Salus Dementia Care Limited

Salus Dementia Care

Inspection report

22 Wood Street
Earl Shilton
Leicester
LE9 7ND

Tel: 01455293437

Date of inspection visit:
28 February 2019

Date of publication:
02 April 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Salus Dementia Care is a domiciliary care service providing care and support to people living in their own homes. The office is based in Earl Shilton Leicestershire. They support people with a variety of care needs including physical disabilities and dementia. At the time of our inspection there were 69 people using the service.

People's experience of using this service:
•□The provider did not have systems in place to assess and monitor associated risks to people's care and support.
•□Where people had needs that required that they needed support at particular times, the provider could not be assured that the support will be available to them.
•□People did not always receive their medicines when they needed. The provider did not have protocols in place to check that people who required support with taking their medicines received this support.
•□People's care needs were not always assessed in line with relevant guidance and legislation.
•□People did not always receive the support that they needed to meet their nutritional needs.
•□Care staff had the skills and experience that they required to support people.
•□Care staff were kind and treated people with dignity and respect.
•□The care that people received was not tailored to their needs. Their care plans and risks assessments did not reflect their needs. They did not always receive their support in a timely manner.
•□People's complaints were not recorded and responded to and resolved satisfactorily.
•□The provider had a poor oversight of the service. There was a poor culture of transparency and communication within the service. They did not have a culture of continuous learning and improvement.
•□The provider did not have effective systems in place to assure them that people received a good standard of care and that they met their regulatory requirements.

Service did not meet the characteristics of Good in most areas: more information in the full report.

Rating at last inspection: Good; 20 August 2016

Why we inspected: planned inspection based on previous rating.

Action we told provider to take (refer to end of full report)

Follow up: ongoing monitoring; we will continue to monitor this service and respond accordingly. We plan to inspect in line with our re-inspection schedule for those services rated requires improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not well-led.

Details are in our Well-Led findings below.

Salus Dementia Care

Detailed findings

Background to this inspection

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

Inspection team:
The inspection team consisted of two inspectors and one expert by experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience's area of expertise included supporting an older person living with dementia.

Service and service type:
Salus Dementia Care is a domiciliary care service providing personal care and support to people living in their own homes.

The service did not have a registered manager. The registered manager had resigned in January 2019. There was an acting manager who was supporting the service. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

The inspection was announced. We gave the service two days' notice of the inspection site visit because it is a domiciliary service and we needed to be sure that the manager would be available at our visit.

Inspection site visit activity started on 18 February 2019 when we made calls to people who used the service and ended on 28 February 2019. We visited the office location on 28 February 2019 to see the manager and office staff; and to review care records and policies and procedures.

What we did:
Before the inspection we reviewed information we held about the service such as notifications. These are events which happened in the service that the provider is required to tell us about. The provider completed a Provider Information Return seven months before our inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During inspection, we spoke with six people who used the service, three relatives, four care staff, the two directors and the acting manager.

We reviewed a range of records about people's care and how the service was managed. This included care records of the three people who used the service. We reviewed associated documents including their risk assessments and records of the care they received. We looked at the recruitment checks carried out for two care staff employed at the service. We also reviewed documents and systems the provider used to assure themselves they provided a good standard of care.

After our visit, we reviewed information sent to us by the acting manager. This included staff training records and their improvement plan. We also considered further feedback that was sent to us by a person who used the service.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

• People had mixed reviews of the how safe they felt when they received care from Salus Dementia Care. Some people told us that they felt safe depending on which care staff provided the support. Others told us that they usually received care from the same care staff which made them feel safe. Some other people felt that the care staff provided safe care but there were administrative issues which did not make them feel safe. They went on to tell us that the administrative issues affected the timekeeping of the care staff which meant that they did not always receive their care support at the times that they needed it.

• The provider did not have appropriate systems in place to assess and monitor associated risks to people's care and support. People's records included risk assessments. However, risk assessments were sparsely written and did not include significant information about risks to people's care. Therefore, there were no plans in place to support staff to minimise risks to people and themselves. For example, one person's care plan showed that they had multiple health conditions which could affect their ability to mobilise safely. None of this information was reflected on their risks assessment for support that they need to mobilise from one place to another. The acting manager told us that they had also identified this issue and would work with the management team to complete new risks assessments for people.

