MNA Home Care Services Limited

MNA Home Care Services LTD

Inspection report

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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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This comprehensive inspection took place on 17, 18 and 19 October 2017 and was announced. We gave the registered manager two working days' notice as the location provided a service to people in their own homes and we needed to confirm the registered manager would be available when we inspected.

The last inspection took place in August 2016 and the service was rated 'good' in all five key questions and overall. However the last inspection took place at Research House and the service had since moved to a new location. This was the first inspection at the new location.

MNA is a domiciliary care agency that provides care to people in their own homes. At the time of the inspection there were 562 people using the service. The service offered support to a range of people, for example, people living with dementia, and the support hours varied depending on people's need. Services were mainly commissioned by the London Boroughs of Brent, Ealing and Harrow.

The service had a registered manager. 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. The registered manager was also one of the directors and owners of the service.

People using the service said they felt safe. Care workers we spoke with knew how to respond to safeguarding concerns. They had the relevant training, supervision and appraisals to develop the necessary skills to support people using the service.

People had risk assessments and risk management plans in place to minimise risks. Incidents and accidents were recorded. Learning outcomes were not recorded on the incident and accident form but the registered manager agreed to update the form to include this information.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However the provider was not always consistent in ensuring every person who required it, had a completed mental capacity assessment to evidence that they did not have the capacity to make decisions about their care. The registered manager said they would address this.

There was a policy and procedure in place for the management of medicines which was adhered to by care workers.

People's dietary requirements were met and we saw evidence that relevant health care professionals were involved to maintain people's health and wellbeing.

People's privacy and dignity was respected and care plans identified people's cultural needs, how they liked to be addressed and how they wanted their support delivered.

People were involved in their care plans and making day to day decisions. People told us they generally had the same care workers and this provided consistency of care.

People using the service and care workers said the managers were accessible and responded to concerns.

The service had a number of systems in place to monitor, manage and improve service delivery. This included a complaints system, audits, care worker observations and satisfaction surveys.

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.

Safeguarding and whistle blowing policies were up to date and staff knew how to respond to safeguarding concerns.

People had risk assessments and management plans to minimise the risk of harm to people and others. Incidents and accidents were recorded and managed appropriately but learning outcomes were not always consistently recorded.

Safe recruitment procedures were followed.

The provider had the relevant training and audits in place for the safe management of medicines.

Is the service effective?

Good

The service was effective.

The provider mostly acted in accordance with the requirements of the Mental Capacity Act (2005), however they were not always consistent in recording if they had assessed if people had the capacity to consent to their care.

Care workers were supported to develop professionally through training, supervision and yearly appraisals.

People's nutritional needs and dietary requirements were assessed and we saw evidence of involvement with relevant healthcare professionals to support people to maintain good health

Is the service caring?

Good

The service was caring.

People using the service provided positive feedback about their care and said care workers treated them kindly and with respect.

Care plans identified people's cultural needs and the provider tried to match people with care workers who could meet these

needs.

Staff we spoke with understood people's right to choose and supported people to make day to day decisions about their care.

Is the service responsive?

Good

The service was responsive.

People and their families, where appropriate, were involved in planning people's care. Care plans included people's preferences and guidance on how they would like their care delivered. Reviews were held at least annually.

The service had a complaints procedure and people knew how to make a complaint if they wished to.

Is the service well-led?

Good

The service was well led.

The managers had a good overview of the service and people's needs.

People using the service and care workers felt able to approach the managers and said they listened to concerns.

The provider had a number of data management and audit systems in place to monitor the quality of the care provided.

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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 announced inspection took place on 17, 18 and 19 October 2017 and we gave the registered manager two working days' notice as the location provided a service to people in their own homes and we needed to confirm the registered manager would be available when we inspected.

The inspection was carried out by one inspector and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, we received a Provider Information Return (PIR). This 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. Additionally we looked at all the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We contacted the local authority's Commissioning Team and Safeguarding Team for their feedback about the service. We also contacted fifty people by telephone for their feedback. We spoke with fourteen people who used the service and eight relatives.

