Care Quality Commission

Veatreey Development Ltd

Rowan Tree Lodge

Inspection report

30 Dover Road
Southport
PR8 4TB
Tel: 01704 566312

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

This unannounced inspection of Rowan Tree Lodge took place on 26th August 2015.

Rowan Tree Lodge is a large detached house converted into a nursing and care home for up to 16 older people. It is situated in a residential area of Southport with access to local amenities and public transport in the town centre. The service provides accommodation over three floors, with lift access between floors. The home has 14 single bedrooms and one double bedroom. There is a lounge area and dining room and a separate quiet lounge to the front of the property and enclosed gardens to the rear.

A registered manager was in post. 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.

People and relatives we spoke with told us they felt the home was a safe place to live. One relative told us "I find this a nice and welcoming home and I am sure (my relative) is safe, well cared for and well fed."

Summary of findings

The staff we spoke with told us they had received safeguarding training and were aware of what constituted abuse and knew how to report an alleged incident.

Care plans viewed showed that peoples consent was gained regarding their care and treatment. When people were unable to give consent, advocates were involved in decision making. People's ability to make decisions was not always clearly recorded within the care files. We observed staff gaining people's consent before assisting them with personal care or meals.

People's care plans lacked detail so there was a risk the staff did not have the information they needed to provide people with care and support in accordance with individual need.

Planned treatment was not always evidenced as being provided within the care file. This means that there is a risk that people may not receive appropriate care and treatment.

Risks to people's health and safety were not always recorded to help form the plan of care. The staff however, had a good understanding of people's risks and the measures in place to maximise their safety.

Staff and visitors told us there were adequate numbers of staff to meet people's needs and most people we spoke with agreed with this.

Recruitment procedures were robust. All relevant recruitment checks had been completed prior to staff starting work at the home to ensure staff were suitable to work with vulnerable people.

Systems were in place to maintain the safety of the home. This included health and safety checks and audits of the environment.

We found medicines were administered safely to people. People told us they received their medicines on time and when they needed them.

People told us they were treated with respect and dignity by staff and that staff knew them well. This view was shared with visitors we spoke with. Staff carried out personal care activities in private and people did not have to wait long if they needed staff support.

We found staff support was given in respectful and caring manner. Staff took time to listen to people and to communicate in a way that the person understood.

Staff had a good understanding of people's care needs and interactions between staff and people living in the home was caring and respectful.

We received positive feedback from people regarding meals. Peoples nutritional needs were monitored by the staff and people's dietary requirements and preferences were taken into account.

Care records we viewed showed staff sought specialist advice from a number of health professionals so that people received appropriate care and treatment to maintain their health.

A process was in place for managing complaints and this was displayed within the home.

There were arrangements in place to gather feedback regarding the service from people and their relatives. These included satisfaction surveys, residents' and relatives' meetings and a suggestion box.

There was a system of auditing in place to monitor the quality and safety of the service. This included the environment and equipment.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People we spoke with told us they felt safe living in the home and their relatives agreed with this. Staff were aware of what constituted abuse and told us they would report an alleged incident and knew how to do this.

Risk assessments were not always completed accurately however staff were aware of people's individual risks and the measures needed to ensure their safety.

Arrangements were in place for checking the environment and equipment to ensure it was safe.

There were sufficient staff on duty to meet people's needs. Staff had been safely recruited to ensure they were suitable to work with vulnerable people.

Medicines were administered to people as prescribed.

Is the service effective?

Good

The service was effective.

Peoples consent was gained regarding their care and treatment. When people were unable to give consent, advocates were involved in decision making. People's ability to make decisions was not always recorded clearly within the care files.

We observed staff gaining people's consent before assisting them with personal care or meals.

Staff were supported through a programme of induction, training, supervision and appraisal so they had the knowledge and skills required to provide safe and effective care.

Staff sought advice from healthcare professionals to maintain people's health and wellbeing.

Feedback regarding meals was positive, with people informing us they had choice and that meals were enjoyable.

People had access to aids and equipment to meet their needs and promote independence.

Is the service caring?

Good

The service was caring.

Staff were warm, gentle and caring in their approach and had a good understanding of people's care needs.

Summary of findings

People's privacy and dignity was respected, for instance staff knocked on doors before entering people's rooms.

Visitors were made welcome in the home and no visiting restrictions were in place.

Advocacy services were available and utilised when required.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care plans lacked detail and planned treatment was not always evidenced as being provided. This means that there is a risk that people may not receive appropriate care and treatment.

