 30 people in one adapted building.

People's experience of using this service and what we found
People did not receive safe care. The registered manager had not developed a way of checking the safety and quality of care provided and as a result many aspects of poor care had not been identified.

Arrangements to protect people during the COVID-19 pandemic were insufficient with no evidence that the registered provider had sought to keep in touch with updates and requirements needed to keep people safe. The premises were not always hygienic or well maintained.

People were not always safeguarded from abuse. The registered manager did not demonstrate an understanding of what constituted abuse or how to report it effectively. People were at risk of serious injury through a number of unwitnessed falls that were not analysed effectively and or referred to other agencies that could assist to minimise such occurrences. There was no reflective learning after incidents had occurred and the risk of re-occurrence was very likely.

Staffing levels were maintained although dependency tools used were unclear as to how numbers of staff on duty were matched to people's needs. Medication management was safe.

The service was not always effective. Assessment information for people who came to live at Acorn Manor Residential Home was incomplete, lacking in detail and did not demonstrate a person-centred basis for care practice. One person us "I have been independent in the past, but no-one has looked at what I can do for myself". Staff training had been completed but was not effective. Staff did not follow the principles of the Mental Capacity Act and had basic understanding of the needs of those who lived with dementia.
We have made a recommendation about the best practice and following guidance related to the mental capacity act.
The design of the building did not fully reflect good practice to cater for the needs of people living with dementia. Liaison with other professionals was incomplete, for example, there was limited evidence of follow up with falls teams to gain support for people who were at risk of regularly falling and becoming injured. People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service was not always caring. The independence of people was not always taken into account and sensitive information was not always kept secure. People were not provided with the contact details of other agencies that could support them, for example, advocacy services.

The service was not always responsive. People were not provided with effective formats of information

reflecting their communication needs. People told us that they did not feel involved in decision-making and had not seen their care plans. Care was not person-centred as generalisations were made about people who were living with dementia and/or other health conditions. The complaints procedure was not transparent to people. Activities were not always in line with peoples assessed social interests.

Staff interactions with people were caring and positive. People's comments included. "It is not what I expected. The home is not the problem; it is just a new way of living" and "Staff are kind and they are always around if I need them".

Relatives we spoke with had had limited opportunity to visit their loved ones during the pandemic and therefore their views were based on information that they had received from the registered manager and staff in terms of their loved one's experiences within the home. They told us that "I have been assured that [name] has settled in", "The manager and staff have been really helpful when[name] went to live there" and "Yes I am more than happy with the care"

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

Rating at last inspection
This service was registered with us on 17/07/2020 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns about infection control, the management of accidents and incidents, and the governance of the service. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see all sections of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person-centred care, safe care and treatment and governance at this inspection.

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 work alongside the provider and 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Acorn Manor Residential 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 Care Act 2014.

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 was completed by two inspectors.

Service and service type
Acorn Manor Residential Home 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who used the service and four relatives about their experience of the care provided. We spoke with 11 members of staff including the registered provider, registered manager, deputy manager, senior care worker, care workers, domestic, kitchen and maintenance staff. Some staff did not respond to our calls.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records and staff rotas. We spoke also received feedback from the local infection prevention control team and the food standards agency who visited the service in response to concerns we had identified at our visit.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- The registered manager lacked knowledge and was not following current Public Health England (PHE) guidance in relation to COVID-19 to reduce the risk of infection. This meant there was a failure to do all that is reasonably practicable to mitigate the risks of COVID-19 and protect people from contracting a highly infectious and dangerous virus.
- Staff did not always follow published guidance in relation to wearing personal protective equipment (PPE).
- The service was not visibly clean. Areas of the bedrooms and communal areas were dirty. Schedules for cleaning had not been fully completed. Enhanced cleaning of rooms, shared facilities and touch points was not in place. Equipment including fridges and freezers were dirty. The registered provider addressed the concerns regarding kitchen equipment immediately.
- There was no clear guidance for how visits were taking place, where, or how they were monitored. There was no prominent signage or information at the entry points to the service as to what was required of visitors.
- The risk of COVID-19 to individuals and staff with underlying health conditions had not been assessed. People readmitted to the service following discharge from hospital had been tested for COVID-19 but did not then undergo any period of isolation.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate that risks associated with infection control were safely managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to the concerns we identified the local infection control and prevention team visited the service to provide additional training and support to the registered manager and staff. The food standards agency also undertook an inspection of the kitchen and awarded the service with a four-star rating.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from abuse. The registered manager had not always recognised potential safeguarding concerns or reported concerns such as unexplained injuries, to the local authority in line with local safeguarding protocols.
- CQC made a safeguarding referral to the local authority during the inspection relating to an incident involving one person. The registered manager had failed to recognise this incident as a potential safeguarding concern.
- CQC also shared other information relating to low level safeguarding concerns that had been identified during November 2020 that had not been shared with the local authority in line with their contractual

