Kintyre Care Centre
Care Home Service

Shore Street
Campbeltown
PA28 6BS

Telephone: 01586 553615

Type of inspection:
Unannounced

Completed on:
25 July 2024

Service provided by:
Argyll and Bute Council

Service provider number:
SP2003003373

Service no:
CS2023000081

HAPPY TO TRANSLATE

About the service

Kintyre Care Centre is a care service that provides nursing care for 38 older people, including people living with dementia. The provider is Argyll and Bute Council.

The service is based in Campbeltown, close to shops and local amenities. There are car parking spaces available next to the home.

Residents have access to a communal lounge and dining facilities on each of the two floors of the home. The accommodation offers single bedrooms for all residents with en suite toilet facilities. Shared bathrooms and shower rooms are available on each floor. There is an enclosed patio area which residents can access through the lounge area on the ground floor. There is lift access to the upper floor.

There were 34 people living in Kintyre Care Centre at the time of the inspection.

About the inspection

This was an unannounced inspection which took place on 21, 22, 23 and 24 July 2024 at varied times between the hours of 8:00 and 22:00. The inspection was carried out by two inspectors from the Care Inspectorate.

To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke informally with people using the service and seven of their family or representatives
- spoke with 11 staff and management
- reviewed Care Inspectorate survey responses from five family members, nine staff, and six visiting professionals
- observed practice and daily life
- reviewed documents
- spoke with two visiting professionals.

Key messages

- People's health and wellbeing were well managed by the service.
- Quality assurance and governance processes needed to improve to support service improvement.
- Staff training was not adequately monitored to ensure staff were able to maintain their skills.
- Environmental improvements were required to ensure a safe, comfortable and homely environment.
- Staff took time with people to deliver sensitive and individualised care.
- Personal plans were used well to support good care and were reviewed regularly.
- People had access to a range of well-planned and meaningful activities.
- The service had not met outstanding requirements and areas for improvement from the previous inspection.
- As part of this inspection, we assessed the service's self-evaluation of key areas. We found that the service had begun to use self-evaluation, however, further work is required to develop this approach to support improvement.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	4 - Good
How good is our leadership?	3 - Adequate
How good is our staff team?	3 - Adequate
How good is our setting?	2 - Weak
How well is our care and support planned?	4 - Good

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 4 - Good

We evaluated this key question as good because we found important strengths which had a positive impact on people's experiences and outcomes.

The service had health assessments in place which were regularly reviewed and updated as people's needs changed. Robust medication systems helped to ensure people's medication was safely managed and there was sufficient oversight and training for staff responsible for administering medication. Health assessments covered a range of areas including skin integrity, nutritional needs, and falls, and were carefully completed to reflect the level of care required. Feedback from external professionals confirmed that staff understood people's health needs and were confident about communicating changes and seeking support where required. This helped to ensure people's healthcare needs were monitored by the service.

Handover discussions between shifts reflected people's activity levels, mood and general wellbeing, but lacked detail about clinical needs. The service had been using an increased level of agency nursing staff to cover night shifts which can impact on the continuity of care. Handover information should be robust to ensure people's healthcare needs are accurately communicated and well understood by staff leading all shifts. (See area for improvement 1).

The service provided a range of meals and snacks which supported a healthy attitude to food and drink. Mealtimes were well organised and relaxed with people given the right amount of support to eat well. Food options were varied and people were supported to make choices about their preferences. Snacks and fluids were available throughout the day and night and sufficient monitoring and sharing of information was in place for people with particular nutritional needs. We asked the provider to review the range of diabetic options and to consider ways to improve the presentation of textured meals. This was to ensure people with specific dietary needs had access to a similar range and choice of well-presented and enjoyable meals as others.

Areas for improvement

1. To ensure staff responsible for leading shifts have clear information about people's healthcare needs, the provider should ensure that relevant clinical information is accurately recorded and shared at all shift handovers.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty' (HSCS 3.19).

How good is our leadership? 3 - Adequate

We identified strengths in local leadership which had a positive impact on people's experiences and outcomes. Improvements in governance were required to ensure people could consistently experience positive outcomes. We have evaluated this key question as adequate.

The manager of the service had developed quality assurance systems to monitor the quality of a wide range of areas of the service including personal plans, medication systems, complaints and accidents and incidents. Audits were completed regularly and analysed to help understand where improvements were required in the service. This information was shared with key staff through daily clinical meetings and wider staff meetings. There was good oversight of staff registrations with regulatory bodies such as the Nursing and Midwifery Council (NMC) and Scottish Social Services Council. This meant people were supported by staff who had been assessed as competent.