• Care staff told us that any concerns they had about people's safety was reported to the managers. However, we saw that they did not record or refer the information to other relevant professionals. We saw that they did not consider this information in planning people's care which meant that the potential of a reoccurrence of the incident remained when people received care. During our meeting with the management team, they shared an example of how a whistleblowing was not properly managed, recorded and investigated. This meant that the person receiving care and the person who shared that information were not protected from restrictions to their safety, choice and control.

• The provider had a safeguarding policy. Care staff were aware of their responsibilities to keep people safe from abuse and avoidable harm. They reported any concerns to the managers. The provider did not have systems in place to ensure that any issues regarding the safeguarding of people are thoroughly investigated and reported to the appropriate agencies such as local safeguarding authority and the Care Quality Commission.

Staffing and recruitment

• The provider did not always ensure that care staff were available to meet people's needs as agreed with

them. This meant where people had needs that required that they needed support at particular times, the support was not always available to them. These people repeatedly told us that this made them feel "very frustrated". A person gave us several examples of when they had not received care when they needed it. They said, "six weeks ago I was in tears a couple of times on the phone to them. I feel very vulnerable. It is why I've asked for them to help."

•□We found that staff were not deployed effectively. Care staff told us that there were issues with their rotas. A care staff told us, "Rotas are awful. Runs [routes] are not well known enough by people in the office." They went on to say this meant that care staff could not always get to people on time to provide the support that they needed. It was then left to the care staff to explain this situation to the person. They said, "Office staff cram calls in. This is especially at [place] calls."

•□We reviewed the provider 'late and missed visits policy and procedure'. We saw that they did not apply this in their practice. The acting manager told us that the management team had not been able to routinely monitor missed visits. Their current system of checking that care staff attended a care visit included a verbal confirmation from the care staff. This did not also include a confirmation from people that required the care and support. They told us that they intended to start monitoring this in the future by using the report function on their electronic call monitoring system.

•□The provider had systems in place for recording visits completed by care staff. However, these systems where not consistently used or monitored. The acting manager told us that they were in the process of supporting the staff team to use and be accountable for using the systems for recording and monitoring care visits. We reviewed records which showed that they had started work at beginning of February 2019 to identify, record and respond to incidents of missed visits. During our inspection, the acting manager told us that staff had identified some issues with their electronic monitoring system. They arranged for support to sort the issues out.

Using medicines safely

•□People did not always receive their medicines when they needed. Most of the people we spoke with administered their own medicines, one person required support from care staff to prompt and administer their medicines. They told us that staff were not always available to provide this support. They said, "They [care staff] are supposed to give it to me in the evening. I never know what time they'll be here so I do my own. They do remember but it's too late usually."

•□The provider had no protocols in place to check that people who required support with taking their medicines received this support. The provider had a 'medication audit policy and procedure'. They did not apply their policy and procedure in practice.

•□We found that the provider did not always follow their own protocols where people received their medicines covertly. The managers told us that the week before our inspection that they became aware of a situation where a person received their medicines covertly. The acting manager had taken steps to gather information and provide support, including liaising with the person's GP and getting this support to be provided by the person's informal network until they put all the required plans in place for staff to provide this support. We saw in the provider's records that that concerns with covert medicines had been identified in December 2017. However, this was not robustly recorded or used to ensure that protocols were implemented for future purpose.

Learning lessons when things go wrong

• The provider did not have systems and protocols in place for reporting, recording, analysing information relevant to the safety and safeguarding of people that use the service. Therefore, this meant that they could not proactively identify and investigate failings and take the necessary steps to learn and improve from them.

The issues stated above showed that the provider failed to assess and mitigate risks to people when they received care. This constitutes a breach of regulation 12 (2) (a) (b) (g) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Preventing and controlling infection

• People told us that staff always used relevant personal protection equipment. This meant that they took steps to prevent and control the spread of infection.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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

- 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's care needs were not always assessed in line with relevant legislation. We saw from people's care plans that where staff had assessed people's ability to make their own decision, the assessments were not comprehensive and did not reflect all information that staff knew about the person. They did not specify which decisions people may or may not be able to make and what support that they may need to make a decision. The assessments were not completed within the principles of the Mental Capacity Act 2005. The acting manager told us that they had identified these issues and would work with the staff team to improve this.

