Mr Raju Ramasamy and Mr Inayet Patel

Manton House

Inspection report

5-7 Tennyson Avenue
kings Lynn
Norfolk
PE30 2QG

Tel: 01553766135
Website: www.abc-care-solutions.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this home on 13 and 14 April 2016. The inspection was unannounced.

Manton House is registered to provide accommodation and personal care to a maximum of 22 people. People living at the home are older people, some of whom live with dementia. There were sixteen people living in the home when we inspected.

There was a registered manager 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.

Staff understood how to protect people from harm and from the risk of abuse. They understood their responsibilities in keeping people safe. Risks to people's safety had been assessed and actions taken to reduce these risks.

Recruitment processes were in place to ensure that staff employed in the service were suitable for the role. People received their medicines when they needed them and the staff had received enough training to enable them to provide people with effective care. Staff were confident in reporting incidents and accidents and appropriate action was taken when one occurred.

Staff did not always ask people for their consent and people were not always assumed to have capacity to make choices. Staff at times respected people's rights where they were not able to consent to their own treatment. The home was inconsistent in its' compliance with the requirements of the Mental Capacity Act 2005 (MCA).

People were supported to access healthcare professionals when needed and in a timely manner, with prompt action taken in response to changes to a person's health needs. People received enough to eat and drink to meet their needs, however they were not empowered to make choices of food prior to eating.

Staff had good knowledge about the people they cared for and understood how to meet their needs individually. People received most care according to their preferences and people and relatives were consulted about their care when coming into the home.

Some activities were carried out in line with people's preferences, however there was not enough stimulation and a variety of planned activities.

Although staff were caring towards people, practices did not always respect people's privacy when entering their rooms and their dignity at mealtimes. We have made a recommendation about seeking more current guidance in respect of dementia care. Staff were kind and compassionate. They consistently demonstrated

humour and warmth during their interactions with people. Feedback from people and their relatives about the care they received was complimentary..

Staff were well motivated. There was good teamwork within the service and staff felt supported in their roles.

Feedback was not actively sought from people using the service and their relatives so any action could be taken to improve. There were some systems in place to assess and monitor the quality of the care provided, however feedback was not always acted upon.

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 were supported by a sufficient number of competent staff.

Risk assessments were in place for individuals and the environment and these were followed to minimise avoidable harm. Risks to people's safety had been assessed and actions taken to minimise these risk where possible.

People received their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not always effective.

The staff had received enough training to enable them to provide people with effective care, but competency was not formally reviewed.

Staff did not always seek consent, and people were not always supported to make their own choices.

People had timely access to healthcare services and staff followed advice given from healthcare professionals.

People's nutritional and hydration needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

There were some practices in the home that did not promote choice, privacy and dignity.

People living at the home, visitors and health professionals felt that staff were kind, thoughtful and caring.

People and their relatives were involved in making some decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always provided with a range of suitable one to one and group activities that met their needs and preferences.

Individual preferences were not always actively sought.

Complaints and issues raised were acted upon in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service did not always seek or act on feedback from people using the service.

The culture of the staff in the home was positive and the manager was well supported.

Manton House

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 inspection took place on 13 and 14 April 2016 and was unannounced. It was carried out by one inspector.

Before the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

During the inspection, we spoke with five people living in the home, five visitors and a visiting healthcare professional. The staff we spoke with included the registered manager, the deputy manager, five care workers, the cook and the activities coordinator. We also spoke with a quality assurance member of staff from the provider's head office.

Some of the people in the home were not able to tell us in detail about the care they were receiving. We therefore observed how care was delivered by the staff throughout the day. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed care records and risk assessments for four people who lived at the home and checked a sample of medicine administration records.

We looked at staff training records and reviewed information on how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

People visiting the home said that they felt confident that their relatives were safe. All the staff we spoke with knew how to protect people from harm and were able to identify different forms of abuse. They also knew how to report any concerns if they had any. The staff training records confirmed that they had received safeguarding training. Staff explained how they would report and deal with any bullying or harassment or concerns about poor practice should they arise.