Risks to people's health and safety were not always recorded to help form the plan of care. The staff however, had a good understanding of people's risks and the measures in place to maximise their safety.

People's preferences around daily living and how they wish to be supported were included in their plan of care.

There was a social activities programme for people to take part in. People's feedback regarding activities was mixed as some people were unsure what activities were available.

Is the service well-led?

Good

The service was well led.

The home had a registered manager in post. Overall we received positive feedback about the management of the home. Staff and relatives informed us the manager was approachable and encouraged teamwork.

Staff were aware of the whistleblowing policy and told us they would use it if needed.

Systems were in place to check the quality of the service and drive forward improvements.

Rowan Tree Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 11 & 12 August 2015. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. This usually includes a review of the Provider Information Return (PIR). However, we had not requested the provider submit a PIR prior to this inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at the notifications the Care Quality Commission had received about the service. We contacted the commissioners of the service to obtain their views.

During the inspection we spoke with six people who lived at the home, the manager, the chef, three visitors and two care staff.

We looked at the care files for three people, three staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We made general observations, looked around the home, including some people's bedrooms, bathrooms, the dining room and lounges.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Rowan Tree Lodge and visitors also agreed. One person told us "I feel safe here" and another person said "I am not frightened of anything or anyone."

Arrangements were in place for checking the environment to ensure it was safe. This included health and safety checks and audits of the environment. The manager had arranged for a recent external health and safety audit of the building to be conducted. We were provided with a copy of this audit following the inspection and the manager advised us that the required actions had been completed to ensure the safety of people living in the home.

A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and use of bed rails. For one person we saw there was no risk assessment around the risks of falls which had been identified by the staff as a care need. Measures had however been put in place to maximise the person's safety and staff had a good understanding of the person's care needs and how to keep them safe. The manager agreed to review care files for people to ensure all risks were clearly recorded.

A nutritional assessment was used to help assess when people were not eating and drinking adequately and may therefore require external dietetic support. The nutritional assessment did not clearly identify what actions were needed by the staff as the scoring tool, which advises on actions required based on the assessed score, was not in the care files for staff to refer to. The manager said they would ensure the scoring tool was made available alongside the nutritional assessment. When looking at people's plan of care we saw appropriate actions had been taken by the staff to support people with their nutritional needs.

The staff we spoke with told us they had received safeguarding adults training and were aware of what constituted abuse and how to report an alleged incident. Safeguarding policies and procedures were available though the manager was unable to locate the Local Authority's safeguarding procedure. They advised us this document would be obtained as soon as possible. Contact details for the Local Authority were displayed and staff were aware of these.

We looked at how the home was staffed. Staff told us that there were enough staff on duty to ensure people received the support they needed. Staff checked on people's safety ensuring their comfort, safety and wellbeing. Most people living at the home agreed that there were enough staff and one person told us "Staff are good and they don't keep me waiting when I need them." Nobody told us they had to wait for support and we observed people receiving support in a timely way throughout the day.

We looked at the staffing rota and this showed the number of staff available. The staff ratio was consistently in place to provide necessary safe care. At the time of our inspection the manager was on duty with a trained nurse, two care staff and a cook. Care staff undertook laundry duties and domestic staff were employed two days a week. At night the home was staffed by a trained nurse and a member of the care team. A maintenance person was employed to cover Rowan Tree Lodge and Ascot Lodge, a local nursing home owned by the same provider. The manager informed us bank staff were employed and existing staff worked between the two homes to cover vacant shifts, for example, sickness and holidays.

We looked at how staff were recruited. We saw three personnel files and asked the manager for evidence of applications forms, references and identification of prospective employees. Disclosure and Barring Service (DBS) checks had also been carried out prior to new members of staff working at the home. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. The appropriate checks were in place to ensure prospective staff were suitable to work with vulnerable people. We did note one staff member's application form did not list past employment however the manager was able to tell us these details. The manager had completed a record of interview for new staff to help evidence suitability for the job role.

Good

Is the service safe?

We looked at how medicines were managed in the home. People we spoke with told us they received their medicines when they needed them. One person said "They see to my medicines very well."

Medicines were mainly kept secure in a locked medicine trolley and additional stock was stored safely in a locked medicine room. Temperatures of both were monitored and recorded. One prescribed product that was added to drinks for people who may have swallowing difficulties, was observed on a table in the dining room and staff were alerted to the need to ensure it was kept locked away and this was removed by staff. Lockable drawers were available in people's rooms if they wished to self-administer their medication to enable them to keep their medicines secure.