The service had transferred from another provider within the last 18 months and there was work ongoing to ensure organisational policies and procedures met the needs of the service. While the manager had good quality assurance processes at a local level, there was a lack of clarity about provider governance procedures. Policies and procedures in some instances didn't align with the needs of the service, including policies for medication which were based on hospital guidance not appropriate for care homes. (See requirement 1).

The service had a 'service improvement plan' in place which had been regularly updated to reflect ongoing improvement work. We asked the service to ensure the improvement plan included feedback from people and families to ensure people's views helped to identify priorities for improvements.

Practice observations were taking place which provided assurance that staff were regularly monitored and given feedback to develop their knowledge and skills. We asked the manager of the service to consider how the outcome of observations could be reflected in staff supervision discussions. This was to help identify and plan future training and development needs to improve care for people. (See What the service has done to meet any requirements we made at or since the last inspection).

The service had systems in place for recording significant incidents and accidents but these hadn't been consistently reported to the Care Inspectorate in line with good practice guidance. This meant we couldn't be assured all incidents were adequately reviewed. (See area for improvement 1).

People and their family members told us they felt confident to provide feedback to leaders in the service and that leaders were accessible and responsive. There were systems in place to record and escalate complaints and we saw evidence of involvement of external partners, including social work and health colleagues where required. This helped ensure people's rights were upheld where complex situations or concerns arose. We asked the provider to ensure people and families have access to advocacy support where there are areas of disagreement or dissatisfaction.

Requirements

1. By 31 March 2025, the provider must ensure adequate governance of the service. To do this, the provider must, at a minimum:

a) Ensure policies and procedures are in place which are appropriate for the service type. This includes, but should not be limited to, an appropriate medication policy and maintenance policy. Policies should be regularly reviewed and updated as required.
b) Ensure a process is in place for clinical supervision of the manager of the service.
c) Ensure a clear process is in place for oversight of local quality assurance processes.
d) Ensure the manager of the service is included in governance procedures and informed of the outcome of external audits or reports.

This is to comply with Regulation 3 (Principles) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

Areas for improvement

1. To keep people safe the service should ensure that, in the absence of the manager, there is a clear process for making notifications to the Care Inspectorate. All notifications should be made timeously in line with the guidance document 'Records that all registered care services (except childminding) must keep and guidance on notification reporting' (Care Inspectorate, 2020).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

How good is our staff team? 3 - Adequate

We evaluated this key question as adequate. We found some strengths which had a positive impact on people's experiences, but these only just outweighed areas for improvement.

The service used dependency tools to support staffing decisions, but this was not well reflected in support hours which were relatively static, particularly in the evenings. Staffing arrangements and decisions were not transparent or available to people using the service or their relatives.

Staff were deployed effectively during the day to meet people's personal care needs. We observed mealtimes which were well organised and provided sufficient time for people to have the support they needed. People benefitted from a warm atmosphere in the service because staff treated them with kindness and took time to get to know them well. Care staff were deployed by senior staff who demonstrated a good understanding of people's support needs. Staff worked together to ensure people's needs were met and ensure people were safe and comfortable. Staff gave positive feedback about their colleagues and told us the team worked well together. Staff told us they felt supported in their role and had access to senior staff when needed. Staffing numbers were lower in the evenings and did not reflect the assessed dependency levels of people using the service. People and families told us that they expected to wait longer for support in the evenings. We asked the provider to ensure staffing decisions were transparent and reflected the assessed needs of people at all times of the day. (See area for improvement 1).

Staff had undertaken some core training including safer moving and assisting and medication training. There was limited evidence of analysis of staff training or development needs. We had difficulty tracking the training staff had completed or when refresher training was due. This included mandatory training such as Adult Support and Protection (ASP). This meant we couldn't be assured that people were supported by staff who had undertaken sufficient training to meet their needs and protect them from harm or abuse. (See 'What the service has done to meet any requirements we made at or since the last inspection').

Areas for improvement

1. To keep people safe, the service should ensure that staffing numbers, skills, and deployment reflect the needs of the people using the service at all times of the day and night. Decisions about staffing should be transparent and based on the principles of the Health and Care Staffing (Scotland) Act 2019.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'My needs are met by the right number of people' (HSCS 3.15).

How good is our setting? 2 - Weak

We evaluated this key question as weak. We identified some strengths, but these were compromised by significant weaknesses which substantially affected people's experiences.