During the inspection, we spoke with the registered manager, a director, the operations manager, a care co-ordinator and seven care workers. We looked at the care plans for 20 people who used the service. We saw the employment files for ten care workers which included recruitment records, supervision and appraisals, and we looked at training records for all staff members. We also viewed the service's checks and audits to monitor the quality of the service provided to people.

Good

Is the service safe?

Our findings

People using the service told us they felt safe and relatives said, "They [care workers] are safe, they are good to her", "Very, very safe. I trust them very much. My relative and I feel very comfortable with [care worker] and we recommend him very highly" and "Yes, definitely safe because we are very comfortable with [care workers]. We watch them and we feel he is safe."

Care workers we spoke with were able to tell us what the types of abuse were and how to respond. This included telling the person that they needed to pass the information onto the relevant agency even if that was not what the person wished. One care worker said, "I would report [suspected abuse] to the co-coordinator and if they don't take action, I would report to the manager and if they don't take action, whistle blowing comes in and I report to the Care Quality Commission."

The provider had a 'disaster recovery and business continuity plan' and up to date policies around safeguarding adults, whistleblowing and financial abuse. The provider had systems in place to help investigate and deal with allegations of abuse. We saw MNA had a safeguarding investigation report template which detailed the background, methodology, findings/ conclusion and learning/outcomes for each safeguarding alert. Relevant documents and records were included in the file for each safeguarding alert as evidence contributing to the provider's investigation. We also saw notifications to the Care Quality Commission were made appropriately. This meant that the provider's procedures for safeguarding adults helped to protect people using the service from the risk of abuse.

Individual risks were assessed and there were measures in place to minimise identified risks and keep people as safe as possible. The provider had a risk assessment form that covered a number of areas of risk including, the person's environment, bath and shower assessment, pressure sores, fire safety and finance. The document included the initial medicines risk assessment and we saw this was reviewed annually on a separate form. We also saw a moving and handling assessment and risk management plan. The risk assessment was signed by the person using the service and the assessor and a review was held a minimum of annually.

The provider used a standard incident and accident form that did not specifically record the learning outcomes, however each form also had email correspondence with the local authority to detail what action was taken. The registered manager said in future they would ensure incidents were recorded with outcomes and actions on the actual incident and accident form.

The majority of people stated that they preferred to have regular care workers and the service was consistent whenever possible. Comments included, "[Relative] is comfortable with the same [care workers] that come. They know how to use the equipment and their timekeeping is excellent – we're happy", "I have the same ones most of time", "I have only had one most of time. She is very good. I ask for her" and a relative said, "I really like MNA as we haven't had a lot changes with [care workers]. We have one main carer and the same one on a Sunday night."

All the care workers we spoke with said they had enough time to get from one visit to the next. We looked at the timesheet print outs for ten care workers and a further ten print outs for ten people using the service. The majority of calls were being carried out during the allocated time. Care workers told us, "I don't have problems with timing [getting from one call to the next]", "We can be flexible and do a 9am call at 7am if [person] is going to hospital" and "We all have PIN numbers to log in with. Before we touch the phone, we have to ask the service user. When you finish, you log out. The office does check it very often."

The provider had systems in place to ensure care workers were suitable to work with people using the service. We viewed ten employment files for care workers. The provider followed safe recruitment practices and files contained a number of checks and records including applications with a photo, interview records, two references, identification documents with proof of permission to work in the UK if required, a medical fitness assessment, supervisions, observational spot checks and criminal record checks.

People using the service said care workers knew how to administer medicines correctly and told us, "She puts my cream on properly. She asks if the cream is alright or if I want more" and "I am happy with how they do my medication." Relatives said, "The carer in the morning gives her a bed bath and puts lotions on her so she doesn't get bed sores" and "[The care workers] know his medication and understand about it. They know what to give him. He also has eye drops. We are happy with this support."