agreement.

The registered persons had not made sure that people were safeguarded from abuse. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to people's health, safety and welfare had not been adequately assessed, mitigated and kept under review.
● Staff did not follow the providers policy when people experienced a fall. For example people's falls risk assessments had not been reviewed and neurological observations were not always recorded.
● The registered manager had failed to investigate the root cause of circumstances leading up to incidents such as falls to establish what went wrong and identify how risks to minimise reoccurrence could be reduced.
● Risks to people due to health conditions such as epilepsy had not been assessed.
Systems were not in place or robust enough to demonstrate that risks to people's health and safety were safely managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Recruitment files for that all necessary checks had been done prior to employment. One did not include a current photograph to confirm identity. We raised this with the registered provider.
● The required security checks had been completed prior to staff being starting work. However, one staff file did not include a current photograph to confirm their identity. We raised this with the registered provider.
● Staff rotas outlined the designation and numbers of staff on duty.
● Dependency tools used were unclear as to how staffing levels were matched to people's needs. We observed that there were sufficient care staff on duty to respond to people's needs.

Using medicines safely
● The management of medicines was safe. However, there was not always guidance in place for staff to follow for when to administer 'as required' medicines. The guidance that was in place had not been individualised to reflect the specific needs of the person. This is an area of practice that needs improvement.
● Medicines were stored appropriately and administered on time. Accurate medication administration records (MAR) had been maintained.
● Medicines were administered by staff who had been appropriately trained.

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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's capacity to make decisions, for example to have a COVID-19 swab test or influenza vaccination, had not always been assessed. When decisions had been made in people's best interest, records of the decision-making process and who had been consulted with, had not been maintained.
- There was no evidence in care plans that people who were assessed as having capacity were being involved in decision making in their support.
- Training records outlined that staff had had MCA training, but this learning had not been applied effectively.
- Standard deprivation of liberty applications had been made to the Local Authority. These had either been approved or were pending. and were awaiting being processed.

We recommend the provider consider current guidance and best practice in relation to the Mental Capacity Act and take action to update their practice accordingly.

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

- Initial assessments were not robust and did not encompass all areas of need.

● General terms such as "dementia" were used without any reference to the type or how this could impact on a person's daily life. This also applied to those who had been identified as having epilepsy. There was no indication of the type of epilepsy, how this impacted on people, how it presented itself and the frequency/patterns of such events. Therefore, staff did not have the guidance they needed to support people effectively.
● Medical histories had not always been taken into account. A person had had health issues relating to their eyesight in the past, for example, but this part of the assessment was not completed. Therefore, there was a risk people's medical needs would not be met.
● Other key parts of people's assessments were incomplete with no reference to skin integrity or social interests, for example. Therefore, there was a risk that these needs would not be met.