Care plans contained detailed assessments of risks for individuals covering areas such as manual handling, continence, sleep, health conditions, tissue viability and nutrition. One care plan we looked at had some incomplete sections, however staff were able to tell us how they looked after people individually. Accidents and incidents were reported and acted upon appropriately in a timely manner and records reflected this. People who had falls had their falls risk assessments reviewed and the falls team were involved in reviewing their mobility.

People's risk of developing pressure ulcers was assessed, regularly reviewed and preventative measures were taken by staff. Staff told us that someone had come into the home with a leg wound due to poor skin integrity and that this was attended to by the district nurse and recommendations were followed by the care staff. Where recommended, pressure relieving equipment and cushions had been provided. Repositioning charts were used to help prevent pressure areas, and preventative creams were used as prescribed. This meant that staff knew what signs to look for and that systems were in place to minimise the risk of people developing pressure ulcers.

We found that equipment for detecting, preventing and extinguishing fires was tested regularly. We saw that staff had received fire training the manager was able to tell us what action would be taken in the event of a fire. People living in the home did not have individual evacuation plans, however there was an overall evacuation plan for the home in place. We advised the manager that personal evacuation plans were recommended, and they informed us that they would gain more advice from the fire officer.

Lifting equipment was serviced as required and environmental maintenance and risk assessments were in place to make sure that the premises where people lived were safe. Safety checks included PAT testing and fire alarms, and the emergency lighting had been serviced and tested regularly. Other safety records we looked at included gas safety, hazardous substances, water regulations and water temperatures, liability insurance and food hygiene, as well as business contingency emergency plans which had all been reviewed and recorded appropriately.

One person visiting the home told us, "Staffing levels are good most of the time. There are mostly plenty of them around." They said that there were less staff in the evenings but that it was not a problem. A healthcare professional visiting the home said, "We're never left waiting for staff. There are always plenty of people around, the staff are always with people." The manager used a dependency tool to ensure staffing levels met the changing needs of people living in the home, and people felt that there were enough staff to spend time with them. The home did not use any agency staff and were able to use their own staff to cover sickness and

annual leave.

The provider's recruitment policies were robust, and so contributed to promoting people's safety. Appropriate checks were made before staff were recruited, such as criminal records checks and references. This showed that a rigorous approach had been taken to ensure that only people deemed suitable, in line with the provider's guidance were working at the service. Many staff were qualified with NVQs in Health and Social Care.

Medicines coming in and out of the home were audited regularly to ensure that people had received their medicines as the prescriber intended. We saw that there was a system in place for documenting medicines safely which came into the home with new people. There was also a comprehensive recording system for medicines that were returned to the pharmacy. This helped to ensure that people had their medicines readily available and organised and that any unused medicine was disposed of safely. Medicines were stored securely and kept at the correct temperature, which meant that they were kept according to recommendations and be safe to use. They were locked away and could not be accessed by any other than staff who were trained to handle medicines.

Medicines were managed and administered safely and higher risk medicines were double checked where necessary by staff who were trained to do so. We looked at some medicines administration records and saw that these had been completed correctly and that they indicated that people had received their medicines when they needed them. 'As required' medicines were administered appropriately and any allergies were highlighted. This meant that staff had important information about potential risks to people on each page of their medicines chart therefore lowering risk of error. Each chart was labelled with a front sheet showing the person's photograph as well as details so they were easily identified to minimise the risk of giving the medicine to the wrong person. With high risk medicines, records confirmed that they were managed and monitored appropriately.

Requires Improvement

Is the service effective?

Our findings

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 interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called 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 were being met. We asked the manager if there was anyone living in the home who was subject to a DoLS authorisation. The manager told us that applications had been made for some people due to them living with dementia. We looked at the applications present in some files and found that they had been made. However, capacity assessments did not cover specific decisions and allow for varying capacity. According to the MCA, a person's capacity must be judged in terms of their capacity to make a particular decision at the time it needs to be made, and not their ability to make decisions in general.