The service is relatively modern and designed to support independence for people with disabilities or additional support needs. The layout of the building supported people's mobility, including those who used mobility equipment and wheelchairs. The manager had used the King's Fund Audit 'Is your care home dementia friendly?' (Kings Fund, 2020) to identify improvements in the service for people with Dementia. This included improvements such as garden access and inclusion of Dementia friendly signage. This meant that the environment supported people to maintain as much independence as possible.

The service had an improvement plan which included a range of environmental improvements, some of which had been completed since the last inspection. This included improvements to lounges and people's rooms which were nicely presented and personalised. A new sensory room was available in the Davaar unit which was pleasantly decorated and peaceful. The new sensory room was not used during the inspection. We asked the manager to consider how this could be made more accessible to people who might not be aware of it.

Cleaning schedules were in place and were being followed by staff. Housekeeping staff took pride in their work and the environment was generally clean and tidy. Housekeeping staff we spoke to were not aware of the National Infection Prevention and Control Manual (NIPCM) which provides good practice guidance for domestic staff. We asked the provider to ensure housekeeping staff have sufficient training in Infection Prevention and Control (See 'What the service has done to meet any requirements we made at or since the last inspection'). We noted an ongoing issue with an unpleasant odour in the Davaar unit which has been subject to an Area for Improvement since 2022. This had not been resolved. Carpets in corridors in the Davarr unit were very worn and appeared to be beyond their usable life. This meant that people were not experiencing a comfortable, well looked after environment in all areas of the service. (See requirement 1).

Maintenance staff were completing day to day maintenance tasks well but there was no policy available in the service in relation to maintenance standards. (See requirement 1 under Key Question 2). Daily and weekly maintenance schedules had been developed which assured us that key maintenance tasks such as safety checks were being carried out. Equipment such as hoists, profiling beds, wheelchairs and sensors were regularly checked and maintained. Major safety checks for the fire system, extraction and electrical safety had been completed by external contractors with safety certification displayed on the premises. This contributed to the maintenance and safety of the building.

We observed equipment, boxes, and items such as laundry trollies stored in communal bathrooms and fire exits during the inspection. This posed a risk in the event of fire and hindered people's access to essential

communal areas. (See area for improvement 1). Only one assisted bath was available in the service due to a fault with the assisted bath in the Caledonia Unit. (See 'What the service has done to meet any requirements we made at or since the last inspection'). This meant that people didn't have easy access to bathing facilities suitable for their needs.

The fire safety assessment for the service was significantly out of date and actions from the Scottish Fire and Rescue Service (SFRS) fire safety audit had not been completed. There was no organisational fire safety guidance available in the service and while fire drills and fire safety training had been provided to some staff, this was not adequately tracked. This meant we could not be assured that sufficient fire safety measures were in place to direct staff in the event of a fire. (See requirement 2). We were given assurances during the inspection by the provider's health and safety team that the building was fire safe.

Some improvement work had been undertaken in relation to registration requirements identified at the last inspection. Some major works were still ongoing to improve the environment and were included in an updated environmental improvement plan for the service. (See 'What the service has done to meet any requirements we made at or since the last inspection').

Requirements

1. By 30 November 2024 the provider must ensure that the environment is safe and free from offensive odours. To do this the provider must, at a minimum:

a) Undertake an environmental audit to identify where improvements are required in the environment.
b) Produce an environmental action plan based on SMART principles (Specific, Measurable, Achievable, Realistic, and Time-based) that identifies the actions to be taken to improve the environment.
c) Take action to eliminate the odour in the Davaar unit.
d) Take action to eliminate the risk from electric heaters in communal shower rooms
e) Ensure people who use the service and their representatives have been consulted about environmental improvements and include their views in the action plan.
f) Ensure timescales for improvements are communicated with people using the service and their representatives.

This is to comply with Regulation 10(2)(d) (Fitness of Premises) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'My environment is relaxed, welcoming, peaceful and free from avoidable and intrusive noise and smells' (HSCS 5.20).

2. By 30 November 2024 the provider must ensure that sufficient fire safety arrangements are in place in the service which meet the requirements of the Practical Fire Safety Guidance For Existing Care Homes (Scottish Government, 2022). To do this the provider must at a minimum:

a) undertake a Fire Safety Risk Assessment
b) produce an action plan to address the risks identified in the Fire Safety Risk Assessment. This action plan should include timescales for the completion of required actions.
c) produce a schedule for reviewing the Fire Safety Risk assessment in line with organisational policy
d) ensure a clearly defined Fire Safety Policy is available for the service

e) ensure all staff are given information, instruction and training on the action to be taken in the case of fire and the measures to be taken or observed on the premises

This is to comply with Regulation 10(1) and 10(2)(b) (Fitness of Premises) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'My environment is secure and safe' (HSCS 5.19).