The registered persons had not made sure that care was assessed and planned for in a person-centred manner and that the holistic needs of people had been recognised. This placed people at risk of harm. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Training records were in place and outlined relevant training that had been completed by staff.
● Staff had received dementia awareness training. Where people living with dementia had refused to participate in COVID-19 swab tests, staff had tried again but had not recorded this.
● A structured induction process was in place.
● Staff supervisions and appraisals were evidenced. Staff told us that they had received communication from the registered manager instead of team meetings of late.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support.
● Co-operation with other agencies was not always effective.
● Initial contact with the falls teams had been made after people experienced falls. However, this had not always been followed up despite people experiencing further falls resulting in injury. Therefore, the opportunity to obtain up to date guidance and advice on minimising falls had been missed.
● Initial contact had been made with the Infection Prevention Control team as a result of the COVID-19 pandemic, however, clarification on changes to national guidance had not been sought or kept up to date. . This meant that hygiene practices at Acorn Manor Residential Home did not reflect the correct advice issued by local health teams.
● Care records evidenced that other health professionals such as Doctors and District Nurses had been consulted and appointments fulfilled.

Adapting service, design, decoration to meet people's needs
● The service had not always been fully adapted to meet the needs of people living with dementia. Signage, for example, social distancing information and menus were in written form with no evidence that this met people's communication needs. The activities board included some symbols outlining activities for the week, but this was not prominently displayed in an accessible area.
● Not all peoples' bedrooms had a recognisable photograph to assist in orientation to their room. The registered manager explained that one person tended to remove photographs and documents but no alternative ways of managing this had been looked at.
● The registered provider demonstrated that work to improve decoration within the building had started with new flooring and furniture being purchased. During our visit, the maintenance person was attending to repairs and improvements to the building.

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

● Dining facilities had been arranged to take social distancing into account and this was seen as working effectively.

● New dining room furniture had been purchased and this had been an improvement to the environment.

● Food and fluid charts were in place identifying those people who required extra support to maintain nutrition and hydration. People were offered drinks throughout the day. There was one omission in one person's records.

● Records were completed on admission outlining agreed food preferences and any allergies. We did not receive any specific comments on the quality of the food provided.

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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
- People were not always involved in aspects of their care.
- People's independence was not always promoted. People told us that daily tasks that once they had been independent with prior to coming to live at the service had not been considered.
- People told us that they needed support to make important decisions but had not received information on the role of or contact details of advocacy groups.
- There was little information on care plans about protocols for ensuring effective communication with people.

Respecting and promoting people's privacy, dignity and independence
- People were not always treated with dignity and respect. Some bedrooms were not personalised and were bare. Some people were observed sitting on mattresses with no sheets. There was no information to indicate this was in line with people's preferences.
- People's confidential information was not always kept secure. Some records were found in an unlocked filing cabinet in a lounge area and some people's records were found in other people's files. A local authority assessment in one file did not relate to the accommodation needs of the person and focussed on other care provision.

Ensuring people are well treated and supported; respecting equality and diversity
- Staff interactions with people were positive and friendly.
- Staff sort to provide reassurance to people who had become disorientated or who needed attention.
- Care staff supported people in a dignified and discreet manner with attention paid to communicating with people in an appropriate manner.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated .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

- Care plans were not always person- centred and people told us they had not seen their care plans.
- There was record in care plans about people's needs during the pandemic and no information about people's routines, when they were awake at night, for instance.
- 'Care plans made generalised descriptions of people living with dementia. No reference was made to the types of dementia that people had and how this impacted on people's lives. The same applied with those living with epilepsy. Care plans regarding dementia care and epilepsy were received following the inspection demonstrating that work to make improvements had been undertaken.
- 'Where individuals displayed behaviours that challenged; not all people strategies outlined as to how staff could assist in people becoming less distressed'.

- Care plans had been reviewed.

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.

- People's communication needs were not always met.
- Information such as the complaints procedure was presented in writing with no indication whether this reflected the communication needs of people.
- The information for people on display was in written format only. This format did not meet the communication needs of everyone living at the service
- The menu located in the dining room was left blank throughout our visit.
- A service user guide had been placed in people's rooms but there was no evidence that this was accessible and meaningful to people.