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

- People did not always receive the support that they needed to meet their nutritional needs. They told us that this was mainly due to the times that staff arrived to provide this support to them.

- One person told us that their care staff had been regularly late in the mornings, which meant the care staff returned 30 minutes later to support them with their lunch. They said, "I can't eat two meals straight after each other. I was in tears. I'm frustrated. I'm supposed to have breakfast and lunch. You can't have half an hour difference between them. I've lost weight already. I need to have regular meals and this isn't helping." Another person told us, "I'd like more help preparing it [meal] it's what I asked for. I can't wait and wait to eat though." This showed that support was not appropriately timed and flexible to meet people's needs.

- People and their relatives told us that some staff involved them when they supported them with their meals. They asked people their preferences and provided support accordingly. A relative told us, "They [care staff] ask what [person] would like. I get things ready too and they help. It is very successful."

Staff working with other agencies to provide consistent, effective, timely care

- There were no systems for effective communication within the service. The provider could not be assured that when people transferred from other services, staff had relevant information to provide consistent and

tailored support to them. For example, the managers told us about the complex needs of a person who had used the service for four weeks. They told us that they did not have all the relevant information about this person's care and they were not aware if and where the previous manager may have recorded the information. The acting manager had started work to contact relevant professionals involved with the person's care.

Supporting people to live healthier lives, access healthcare services and support

- People that we spoke with told us that they were able to arrange their own health appointment independently or with support from their family. They told us that the care staff recognised any changes to their health and were able to support appropriately. One person told us, "They [care staff] are pretty good at seeing [when [name] is unwell]." Another person told us, "They generally notice. For example, last night I wasn't my usual self, [care staff] knew straight away. They knew something was wrong." They went on to tell us that they had not needed them to contact health professionals but felt confident they know what to do if they had a fall or accident.

Ensuring consent to care and treatment in line with law and guidance

- People told us that care staff sought their consent before they supported them with their needs. One person told us "They [care staff] don't assume things, [care staff name] always asks. They check what I want each time."

Staff support: induction, training, skills and experience

- People told us that most of their care staff had the relevant skills and experience to provide support to them. One person told us, "They [care staff] have told me sometimes about training they've done. I've never felt they haven't known how to do something." Another person said, "I know the regular carer is trained well. They are as good as gold."

- Care staff that we spoke with told us that they received an induction before they started providing care and support to people. They told us that their induction was tailored to their previous skills and experience.

- The acting manager was in the process of embedding new systems of training and formal supervision to ensure that staff had the skills and support to care for people that used the service.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good:People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

•People told us that care staff were kind to them. Some of their feedback included, "They're caring, nice people. They are always willing to help you." "They're very kind. I feel they treat my home like they would their own. I've never felt I need to worry." "They are in the job because they want to be. For example, they make eye contact, they don't look down at me because I've got all these disabilities."

•Care staff took time to listen to them and this made them feel like they mattered. One person told us, "They [care staff] are good at listening because I do get down. They listen to what I have to say." A relative said, "They [care staff] are caring, very friendly. They make [person] feel good."

Supporting people to express their views and be involved in making decisions about their care

•People felt their care staff involved them in decisions about their daily living tasks. They told that staff respected their decisions and supported them accordingly. One person told us, "[Care staff] automatically checks with me about everything. If I want the cold water running first, then add the hot. I feel [care staff] respects whatever I choose to do."

Respecting and promoting people's privacy, dignity and independence

•People were treated with dignity. Care staff respected their privacy and promoted their dignity when they supported people with their needs. They gave us several examples of how care staff did this. One person told us, "They don't look while I [personal care task]. They ask, are you alright with me being here - that is thoughtful." Another said, "We go in the bathroom and close the door. I am happy and comfortable with them. I never feel embarrassed." A relative told us, "I'm not allowed in when they wash and dress [person] the door is closed."

•Care staff also gave us several examples of how they treated people with dignity and respect. A care staff told us, "If changing pads on the bed we make sure curtains are closed, ask them before doing things. Check that they are comfortable. We had dignity training as part of induction."