We looked at medicines management for 20 people and saw medicines were managed safely. The medicines policy dated April 2017 included a separate PRN (as required) medicines guidance and ear, nose and eye drop guidance. In some people's files we saw additional information sheets for some medicines and their side effects. All care workers had undertaken medicines training in the last year. The provider undertook monthly medicines audits of 10% of the people being supported with medicines and we looked at 20 of these audits including the medicines administration records (MAR). Each person had an individual audit that looked at various areas and had actions. If the action was to have supervision with a care worker, a copy of the supervision notes were attached to the audit to demonstrate what action had been taken. This meant that the provider had arrangements in place to help protect people from the risk of not receiving their medicines as prescribed.

Good

Is the service effective?

Our findings

When we asked people and their relatives if the care workers were skilled enough to meet their needs, comments included, "I have had very good treatment from the group of carers",
"Yes I am satisfied with [care worker]. She is very professional. She will go through the files and check them too", "They know what they are doing alright. We have not had any problems and we are quite happy with the service", "They know how to lift and move him, so they don't injure themselves or put him at risk. I feel [care workers] are experienced and they know what they are doing."

The provider had a checklist for the care workers' induction. This included training which was delivered in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to care workers roles and responsibilities within a care setting. Care workers had five days of training and then the new care worker shadowed a more experienced care worker with the people they would be supporting. People did say that although new carers generally shadowed an experienced carer to begin with, this did not always happen. A relative said, "When they bring someone new they shadow but this only happens during the week." Care workers had a handbook and also a small leaflet for easy access that provided guidance for providing general support. They were also given information about different topics such as type II diabetes, the Mental Capacity Act 2005 and dementia. The training database used a colour coded visual system and there was an electronic alert to indicate when training was about to become due. A care worker told us, "If they see you have potential, they're willing to help you progress."

Staff had the required skills and knowledge to meet the needs of the people using the service. We saw evidence of regular supervisions, appraisals and unannounced observational spot checks when care workers were providing support to people to monitor care workers' practice and gather feedback from people using the service about the care they were receiving. Care workers told us, "The supervisor comes and sometimes does a spot check", "We get supervision, spot checks, appraisals and office supervision." and "We get supervision very often. They ask you about the clients and concerns if you have done something wrong. They are very particular about medicines and you have to know when equipment is due for checks."

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. We checked whether the service was working within the principles of the MCA.

Each person had a consent to care and treatment form. If people had the capacity to consent to their care, they ticked what they consented to, for example personal care, and they signed the form. If people did not have the capacity to make specific decisions about their care, the record indicated a best interests decision had been taken. For people who did not have the capacity to consent to their care, the provider undertook a test of capacity. As well as recording if the person had capacity or not, it also asked if there were other legal

representatives involved with the person and had room for additional information such as, 'has dementia but can make decisions'. However we saw that the provider was not consistent in ensuring every file that required it, had a record of the capacity test. The registered manager told us they would go through the files to confirm each person had an up to date record of a capacity test if required. We also saw the provider had been checking with the Office of the Public Guardian to confirm who had legal power of attorneys in place to make decisions on behalf of some people using the service.

Training records indicated care workers had undertaken MCA training. One care worker we spoke with about consent to care said, "We should respect clients' decisions. People have different capacities. Some can make decisions on a daily basis and some can make all decisions." Another care worker told us they supported a visually impaired person. When supporting the person to dress, they took out three to four outfits for the person to choose from and told them about the colours and asked if the person was warm or cold so together they could find the right outfit for the person on that day and the person remained involved in the decision making process.

People we spoke with who said they received support with food and drink preparation and told us they were satisfied with the support provided. The care plans included information on nutrition including any specific dietary needs such as diabetes, allergies or soft foods.

Care plans provided appropriate information to meet people's day-to-day health needs. We saw emails to the local authorities confirming when MNA had contacted or requested a referral to GPs, nurses, medicines reviews, occupational health assessments, chiropodist and the speech and language team . One person stated they were happy with the assistance given by care workers to access medical support and said, "They keep an eye on my general health. They tell the district nurses if I have any problems and arrange for them come to me. They are looking after me."