The majority of medicines were administered from a blister pack (medicines dispensed in a sealed pack). Those medicines not in a blister pack were dated when opened and stock balances counted each day to ensure accurate administration. We checked a sample of medicines in stock against the medication administration records and found these to be correct.

There were some gaps where staff had not signed the medicine administration records (MARs) following administration. Medicine audits had been completed and these gaps had been identified. The manager told us this was being addressed with the staff to improve the recording of medicines.

There was a reordering process for regular medicines, however we did identify there was very little stock left of one person's medicine. This was a risk therefore that the person may have run out of this medicine. We brought this to the manager's attention and this was re-ordered during the inspection. The manager advised us they would review the re-ordering process to ensure stocks were well maintained.

Medicines were administered by registered nurses and the manager told us their competency was assessed when starting in post. There was no record of these competency checks though training records showed the registered nurses had completed medicine training. The manager agreed to maintain a record of competency around the safe administration of medicines.

A medicine policy was available and a separate policy was available for PRN (as required) medicines. Although no people living in the home currently required their medication to be administered covertly (hidden in food or drinks), there was no written guidance to support staff with this practice. The manager informed us new policies were being created and the new medicine policy would contain guidance on the administration of covert medicines.

Staff had access to gloves, aprons, liquid soap and hand towels in accordance with infection control guidelines. Staff did not have access to liquid soap and hand towels in the laundry room. We brought this to the manager's attention and these were made available. We also noted that the laundry room was being used for storage of unwanted items. The manager said these would be removed and stored in a more appropriate place.

Good

Is the service effective?

Our findings

People living at Rowan Tree Lodge all told us that staff arranged visits from appropriate health professionals, such as the General Practitioner (G.P) when needed. One relative told us, "From experience here we know that (my relative) can see a doctor quickly when (my relative) needs to."

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) (MCA). This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. The manager and staff were currently undertaking a course on the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). DoLS is part of the MCA and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.

The manager had applied for authorisation of Deprivation of Liberty Safeguards (DoLS) for three people who lived at the home. We looked at three care files and found a lack of information in their plan of care about the proposed restriction. The manager agreed to record details around the proposed restriction within people's plan of care. This information had been recorded in people's care review and staff were aware of proposed restriction.

The manager told us staff sought consent from people and their relatives and involved them in key decisions around daily life and support. Care files viewed evidenced that people had been consulted about their care and agreed to the support plans in place. When people were unable to make decisions, advocates were involved in decision making. Although assessments of people's mental capacity was evident within some care files, they were not time or decision specific. One assessment viewed did not provide a clear outcome as to the person's ability to make decisions. The manager agreed to review the assessment tool to ensure it reflects people's decision making ability and that it follows the principles of the Mental Capacity Act (2005). Since the inspection, the manager has showed us the new assessment tool which is now in place and examples observed were time and decision specific.

We saw staff seeking people's permission before providing care and prompting people to make their own decisions to help maintain their rights and independence. A staff member told us they always checked to make sure people were in agreement before helping them as a mark of respect. Relatives we spoke with told us they had been involved in making decisions regarding their relatives care and treatment.

The manager provided us with a current training plan and we saw evidence of course certificates in personnel files. Staff had received training in a number of areas. For example, moving and handling, safeguarding, infection control, health and safety, medicines, food hygiene and fire prevention. Other courses offered to staff included, pressure area care, dementia care, equality and diversity and advanced care Advanced care planning training is to improve and support people who are nearing the end of life. Staff told us they had access to a good training programme and training was provided via e-learning and 'face to face'. Question sheets were completed following completion of training courses to assess staff's understanding and knowledge.

New staff received an induction and this this covered areas around safe working, principles of care, people's needs, communication and confidentiality. The manager informed us that new staff were shadowed by an existing member of staff to help them familiarise themselves with the service and to get to know the care and support people needed and wished to receive. For new staff member the manager advised us that the Care Certificate was being introduced. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. One person we spoke with described the staff as "Very nice and good carers" and a relative we spoke with told us that staff "Seem to be very good at their job."

We saw systems were in place to provide staff support. These included monthly staff meetings, two monthly supervisions and an annual appraisal. Dates were recorded when these were held. Staff told us they attended supervision meetings and received good support from the manager.

The manager informed us nearly half of all staff had completed or were working towards a NVQ (National Vocational Qualification)/Diploma level in areas such as health and social care, nutrition or cooking. Staff told us they were studying or had achieved an NVQ in care as part of their professional development.

Good

Is the service effective?