•People were supported to be as independent as they wanted to be. One person told us, "[Care staff] lets me do what I can. If I can't do something I just ask. For example, I can't change the bed, we do it together now. [Care staff] stands on one side, I stand on the other and we do it. It is so important I do things no matter how hard." Another person told us, "[Care staff] let me do what I can. I wash [personal care task] I can, they only help when I can't reach."

Requires Improvement

Is the service responsive?

Our findings

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

Requires Improvement:People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

•The care plans and risks assessments we reviewed were sparsely written. They did not include vital information known to the staff about people's needs. For example, the care plan of a person with complex needs did not have detailed information about their needs or the support that care staff may be required to provide to this person. This showed that care plans and risks assessment were not fit for purpose and did not support staff to care for people and keep them safe from avoidable harm.

•Another person's care records showed that they had a review of their care plan over two weeks before our inspection. The review showed that there had been changes in their needs including the person appointing a loved one to support them with making decision, a decline in their health which required them to need more support at a certain time of the day. We saw that this person's care plan had not be updated to reflect their current needs. This showed that care staff could not rely on the information in care plans to guide them to provide support that people required.

•People told us that they or their relative had been involved in developing their care plan. They told us that their choices were recorded. They did not always find that staff followed the details agreed on their care plans. One person told us, "They came here and asked what I needed. It was quite thorough." They went on to say, "It is not a working plan, they are not following it." They told us this issue was mainly underpinned by the times that care staff arrived to provide support. Another person said, "I was involved, absolutely and I signed it. Most [care staff] don't have a clue what help I need. I have to tell which ever one comes each time."

•The provider did not have systems in place to identify 'time critical' care support. This meant that they did not always deploy resources in a way that ensured that people who needed the most support were prioritised when arranging rota or making any changes to the service. A person who used the service told us, "It is not very well organised at the moment. The timekeeping isn't good enough. They don't seem to understand how important it is, they change times without consulting me. It is all about what suits them best."

The issues stated above showed that the provider failed to provide person centred care. This constitutes a breach of regulation 9 (1) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Improving care quality in response to complaints or concerns
•Where people had raised concerns about the care they received, they did not feel their feedback was listened to or acted on. One person told us about the concern they raised. They said, "I've pretty well stopped mentioning it now. They don't listen, they don't do anything." Another person told us how they had

raised a concern several times without receiving any positive outcome. They said, "I asked the owner of the agency to send me the complaints policy. It was five to six weeks ago. It is still not here."

•□People's told us that their concerns were mainly regarding the timing of their care visit and the impact that this had on them such as the ability to have a meal. They did not feel that any changes to the rota or care staff was communicated to them. One person told us how they had communicated their need for stability of their care through their care staff. They said, "This carer told them at the office. They didn't contact me anyway."

•□Care staff told us that they had raised several concerns about the rota. A care staff told us, "All the problems boil down to the rotas. Staff leave because of the rotas. Everybody already knows about how bad the rotas are. [Rota co-ordinator] struggles because they are having to do the rotas and also provide training at the same time. Staff get stressed by the rotas and then leave, making it harder work for the rest of us."

•□The provider did not have effective systems for recording and responding to the feedback that they received from people and staff. This meant that they could not use the feedback they received to learn and improve the quality of care people received.

The issues stated above showed that the provider failed in their responsibility of receiving and acting on complaints. This constitutes a breach of regulation 16 (1) (2) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

End of life care and support
•□Care staff told us that they had not received training on how to support people at the end of their lives. None of the people who we reviewed their care was receiving end of life care. Staff we spoke to had not been required to support people who were at the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Requires improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had poor oversight of the service. They did not have suitable systems in place to monitor the service that people received, and ensure that staff had the support that they required to provide a good quality of care.

- The service did not have a registered manager. The previous registered manager resigned in January 2019. At the time of our inspection, the service was supported by a consultant in adult social care provision who was in the position of acting manager. The acting manager was in the early stages of implementing an improvement plan. They told us that the acting manager will apply to become the registered manager as a short-term solution while they put plans in place to recruit a long term registered manager.

- During our meeting with the management team, they informed us that the directors had been unaware of issues within the service and they were still in the process of discovering the failings within the service. For example, they found further documented complaints the day before our inspection. These did not have any records of any action that had been taken to deal with the complaints. They said, "There's an accountability problem. Accountability goes right the way from the bottom to the top, and if you haven't got it right at that the top then it can't be right altogether."