We found that during mealtimes, all people in the home except one, who had refused, were given tabards to cover their clothes and consent was not sought with each person for this at the time. They were routinely given plastic cups and bowls, unless the person or their relative had asked for a different option in response to this. We saw that people were not asked for preferences regarding crockery and the tabards before eating or when first coming into the home. When asked, the manager stated that these precautions were due to the fact that the people were living with dementia in the home. This approach did not assume that anyone had the capacity to make the decision at the time, or allow for positive risks to be taken. We observed, and it was confirmed in care plans we looked at, that people could stay in their room to eat when and if they chose to.

All of the staff we spoke with and some visitors to the service told us that people were not given a choice every day of what they would like to eat for lunch. One staff member stated they thought it would be better if they had more choice for breakfasts. Staff told us that if a person did not like what they were given, they would get something else but they were not given a choice beforehand as a matter of routine. Visitors told us that they felt it would feel better for the person if they were empowered to make a choice about what they wanted for their meals as they were still able to choose and remember some information. When asked, the manager informed us that most people wouldn't remember what they had ordered due to living with dementia. This meant that people were not being offered a choice and individual preferences not respected. The manager told us that people were offered something else if they did not like what was on offer that day, and people confirmed that this was the case. The manager showed us pictures which could be used to help people see what they would be having for lunch, however some staff told us that these were not used.

A person living in the home said, "The food is excellent", and this was echoed by another who said it was very good. All food was cooked on the premises. People were supported to eat and drink a sufficient

amount. The cook was able to explain what people liked and disliked as well as tell us who was on a special diet. The cook showed us records of food temperatures, cleaning records for the kitchen and shopping and menu lists. This confirmed that effective systems were in place for ensuring food supplies were always kept and that meals were cooked in a safe environment. The home had been given five stars for food hygiene. The cook told us they would always make something else for someone if they asked. He was able to show us that he catered for people who required a specialist diet, which meant that provisions were equally available to everybody living in the home.

Fluid charts were used in people's bedrooms where the person had been deemed as being a risk of not drinking enough. These confirmed that people were receiving enough drink to meet their individual needs. We noticed that drinks were available to people throughout the day, both in communal areas and in their own rooms, and that staff offered people drinks regularly who required support to have them. People's weight was monitored and recorded in care plans so that action could be taken if needed to refer to a dietician. The records in a bedroom we looked at completed daily by staff showed that fluid and repositioning had been recorded and matched the instructions stated in the care plan. Information regarding people's support needs in respect of nutrition and hydration was consistent.

Staff told us they did not have regular supervisions or appraisals and their competencies were not formally reviewed. There was a policy in place that stated the staff should have supervisions and appraisals throughout the year, however these had not been completed. All of the staff we spoke with told us that they felt well supported and informally discussed any issues with senior care staff and the manager if they needed to. One carer said, "If I'm ever stuck with anything, they're always happy to help."

We spoke with some staff that had joined the service within the last year and they told us about their induction training. They said they had three day inductions of shadowing and their mandatory training. The mandatory training set out by the provider included manual handling, infection control, first aid, challenging behaviour and safeguarding. Staff were able to explain how they carried out manual handling, using equipment safely, and records confirmed that they had regular training within this area. It was noted that one member of staff who supported people with meals had not had food hygiene training, however the manager informed us that this would be done in May. Staff said that they felt they had received adequate training to carry out their roles effectively. However, we observed that consent was not always sought when providing people with support, and that there was no formal procedure for checking staff's competency regarding the principles of the MCA. We saw that training was carried out regularly for most staff but that they did not use supervisions appraisals to monitor performance

People living in the home were supported to access healthcare promptly when they needed it. This included regular visits from the district nurse and a chiropodist. We saw that the manager contacted a GP promptly whenever necessary. A visiting healthcare professional on the day of inspection reviewed some people for their mobility, and acknowledged that the staff followed their recommendations. The deputy manager informed us that they obtained advice from the continence team when necessary, and the manager informed us that a dentist visited whenever needed.

Requires Improvement

Is the service caring?

Our findings

Whilst the majority of staff promoted people's privacy and dignity there were some practices that did not. Some people living in the home shared a room, but the staff told us that there was a curtain between the beds which could always be used to preserve the privacy of individuals. Staff told us that they always covered people up during personal care wherever possible. One carer said, "When we are doing something we always tell them what we are doing…" and that this provided reassurance to people.