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The three care files we looked at showed people had appointments with health and social care professionals. These included the persons GP, social worker, dietician, mental health team, physiotherapist, optician, chiropodist and appointments with local hospitals.

We observed the lunch time meal. There was a relaxed atmosphere and people were able to move freely around the dining room and sit where they felt most comfortable for meals. People were given plenty of time to enjoy their meal and staff offered assistance to people who required some support. Some people chose not to sit in the dining room and they were served their meals in their room. People were asked each day their choices from the menu, though there was no menu available in the dining room for people to see.

We received positive feedback from people regarding the quality of the food. The comments included “The food is good so I don’t really have anything to complain about”, “The food is very good”, “The food is always good and I do enjoy it” and “The food is good with plenty of drinks and snacks and always a choice of main meals.” Fresh fruit was available for people in the dining room. People’s dietary needs and preferences were recorded within their plans of care.

Good

Is the service caring?

Our findings

People we spoke with told us the staff were kind and caring and treated them with respect. One person described staff as “Most polite and careful about dignity and privacy” and other people said “Staff do treat me with respect” and “The staff are good about privacy and dignity and treat me very well.” We observed interactions between staff and people living in the home was caring, warm, gentle and respectful and staff were attentive in their approach. Staff were polite and took time to listen and to respond in a way that the person they engaged with understood. Staff used varying methods of communication to ensure they were able to effectively communicate with people. We observed staff spending time chatting with people in the lounge.

Personal care activities were carried out in private and people did not have to wait long if they needed support. We observed staff offering reassurance when supporting people, such as when supporting a person to mobilise and ensuring their comfort and wellbeing before attending to someone else.

We observed and heard people being encouraged to make choices about issues such as what to have for lunch, whether they wanted to participate in activities, where they wanted to sit and spend time and what they wanted to watch on television.

Relatives visiting during the inspection told us there were no restrictions on visiting times, which encouraged relationships to be maintained.

Care plans viewed included brief details of a person’s life history and preferences and staff were aware of these. People told us their spiritual and religious needs were respected and that the clergy visited the home. One relative told us “Staff do know (my relative’s) likes and dislikes.”

For people who had no family or friends to represent them contact details for a local advocacy service were available and care files showed advocates were involved when required.

Requires improvement

Is the service responsive?

Our findings

We looked at three people's care files and saw that people had a plan of care that was reviewed regularly and contained information regarding people's care needs, such as mobility, skin integrity, personal care, communication and nutrition.

However, we found that care was not always planned appropriately to meet people's needs. Some care plans lacked detail regarding the support a person required. For example, one person's plan of care did not record details about daily clinical treatment needed to maintain their health and wellbeing. Staff we spoke with were however clear about what treatment was required. Another care plan lacked detail around supporting a person who was receiving 'as required' (PRN) medication when anxious and the support needed for a person who displayed behaviours that may challenge. This means there is a risk people may not receive safe and effective care and treatment as staff may not have the required information to meet their needs.

Most care files viewed showed that planned care was provided, such as monitoring people's weight or nutritional intake, although this was not always the case. For example one care plan advised blood sugar levels should be monitored monthly; however the document viewed showed a record of this only twice this year, the last recording being two months ago. This means there is a risk that changes in peoples health and wellbeing may not be identified. The manager was made aware of this and agreed to ensure the persons blood sugar levels were monitored.

Where risks had been identified, a plan of care was usually in place to advise how the risk was managed. For instance, a person was assessed as being at risk of malnutrition and a detailed care plan advised the support required to manage this. However one person's file evidenced three separate incident forms in relation to falls, yet there was no risk assessment or care plan in place to accurately assess the risk to the person and ensure appropriate measures were in place to manage the risk. Another person's risk assessment identified there was a risk the person may not take their medicine and may hide it. This was not recorded in the person's medicines care plan to ensure staff were aware of this risk and how to support the person safely.

Staff we spoke with had a good understanding of people's needs, care and treatment. However, people were at risk of not receiving appropriate care, support and treatment if their care was not planned effectively. We raised this with the manager during the inspection and they agreed to review people's care files to ensure risks were assessed accurately and that people's care plans contained detailed information about all care needs. Since the inspection the manager has advised us that all care plans and risk assessments have been reviewed.

Failure to plan and deliver care and treatment in accordance with individual need is a breach of Regulation 9 (3) (b-i) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were involved with their care planning. People we spoke with told us they were happy that the care they received was focussed on them and their individual needs. Care files viewed evidenced that people's care and treatment had been discussed with them, their relative or an advocate. Care files we viewed had been reviewed regularly.