- We saw that that the provider had a quality assurance system in place. However, this was not effective to help them keep in check the performance of the service. Their system could not assure them that people consistently received a high standard of care and that they met their regulatory requirements.

- We reviewed records which showed that the quality assurance that they did have in place was not used consistently. We reviewed records from January 2018 to June 2018. The records showed that were issues had been identified, no action was taken to make necessary improvements. We found that some of the issues identified by these records where still present at the time of our inspection. Our review showed that there were no records completed after June 2018.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- There was a poor culture of transparency and good communication within the service. Care staff told us

that their rotas were changed frequently and that changes were not always communicated effectively. A care staff gave us an example of how this meant that there was a delay to a care staff attending to support a person with medical conditions that required that they were supported promptly.

• Some of the feedback we received from people included that the managers had not responded to their request to share the rota of their care with them. This was so that they could have an awareness of the care staff that they could be expecting to support them. One person told us, "I don't have a clue who is coming tomorrow or Friday for example. I asked for an email telling me who is coming, they promised they would do it and they haven't." They went on to say "They say so and so is coming, then it turns out to be someone one else. I had [care staff] at lunch time. He said he would be with me the next day but he wasn't. The next day I got out of bed. I'd left the chain off the door because I thought it would be him, all of a sudden a [person description] had come in. I didn't know who it was. I was terrified. It turned out it was another carer". A relative told us, "It's just whoever shows up, we never know. We are not complaining because they're all lovely."

• The provider did not have a system in place to ensure that when rotas changed that care staff involved had received the updates in good time. They did not ensure that any changes were effectively communicated to the people that used the service. A care staff told us, "Communication between [the] office and carers is terrible. Communication between [the] office and clients, well, things get missed because they are busy."

• Staff told us that they had repeatedly raised issues regarding the rotas in the past. They told us that action had not been taken to resolve these issues. A care staff told us "I have previously come in with other carers to complain about this [rota]. Hoping that things will change with changes in management as there are now people with the right attitude. [There are] unhappy staff due to constant changes with the rota, staff are constantly leaving because of the rota."

• The acting manager told us that they had made the staff team accountable for the information recording systems in order to start dealing with the issues regarding 'missed visits'. However, they did not have systems in place to monitor that staff were using this effectively and that any missed visits were followed up promptly. This meant that there remained a risk that people may not receive care at agreed time and may suffer adverse impact to their wellbeing as a result of this.

Continuous learning and improving care

• The service did not have a culture of continuous learning and improvement. We saw from quality assurance documents that issues had been raised with the previous manager and directors which were not addressed. Some of the concerns included issues with covert medicines, training, overlapping call times, missed calls, rotas issues – one resulting in a person not receiving their medicines because a care staff did not get their rota.

• The provider did not have a system for collecting staff and people's feedback. Some people had positive experience of the directors. However, this was when the directors supported them in the role of a care worker. Care staff did not have opportunities to meet with the management team for support and advice. Records we reviewed showed that there had not been a meeting with staff since August 2018.

• There were no systems in place to check that the care staff applied their training in practice. The acting manager told us that they had reassigned staff responsibilities which would equip them with the skills and availability to check the competencies of care staff to support people with their needs.

The issues stated above showed that the provider failed to establish sufficient protocols in place to assess, monitor and improve the quality, health, safety and welfare of service users. This constitutes a breach of regulation 17 (1) (2) (a) (b) (c) (e) (f) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Working in partnership with others

- The acting manager had started a process of improvement which included protocols of working with other professionals in assessments of care packages and ongoing management of the care that people received. This was in the early stages of implementation.

- Staff had faith in the acting manager to make the improvement that were required in the service. A care staff told us, "Now we have new managers I am hoping there will be changes. [Acting manager] doesn't take any nonsense, [they are] more organised, passionate about it. I think [acting manager] genuinely cares. It is getting a bit better recently, it had been awful before."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to provide person centred care.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess and mitigate risks to people when they received care.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed in their responsibility of receiving and acting on complaints.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish sufficient protocols in place to assess, monitor and improve the quality, health, safety and welfare of service users.