Good

Is the service caring?

Our findings

People we spoke with described care workers as friendly, caring and knew their likes and dislikes. They said, "They are kind in everything they do", "Yes, they are kind in their manner and way they speak to me", "[Care worker] is very, very nice. I say we are like sisters. She is not rude or anything like that. She says 'good morning how are you?'", "They are caring. They come in they make sure I get a meal and make sure I have taken my medication", "They come in, say good morning and we joke together. This helps to encourage [person] to have his care", "She is very gentle with [person]. When she comes in she makes sure she is dressed properly and never handles [person] badly. [Person] is happy with her" and "The carer knows him very well. He doesn't like hot or cold water in the shower. He makes sure the shower is at the right temperature."

People's care plans recorded their cultural and religious needs and provided some background history. A co-ordinator told us they tried to match people with the appropriate care worker and areas such as language were taken into consideration, saying, "We try to support people with their own language. Give them that choice and it makes their lives better." A relative told us, "This particular [care worker] is skilled but the cover ones are not so good" [because once or twice the service sent care workers who did not speak the person's language]. Other comments included, "We are both from [culture] so he knows about our culture and has a very good understanding", "[Care worker] is aware when we are fasting, or when we are praying she knows not to come into the room. She acknowledges our celebrations. The [care worker] who comes can speak the same language as my relative so there are no language problems. She is happy as we have common roots" and "My relative doesn't want a lady carer he wants a man. They almost always send the same man otherwise [another male care worker] comes instead. He feels comfortable with them both."

People were involved in making decisions about their care. One person said, "I have a say in how we do things" and relatives said, "I feel involved with the care, they take good care of him", "They work with us as a team it works well", "[Person] can talk to [care worker]. It's the way that they ask questions before doing anything. For instance, we don't have meat in the house and they respect that. [Person] hasn't complained and he is most definitely the kind of man who would say if he was not okay" and "The carer works with the family. She is always in contact with us and keeps us up to date with how she (relative) is. She makes us aware of what is happening it is good teamwork." A care worker told us, "The first thing is to have a look at the file after you greet them. It is always written 'I like my care worker to….' Ask them. Don't assume what they want. Every person has different tastes on different days. Always go to have a chat with them to get to know them."

People told us care workers respected their dignity and privacy. Comments included, "Yes, If I tell I have a problem she never shares them with anybody. I tell everything to her so she can share it with the doctor and she has done this and I am happy with this" and relatives said, "Yeah she's very kind and the cover ones are too. She definitely respects my relative's privacy and dignity. She is very familiar with our culture and religion and knows her preferences too."

When we asked care workers what was important when they were supporting people with personal care,

they told us, "It is important to give them dignity and privacy. [Acknowledge] they are a person and have feelings. Take care of how you handle them. Ask them - even if they have a shower every day, they have the right to say I don't want it today", "I have to treat people as I would myself. Give them dignity. Tell them what you are going to do for them. Ask them about themselves. Encourage them, don't just interrupt them. Give them care, dignity and privacy. It's their choice and you have to respect their choice" and "Talk to them and keep them involved in the whole process. It's like teamwork between the service user and myself." People using the service said, "I can't stand properly, the carer holds me when she gives me a shower. She makes me feel safe" and "She asks how I want the shower water, I say warm and not hot." A relative said, "[Care worker] is very gentle with him and has a great sense of humour. She talks with him, makes a joke and this encourages him to do things."

Good

Is the service responsive?

Our findings

People told us they felt involved in their care and had their needs met. Comments included, "They come every month to collect the care plan. They always check the carer is polite and is she doing what you ask her to. I tell them she is very good", "She stays for as long as I need her. She's very flexible, we're a team", "They agency came and talked to me about my care.", "I was involved in the care plan and we had the majority say in it", "I was very involved in the care plan and it gets reviewed twice a year", "They do check [my care plan] and review it every six to eight weeks and amend the paperwork after we've discussed things", "Someone comes around every so often and asks if I am satisfied. I feel they are watching carers and checking everything", "My carer does everything that she needs to do", "I think they meet all my needs" and "Yes they do everything they are meant to do in every way."