People could choose how to spend their day, for example some people chose to sit in the lounge, whilst other people preferred to watch television in their rooms.

We observed staff responding to people's needs on an individual basis. For example, one person required their dietary intake to be monitored due to an identified risk and this was regularly recorded to ensure they received adequate nutrition and hydration. Their weight was regularly monitored. Another person required specific methods of communication and we observed staff communicating with them in a way that was effective for them.

Brief details of people's social background and interests were recorded in a social profile to help staff get to know the people they supported.

Residents' meetings took place to enable people to raise any issues or comments regarding the service and minutes of these meetings were observed. A future meeting was advertised within the home. There was also a suggestions box in the entrance hall to enable people to make comments/suggestions about the service, which the manager checked regularly. A relative told us "I have taken part in a meeting and a survey from which we did get some feedback".

Requires improvement

Is the service responsive?

An activities board was displayed in the lounge for people to see what social arrangements were in place. This included musical entertainment, crafts and exercises. There was no activities organiser; social activities were staff led and staff told us these were arranged according to individual need. During our inspection we saw staff sitting with people chatting about the news and weather and completing jigsaw puzzles with them. People were also encouraged to take part in a sing along and the manager told us staff often support people to go out of the home, such as to local coffee shops. There was a pleasant relaxed atmosphere and for people who wished to stay in their room, the staff visited them on a regular basis to reduce the risk of isolation. People we spoke with were unsure about activities available. One person told us "They have some activities here" and one relative told us "There does not seem to be much by way of activities here, but enough for (my relative)."

People had access to a complaints' procedure and this was displayed in the main entrance of the home. The manager told us no written complaints had been received recently but any issues raised by people living in the home or their relatives, were recorded as a concern. We could see that a written response was available for each of these. People living in Rowan Tree Lodge told us they would be happy to raise any concerns with staff but not everybody was aware of the complaints procedure. A relative told us "I am aware of the complaints procedure." People we spoke with told us they did not have any complaints about the service or the care they received.

Good

Is the service well-led?

Our findings

The home had a registered manager in post. Overall we received positive feedback about the management of the service. Staff told us the manager was approachable and ensured the home ran well. The manager for Rowan Tree Lodge held the acting manager position for Ascot Lodge and their hours of working were shared between the two homes. Staff told us this did not cause any issues as the manager was always contactable by phone if they were not present in one of the home. "The manager encourages team work and the home is really run well", "The home is running well" and "This is the residents' home and that's what is important to us." One person told us their relative was "Talking regularly to the manager." Not all people we spoke with were aware of who the manager was.

Staff told us communication was good and that the manager listened to their ideas and views. Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue. This helps to promote an open culture within the home.

The home had a number of systems in place to monitor the quality of the service provided and improve practice. This included a number of checks and contracts for equipment and services such as, fire prevention, gas and electric. These were all in date. The manager and nurses also completed a number of audits within the home to quality assure the service being provided and these covered areas such as medicines, care plans, infection control, call bells, water temperatures, housekeeping, laundry, hand washing and health and safety. The audits contained action plans which identified improvements necessary to improve the quality of the service.

Medicine audits included a review of MARs to ensure medicines were administered to people in accordance with their prescription. We discussed with the manager the need for more robust auditing around care planning as care reviews had not picked up on the areas of concerns we found during our inspection. The manager agreed to review the auditing process and since the inspection, has advised us that a more detailed care plan audit is now in place.

Arrangements for feedback about the service included satisfaction surveys for people who lived at the home and for relatives. These had been distributed in May 2015 and provided positive feedback about the service. Accommodation was an area of the surveys which scored less and the manager was aware of this. We saw work was on-going to improve the standard of the bedrooms and the lounge had recently been decorated. Where a relative had raised a comment via a survey, the manager told us about the action they had taken; they responded in a timely manner to the person concerned.

People who lived at the home attended meetings and a number of these were also extended to relatives. We saw minutes of residents' meetings and these covered a number of areas such as, meals, accommodation and standard of care. Staff meetings were also held and agenda items were structured so relevant information about how the home was operating was shared with the staff. Meetings also provided staff with an opportunity to discuss care practises and staff development. Staff told us these meetings were arranged on regular basis.

The home's policies and procedures were reviewed regularly by the manager to ensure the information was current and in accordance with 'best practice' and current legislation. The manager advised new policies and procedures were in the process of being developed.

The manager had notified the Care Quality Commission of events and incidents that occurred in the home in accordance with our statutory notification requirements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 who used the service did not have effective plans of care to meet their individual needs.**