However, we noticed that staff did not knock before entering people's rooms. When asked about this, the manager said that people were likely not to hear. We concluded that whilst a lot of staff practise promoted people's privacy, this aspect impeded it to some degree. Where active choice had not been offered with regards to using tabards and plastic crockery at mealtimes, this could also compromise people's dignity. Although staff showed caring attitudes towards people, there was some lack of understanding in the home about caring for people with a dementia-related illness.

The people we spoke with told us that the staff were kind and caring. One person living in the home told us, "The people [staff] are brilliant, they're very polite. There's no shyness, you can have a laugh and a joke with them." Another told us, "I can't fault them." Visitors to the home said, "The staff are really friendly, that's the main thing." Another visitor said, "Nothing is too much trouble for them."

We observed caring interactions between staff and people living in the home and reassuring contact such as hand holding, and staff ensuring that people were comfortable. One carer said, "You have time to sit with them, rather than just doing things, washing, even if it's just ten minutes to hear their stories." Staff emphasised that they knew the people living at the home well and this was reflected by visitors. Visitors told us how their relative was made to feel special on their birthday as the cook had made a cake especially for them, and they told us that they did this for everybody's birthdays. We noticed some cards to thank the home staff which were complimentary to people's care.

Staff were able to give examples of how they communicated in day to day care to promote choice in terms of providing personal care. One carer said, "When I get [person] up in the mornings I always ask her what she wants to wear." When asked about facilitating choice, other staff added that they used different sorts of communication to try and optimise people's choices, "Sometimes with a facial expression you can tell whether someone likes something or not". Another staff member said, "You've got to gesture and speak clearly. Some people who don't speak much will still give an answer." Another carer explained how they have learned about dementia and how to communicate with people, "Go with their world, not correcting them."

Staff told us how they promoted privacy and dignity for people. One member of staff described how they treated people as according to their wishes, and how they maintained people's dignity whilst carrying out personal care and ensuring that care was carried out whenever it was needed. They said that people's dignity was important, saying, "They are a member of society just like us." All visitors to the home that we spoke with told us that their relatives were always clean and tidy, and this was how they liked to be. One

visitor said, "[Relative] has always got clean clothes on."

Relatives were involved in care planning where appropriate. Where relatives had made suggestions, they were acted upon. For example, one visitor told us that their friend liked to have a drop of sherry in the evenings and that this was given by staff. People were supported to maintain their personal relationships. Staff told us how they made people welcome in the home at any time by offering them drinks, and ensuring that they built a strong relationship with families. This was reflected by visitors we spoke with. The manager told us that they always invited the families to parties and celebrations that they held.

We recommend that the provider seek more current guidance around dementia care.

Requires Improvement

Is the service responsive?

Our findings

People were sometimes supported to follow their interests. Some people who lived at the service stated that they enjoyed cooking but there was no provision in place for them to be offered this as an activity. The visitors we spoke with felt that people did not get enough physical activity such as walking around during the day, and that this was partly due to not having a separate dining area that people could walk to. One visitor said, "I'd like to see [relative] walk more as she was really active and now she sits in the chair all day." All the visitors to the home that we spoke with told us that they would have liked to see more activities. Staff echoed this but one carer said, "When we get time we pull something out to do with people." The staff we spoke with all felt that people would benefit from more stimulation and that the current activities weren't enough, and this was reflected in results from the staff survey.

There was an activities co-ordinator who worked part time during the weekdays. We spoke with the activities co-ordinator who told us that they carried out various one to one activities including knitting, jigsaws, reminiscing and dominoes with people. With people who were unable to participate in these activities, she did hand massages and nail care whilst talking to people. The manager stated that they have occasional visiting entertainment and parties. The manager told us that one person had an occasional visit from a minister but that she would contact someone in respect of any individual's religious wishes should they or their family request it. We observed people playing skittles in the lounge in the afternoon with the care staff.