Areas for improvement

1. To ensure people have access to all communal areas of the service and to adhere to fire safety precautions, the provider should ensure that no unnecessary equipment or boxes are stored in communal bathrooms, lounges, corridors or fire escape routes.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I can independently access the parts of the premises I use and the environment has been designed to promote this' (HSCS 5.11).

How well is our care and support planned? 4 - Good

We identified a number of important strengths in personal planning which impacted positively on people's experiences and outcomes. We have evaluated this key question as good.

Personal plans contained good quality information about people's care and support needs in most instances, but some information could have been more clearly recorded. Where people have specific support needs, for example in relation to their dietary needs, personal plans should contain sufficient detail about the actions staff should take to support them. People told us they felt included in planning their care, but their involvement was not always clearly recorded. We asked the service to ensure staff have sufficient training and support to make sure personal plans follow good practice guidance such as the Guide for Providers on Personal Planning (Care Inspectorate, 2021).

Personal plans contained a range of useful assessments which had been carefully completed. Care planning in relation to managing stress and distress was done effectively. The service had close links with local mental health services which supported good practice in this area. Where supplementary charts were in use, for instance to record people's dietary intake or support with personal care hygiene, these contained useful information and had been thoroughly completed by staff. This meant that good quality records were available to identify changes in people's health or wellbeing needs which could be shared with external professionals where necessary.
Daily clinical meetings helped to ensure key information was shared appropriately in the team. This helped leaders to identify where external support was required. Professional visits and advice were recorded well in people's personal plans. Feedback from external professionals reflected that the service was open to external advice and made referrals appropriately.

Six-monthly care reviews were taking place. This meant that people and their representatives had opportunities to discuss their personal plans with those involved in providing their care. We asked the service to ensure they obtained a copy of review minutes or took their own minutes in all instances to ensure agreed actions were addressed appropriately. Risk assessments were used appropriately and we saw examples of people with complex health needs being supported to live full and active lives with the right support in place for them. Risk assessments were regularly reviewed and discussed with people and professionals where necessary. Leaders had a good understanding of people's legal rights, and the correct legal documentation was in place where people were assessed as lacking capacity for aspects of decision-making. This ensured people's legal rights were upheld.

The service provided a wide range of activities and opportunities for people to be connected to their local community. The team responsible for leading activities were skilled and motivated which supported people and the wider staff team to get involved in meaningful activity. There was a 'can do' attitude to activities and lots of ideas to ensure people who were less able also had opportunities to be involved. We asked the manager of the service to work with the activities team to reflect on how people's preferences about activities were recorded and how best to evaluate people's participation and enjoyment. This was to ensure activities continued to reflect people's preferences.

The service had discussed future care planning with people, but the quality of recording about palliative and end of life care choices varied. We asked the service to ensure sufficient time was provided to enable people and their families to make their choices known and to record these carefully.

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

By the 31 March 2024, the provider must ensure that people are able to access their monies when they wish and, to ensure that safeguards are in place to protect this. In order to do this the provider must:

(a) Ensure people can access their funds when they or a representative choose.

(b) Implement safeguards, to ensure that peoples funds are secure and managed in line with good practice.

This is in order to comply with Regulation 4 (1)(b) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state: 'If I need help managing my money and personal affairs, I am able to have as much control as possible and my interests are safeguarded'. (HSCS 2.5)

This requirement was made on 10 January 2024.

Action taken on previous requirement

The service had created a local procedure for managing residents' personal allowances in line with good practice guidance. Resident finances were reconciled weekly and tracked on a spreadsheet which was checked and signed off by the manager or depute manager of the service. People could access information about the money held for them at the service when they wished to do so. This meant that the finances held for people were tracked and they could access their finances when required.

Some residents still had a small amount of money which was 'frozen' in a holding bank account which the provider and residents cannot access at present. Residents in this situation or their representatives were aware of this and had records of the amount of money held in this account. The provider was continuing to work on a solution to enable people to access these funds.

Met - within timescales

Requirement 2

By 31 March 2024, the provider must ensure that people experience a service with well trained and informed staff. This must include, but not be limited to:

a) Ensuring that all staff receive an induction and training relevant to their role; including dementia care, communication, restraint and restrictive practice, medication and stress and distress training.
b) Regular quality assurance checks, to demonstrate how the training received is being implemented in

practice throughout the care service.
c) Regular monitoring of staff practice to provide assurance, that staff practice is consistent with current good practice guidance.
d) Regular staff supervision, to ensure staff learning and development needs are reviewed and addressed.