There was a mixed response from the people we spoke with when they were asked if the care workers arrived on time. "No they're not on time; they're late most of the time", "You can tell the time by the carer who comes in the evening. The ones that come at the weekend can be late", "Within reason she is on time and she always apologises if she is very late. She always stays until she has done what needs to be done", "Always on time unless an unforeseen thing happens. They do not ring to let me know, I have to ring them. They stay for the right amount of time" and "Yes on time and stay for the right amount time." The registered manager told us that they monitored time keeping through electronic monitoring system print outs and that they were addressing the concerns over weekend care through recruitment and stipulating all care workers must work some weekends so there was consistency.

When co-ordinators received a care package from the local authority, they contacted the person and asked about their routine so they had a choice about call times. As some people were coming directly from hospital it was not always possible to speak to them before the first visit. Supervisors tried to go out on the first visit with the care worker to do the risk assessment and go through the care notes with the person. People had service user agreements, support plans and re-enablement assessments from the local authority who commissioned the service. These were used as the basis for the initial care plan. If however the person was referred privately, the service undertook a care needs assessment prior to completing the care plan.

People's care plans identified how they wanted their care and support to be provided. Care plans had information about people using the service including contact information, some family background, their preferred name, their ethnicity, medical history, income, their current needs, for example requires a hearing aid, refuses incontinence pads, and has poor short term memory, the care objectives and why they required a care worker. It also recorded the various calls on each day and provided a summary of what tasks the care worker was required to complete during the visit. The care plan gave guidelines on how to administer medicines and the level of support people required. Files recorded known allergies, skin conditions or other relevant information, such as diabetic, poor eyesight, or depression. Care plans were signed by the person using the service and the assessor and dated. The care plan was reviewed annually and reviews were flagged up on the system through alerts.

There was an appropriate complaints procedure and the complaints policy was in several languages including Hindi, Polish, Urdu and Punjabi. The service user guide included the complaints procedure and contact details for the registered manager, local safeguarding teams and the Care Quality Commission so people knew who to contact if they wanted to make a complaint or raise a concern.

The complaints folder had a log at the front for the year and headings with a general written summary and learning for the year. This noted that as most complaints involved care workers, they were asked to come in for supervision, coaching and refresher training as appropriate. The local authorities required the provider to use their complaint forms, so although the provider did have their own complaint form, the complaints we saw were recorded on local authority forms. These forms included outcomes and quality visits done if required, supervisions and warning letters to care workers and letters to the people raising the complaint as required.

People said their complaints were addressed appropriately. "Yes they do listen. On those two occasions when I complained, they were very apologetic and we were satisfied with their responses" and "It's the consistency of having the same worker. There were a few hiccups with covers doing the wrong times but they sorted things out immediately. I'm very pleased with the response."

Managers and co-ordinators told us there was continual and ongoing liaison with people using the service, families and other professionals so there was a good line of communication. They also told us that for some people using the service their contact for feedback was so regular, some people felt it was too much and this has been reduced accordingly for those people.

We also saw all conversations with people were recorded in people's online files which the office staff used. If a concern rather than a formal complaint was raised, the co-ordinator completed a home visit to the person.

We saw a number of compliments that included one from a relative in July 2017, "…we write in acknowledgment of the excellent carer support afforded to [person] by [staff]… diligent, helpful, enthusiastic, willing and thorough in every aspect of his care" and from a local authority also in July 2017, "Prior to MNA starting, [person] was noncompliant. MNA have sent in the same carers for all calls, therefore there is continuity and [person] has now built a rapport with the carers."

Good

Is the service well-led?