There was not an activities programme in place for the week or records of activities planned. Group activities were therefore limited and there was not a provision for trips out. The manager stated that they would make a plan for some weekly activities to be put in place. Both staff and visitors told us that there was no designated dining area. They said that they felt this would help break up the day, get people moving and get people together for mealtimes for more stimulation. The manager told us that they had recognised this and that plans were in place to develop a room within the service into a dining room as part of the redecoration process.

People received personalised care. Care plans contained guidance for staff about the support people required in relation to their health, social and personal care needs. One visitor told us that staff had adapted to their relatives' changing needs relating to memory loss very well over the time they had been living in the home. One member of staff said, "Every time we approach someone we assess whether there are any changes to their needs or not." Staff were able to tell us about each person's individual needs. One person who had changing continence needs had recommendations documented in their care plan. Care plans were reviewed monthly or added to any time if there were changes and included personal preferences and routines. People's care plans included a 'map of life' which documented some of their life experience on one page so that people could gain some information quickly about people.

In one person's care plan, there was inconsistent information, stating that a mental capacity assessment was not necessary when there was one in place further in the care plan. It did not include details of the person's beliefs and these parts were left blank. We concluded that although there were gaps and errors in

some care plans, staff knew about people's needs due to communicating well with each other and knowing the people well. The dependency tool also reflected changing needs when somebody's health may have deteriorated leading them to need more time for personal care. Each day between shifts, a verbal handover was used to update staff on any changes or events that had happened.

Visitors to the home said that if they have had any complaints or questions, the manager was very approachable and either resolved things straight away, or given a good reason for something. Another visitor said, "The manager is very pleasant, if there was anything wrong we would feel comfortable to highlight it to her." Two visitors told us that on occasions, their relatives clothes had been mixed up, but that it had been dealt with by the manager promptly. There was a complaints procedure in place and accessible to people, but people felt they could always talk to the manager rather than make a formal complaint.

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Requires Improvement

Is the service well-led?

Our findings

There were some effective quality assurance processes in place, but they were not always acted upon proactively and could be improved to facilitate analysis of the service quality and drive improvement. The provider had limited systems in place to ensure themselves of the standard of the service and drive improvement where possible. The views of people or their relatives about the care they received had not been actively sought, but the manager told us that the only negative feedback was around the car parking facilities. These could not be changed due to the space available. The provider carried out some infection control monitoring visits to the home, which was being carried out on the day of inspection. Following this, the manager addressed any minor concerns immediately. The manager told us that an external pharmacist also occasionally performed checks on people's medicines. The manager and deputy carried out daily and monthly audits for medicines to ensure mistakes had not been made in administering them.

We found that people felt the activities needed improving and that more choice of food should be available. When discussed with the manager, they told us that they did not formally seek the views of people on a regular basis and were not aware of these issues. The provider monitored the quality of the service by asking staff for yearly feedback. Quality assurance material had been analysed from the staff questionnaires, and these were generally positive. The staff quality assurance survey had picked up that staff felt that they were well-informed about people's individual needs when they came into the home. However, where the staff survey had picked up some areas for possible improvement, actions had not been identified and taken forward, including some comments on social activities.

The service had a positive working culture with a low staff turnover. Most of the staff we spoke with said that everyone got on well working as a team. The manager was very visible around the home. One person living in the home said, "[Manager] comes to check on me a couple of times a day". A healthcare professional visiting the service told us that they felt the manager was approachable and helpful. A visitor said, "As a manager she's quite hands-on." We noticed that the manager spoke with everyone living in the home and had positive interactions and good rapports with people. Staff told us that they felt well-supported and able to openly discuss things with their peers, seniors and the manager. We concluded that there was a positive, caring culture of the team working together. Some staff told us that they did not take proper break times, but that it was not a big problem.

The manager told us that they felt well supported by the provider, and if any resources were needed they were provided very quickly. There was whistleblowing information easily available to staff. The manager had made contact with the Care Quality Commission (CQC) when appropriate to submit notifications about safeguarding incidents. We concluded that although the culture of the staff team was positive, there was not active feedback gained from people and relatives such as meetings about the service to help drive improvements to the care provided.