This is in order to comply with Regulations 9, (2)(b) (fitness of employees) and 15, (b)(i)(staffing), of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes'. (HSCS 3.14)

This requirement was made on 10 January 2024.

Action taken on previous requirement

The service did not have adequate records of staff training, including some mandatory training such as Adult Support and Protection (ASP) or dementia training. Staff competency checks were taking place and staff had access to supervision but these did not make sufficient reference to staff training and development. There was no analysis of staff training needs and no way of tracking when staff were due to complete refresher training.

This requirement was not met and we have agreed an extension until 30 November 2024.

Not met

Requirement 3

By 31 March 2024, the provider must operate within their registration conditions and meet the registration environmental improvement plan that is outstanding.

This must include but not be limited to:
a) Have 38 residents as a maximum number, and use the specified numbered rooms 17 and 37 only for short term respite stays.
b) Complete outstanding actions from the agreed environmental plan, that is part of the conditions of registration.

This is to comply with Regulation 14. (d) (facilities in care homes) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210) .

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that 'The premises have been adapted, equipped and furnished to meet my needs and wishes' (HSCS 5.18).

This requirement was made on 10 January 2024.

Action taken on previous requirement

The service has re-purposed rooms 17 and 37 for short term stays. The service now accommodates a maximum of 38 residents.

Some actions from the agreed environmental plan had been completed but a number of actions were still outstanding, including improvements to windows and exterior of the building.

We have asked the provider to produce an updated environmental action plan based on SMART principles (Specific, Measurable, Achievable, Realistic, and Time-based). This action plan must identify a realistic timescale for completing the outstanding environmental improvements.

This requirement was not met and we have agreed an extension to 30 November 2024.

Not met

Requirement 4

By 31 March 2024, to improve the safety and accessibility of the environment for people supported the provider must:

a) Ensure that all maintenance tasks are actioned in a timeous manner including, working assisted bathing options.
b) Address actions from the Kings Fund Tool using specific, measurable, achievable realistic and timely (SMART) principles.
c) Make outdoor space accessible for people by removing coded access to doors.

This is to comply with Regulation 14. (d) (facilities in care homes) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that 'I can easily access a toilet from the rooms I use and can use this when I need to' (HSCS 5.2) and 'I experience an environment that is well looked after with clean, tidy and well maintained premises, furnishings and equipment' (HSCS 5.24).

This requirement was made on 10 January 2024.

Action taken on previous requirement
The service had addressed actions from the Kings Fund Tool which had improved the environment for people living with dementia. Outdoor space was accessible and the coded access had been removed.

The service had made repairs to the assisted bath in the Caledonia unit but this was not working at the time of inspection. This meant that people still did not have sufficient access to assisted bathing options.

This requirement was not met and we have agreed an extension to 30th November 2024.

Not met

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

To support peoples health and wellbeing, the provider should ensure that fresh drinking water is freely available for people throughout all areas of the home, and explore ways to make fresh water accessible for people on the upper floor.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state: 'I can drink fresh water at all times'. (HCSC 1.39)

This area for improvement was made on 10 January 2024.

Action taken since then
Repairs had been carried out to the upper floor sink in the communal dining area which meant people had access to fresh drinking water on both floors.

This area for improvement has been met.

Previous area for improvement 2

The provider should explore the issues causing an intermittent malodour from communal toilets, located in Davaar unit and make the necessary repairs in order to fully resolve.

This is to ensure care and support is consistent with the Health and Social Care Standards which state that: 'My environment is safe and secure' (HSCS 5.17) and 'My environment is relaxed, welcoming, peaceful and free from avoidable and intrusive noise and smells' (HSCS 5.18).

This area for improvement was made on 30 August 2022.

Action taken since then
The provider had carried out investigations to try to identify the source of the malodour in the Davaar unit but this had not been resolved. The malodour was still apparent and we received feedback from families that the malodour was notable in this area.

This area for improvement was not met and has been made subject to a Requirement under Key Question 4 'How good is our environment'.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	4 - Good
1.3 People's health and wellbeing benefits from their care and support	4 - Good

How good is our leadership?	3 - Adequate
2.2 Quality assurance and improvement is led well	3 - Adequate

How good is our staff team?	3 - Adequate
3.3 Staffing arrangements are right and staff work well together	3 - Adequate

How good is our setting?	2 - Weak
4.1 People experience high quality facilities	2 - Weak

How well is our care and support planned?	4 - Good
5.1 Assessment and personal planning reflects people's outcomes and wishes	4 - Good

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