Our findings

People we spoke with said they knew how to ring the service and they felt listened to. Comments included, "I ring to change an appointment, they do as I ask", "I have their number I can talk to them" and "I phone them if the carers don't get here on time and they don't phone me. They do listen and sort out the problem." Overall people and relatives felt MNA provided a good service and told us, "On the whole I am satisfied generally I happy with them", "They are very good, I am getting a good service", "It is good. We couldn't wish for better treatment", "They are good as I am happy with my carer", "Yes they communicate well, we cooperate with each other and they keep us abreast. We are thrilled she is being looked after well" and "The carer is a very good, kind gentleman. He is doing his job properly and doing what my relative wants."

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law. The service was a family run business and the registered manager was also one of the directors and owners. When we asked care workers if the management team was available and listened to them, they told us, "It's a family based organisation and I've always felt very comfortable with it. Management take on board everyone's opinion and it is sought after so everyone is comfortable in what we're doing", "They do support me. If you have a concern they follow it up, advise you and make a change" and "The directors operate an open door policy. Just knock on the door. They listen to everybody. We get support. Anything work related they're here to help us as many times as we want. They say we are all a team to work together."

Management meetings were held monthly and we saw topics raised included local authority audits, recruitment, training and complaints. Visiting officers had a quarterly meeting and office staff meetings were held bi-monthly. Care workers meetings were held bi-monthly. Minutes included a discussion of policies and recent incidents so there was consistency in the way care workers responded to incidents. The minutes were displayed on a communal board and the registered manager said their intention in the future was to email them to everyone. About team meetings, care workers said, "They call us in and have a meeting. Mostly they ask what is happening out there. They are helpful. They try to advise", "We discuss issues, for example a missed visit is a safeguarding alert or make sure clients are hydrated, so all out colleagues know [what the procedure is]" and "Everybody can say their mind. All the managers and co-ordinators come. Any carers that are not happy – they will review the issues."

The provider carried out a number of quality assurance checks including home visits and telephone calls to ask for feedback on service delivery. The home visits were signed by the person and the assessor. The last service user surveys were carried out in December 2016 and about 180 people responded. We saw a summary, analysis and follow up actions. The majority of respondents rated the service and care workers as 'good' to 'excellent'.

The registered manager attended provider forums in all four of the local authorities they supported people from, a specific registered manager's meeting and accessed training with the local authorities. They received emails from Skills for Care and the United Kingdom Homecare Association (UKHCA) to keep up to date with

current practice.

Additionally one local authority told us the service took part in a "Discharge to Assess" pilot for a period of five months that was run by the Clinical Commissioning Group and the local authority. "Feedback that the Contracts Team received from the Hospital Team during this pilot period was that they were very pleased with MNA's approach, responsiveness, collaborative working and their positive, timely and professional response."

The provider had systems in place to monitor quality in the service and we saw that audits were well documented with clear outcomes for people with actions where improvements were needed. The provider undertook a sample audit of people's communication logs each month which was a tick list and an action. We saw that if a communication log was not completed satisfactorily by the care worker, they were called in for supervision to discuss the issue.

The provider undertook monthly audits of the financial records completed by care workers if they handled people's money, for example to go shopping for the person. We looked at ten people's financial audits and saw they were recorded correctly, except for one care worker who had written over their figures on the financial transaction sheet. As an outcome of the audit we saw this care worker had been supported with supervision specifically around finances after the audit and a copy of their supervision record was attached to the audit.

The provider also completed a six monthly audit of people grouped by local authority to review why care workers could not gain entry into people's homes. This included a post audit learning and action to be taken to improve future service delivery.

The provider's IT system had a number of alerts set up on each person's file, for example when they came to the end of a re-enablement package, when the care plan review was due and when home visits or phone contact was due. Dates were kept on a separate spreadsheet so there was an overview of the whole service. Staff employment and training information was also kept on a database that showed when criminal checks, supervisions appraisals and training were due. The service had a development plan for improving performance dated April 2017. The monitoring and auditing systems that were in place to monitor the quality of the service delivered ensured peoples' needs were being met and areas where improvements to care could be made were identified.