The registered persons had not made sure that care was assessed and planned for in a person-centred manner and that the communication needs of people had been recognised. This placed people at risk of harm. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- People did not know how to make a complaint. One relative told us," "No, I wouldn't know how to make a

complaint now you've asked that" and "No I haven't been given a copy of the complaints procedure".
●The process for raising complaints was not always coherent
● A complaints procedure was on display in written form but it was not clear whether this had been explained to people.
● The registered provider told us that no complaints had been received.

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
● The social interests of people were not always recorded on initial assessments. Where information had been included; there was no indication whether activities had been tailored to people's preferences.
● Activities were displayed for the first three days of the week of our visit. One session was referred to as "chiropodist" and it was not clear whether this was an activity or a health appointment.
● A singalong took place during the afternoon of our visit. The activity displayed for the day was watching films. There was no evidence that activities had been organised to reflect the forthcoming Christmas season.
● Records evaluating each person's involvement in activities were in place.

End of life care and support
● No -one had reached this stage of their lives at the time of our visit.
● Information was included in care plans relating to the future wishes of people.
● Do not resuscitate decisions had been included for some people within records.

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

During the inspection we identified a number of incidents which should have been notified to CQC but were not. We have dealt with this outside of the inspection process.

- The registered persons had not had sufficient managerial oversight of risk. The internal quality assurance processes had not been used to monitor the service effectively and had failed to identify and improve shortfalls in relation to infection prevention and control.
- The registered provider hadn't ensured that policies and procedures were up to date and reflected recognised national guidance. Policies from other organisations had been adopted but not amended to fully reflect practice at the service
- The registered persons had failed to identify that records of accidents and incidents, people's care plans, personnel records, personal care records and environmental issues were accurate, complete or up to date.
- The registered persons had failed to ensure that appropriate action was taken to mitigate risks to people's health and safety.

The registered persons had not ensured that the quality assurance and monitoring systems in place were robust and drove improvement. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we shared our findings with the local authority and commissioners who are monitoring the service on a regular basis. The provider has sent us an action plan outlining the improvements they plan to make.

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

- The registered persons did not always promote a person-centred and empowering culture.
- People's independence in managing their own medicines was not promoted or assessed.
- These assessments assumed that people should be reliant on staff to manage some daily tasks and did not evidence consultation with the individual.

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

● The registered manager did not always provide evidence to us in a timely manner following the site visit. Repeated requests had to be made in respect of complaints records and quality assurance comments from service users and families. Information had still been not provided on quality assurance comments at the time of writing this report.

● Policy and procedures were not followed in relation to falls management, accidents and incidents. There was lack of robust analysis undertaken by registered persons to mitigate the risk of unsafe care and treatment to service users.

● We requested a copy of the providers falls procedure after the inspection and was provided with a generic procedure which contained reporting processes to be followed for another geographical location.

● Initially there was no written procedure to deal with those who had sustained head injuries. This was made available to us after the inspection and included reference to head injury observations. This procedure was not being followed by staff.

Working in partnership with others

● The registered provider did not work effectively in partnership with other agencies.

● The registered provider had not informed the environmental health food safety office of the change of ownership of the service as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We did not see any evidence that people who used the service had been asked for their views on the quality of support they received.

● Relatives told us, "I don't know anything about the home other than what was on the internet", "We have regular contact with staff who are very friendly." "We have regular updates from staff and managers" and "The manager was brilliant when [name] first went in."

● There was no indication from relatives that they had been asked for their views on the quality of the service provided

● Staff comments included, "I go straight to seniors as they line manage me." "I do feel supported", "I can always ask if I need anything, but I don't really know the manager".

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 The registered persons had failed to ensure people received person centred care.

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 failed to ensure people were always protected from the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered persons had failed to ensure people were always protected from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to ensure the governance, assurance and auditing systems effectively assessed, monitored and drove improvement in the quality and safety of the services provided and the quality of the experience for people using the service. The registered persons had not always assessed, monitored and mitigated risks to people's

health, safety and welfare.