Cornwall Care Limited

Trengrouse

Inspection report

Trengrouse Way
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out this unannounced comprehensive inspection on the 12 April 2018 after receiving concerns that people were not receiving the care and support they needed. There was a high use of agency staff and that the service lacked leadership and direction. Following this inspection it was judged these allegations were not substantiated. The last comprehensive inspection took place on the 28 February 2017. The service was meeting the requirements of the regulations at that time.

Trengrouse is a 'care home' that provides nursing care for a maximum of 41 adults, with a range of health care needs including dementia, nursing and mental health. At the time of the inspection there were 36 people living at the service. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Trengrouse is situated in the town of Helston. It is a purpose built single storey building with a range of aids and adaptation in place to meet the needs of people living there. It is close to the centre of Helston with links to public transport. There are three separate lounges radiating from a central hub, with peoples rooms leading off from the various lounge areas. All rooms were single occupancy. There was a main dining room but also small dining areas in each lounge. There were a range of bathing facilities in each area designed to meet the needs of the people using the service. There was a central patio area and a garden which people could use if they were being supported.

Risks in relation to people's daily lives were identified, assessed and planned to minimise the possibility of harm whilst helping people to be as independent as possible. Records included evidence of reviews to make sure changes were being monitored and responded to. Care plans included information about people's general health and who was involved in the person's care and welfare.

Some people's health needs meant they needed to have their food and drink intake monitored to ensure they received sufficient each day. We found the records for monitoring were not always complete. Three records recording people's food and fluid intake on a daily basis did not include the amount expected on a daily basis. This was recorded in the main care file but had not been applied to the records used by staff. This meant staff were not reminded of the daily amount required which had the potential to affect their judgements. We have made a recommendation about this.

People received care and support that was responsive to their needs because staff had the information to support them. Staff supported people to access healthcare services. These included, social workers, psychiatrists, general practitioners (GP) and speech and language therapists (SALT). Relatives told us the service always kept them informed of any changes to people's health and when healthcare appointments had been made.

There were sufficient numbers of suitably qualified staff on duty to meet people's needs and there was less

reliance on agency staff to ensure people were familiar with those staff providing care and support.

The way medicines were managed was safe. Staff responsible for the administration of medicines had the necessary competency and skills required. Medicines were stored securely and safely.

Staff completed a thorough recruitment process to ensure they had the appropriate skills and knowledge. There was a wide range of training available to all staff which met the diverse needs of people being supported. Staff were supported through formal supervision.

Staff were supported by the registered manager through regular updates called 'stand up meetings'. These kept the staff team up to date with any changes and provide any essential information that might be needed to be shared to support peoples care and welfare.

Some areas of the environment required attention. For example some chairs had cushions missing, one chair was heavily stained and a table in the lounge area had no chairs around it and therefore restricted people using this area for some time until one was replaced. We spoke with the registered manager about this and were provided with a maintenance plan for the year which identified when furniture and decoration would be taking place.

Infection control measures were in place. Where people were at high risk of infection staff were knowledgeable about the risk and action to be taken. There was a housekeeping team who told us they had the training and equipment to keep the service clean and understood key issues for infection control. However there was an underlying odour in parts of the service. We shared this information with the registered manager. They told us action was being taken to remove the odour by replacing carpets in some rooms with cushion floor. All staff had infection control training as part of their induction. They then undertook refresher on-line training. A new in-house infection control course is being planned, to reflect the particular needs of people using the service.

Safeguarding procedures were in place and staff had a good understanding of how to identify and act on any allegations of abuse.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005. The principles of the Deprivation of Liberty Safeguards were understood and applied correctly.

The manager used effective systems to record and report on, accidents and incidents and take action when required.

There was a system in place for receiving and investigating complaints. People we spoke with had been given information on how to make a complaint and felt confident any concerns raised would be dealt with to their satisfaction.

People told us the registered manager and the staff team were approachable, friendly and supportive.

The provider had systems in place to monitor the quality and safety of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	**Good**
Is the service effective? People's food and fluid information was not being effectively monitored. Weight management was not being effectively recorded. Staff received satisfactory training and support to deliver effective care and support.	**Requires Improvement**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Trengrouse

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 12 April 2018. The inspection was carried out by two adult social care inspectors a specialist advisor and an expert by experience. The specialist advisor had a background in nursing and the expert by experience had personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with seven people who were able to express their views of living at the service. Not everyone was able to verbally communicate with us due to their health care needs. We spoke with seven visiting relatives. We looked around the premises and observed care practices on the day of our visit.

We spoke with the registered manager and deputy manager, operational director and assistant operational director, one nurse and ten care staff. Prior to and following the inspection we spoke with an external professional and we received comments from another professional associated with the service. We looked at eight records relating to the care of people, staff recruitment files, staff duty rosters, staff training records and records relating to the running of the service.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. Two people told us, "They're [staff] are like a family to me here, I'm quite contented here" and 'I have [call bell] one over my bed and I can easily reach it; they [staff] come quite quickly." Relatives told us, "They [staff] keep an eye on [relative] every couple of hours, "Oh yes, [our relative] is very safe here; [they] knows all the carers. They joke with him even though he can't talk or walk anymore."

Systems were in place for managing medicines safely and in line with current clinical guidance. For example, staff responsible for medicines had the knowledge and skills to manage them safely and there were regular updates in medicines training. Some people's level of dementia was such that the need for pain relief could not be communicated. The registered nurse told us they took account of the person's history and any outward signs of discomfort or other signs the person might be in pain and would administer the pain relief as prescribed and necessary. Two people had documentation for covert medication [medicine administered in a disguised form] and there were records of 'Best Interest' decisions [supporting people who lack mental capacity] .However at the time of the inspection those people were accepting their prescribed medicines and so covert administration was not required.

The medicine room was locked when not in use. The medicines fridge temperature was being recorded regularly to ensure medicines requiring colder storage were accurate. Regular medicines audits were taking place to ensure that incidents would not be quickly identified.

There were infection control measures in place. Where people were at high risk of infection staff were knowledgeable about the risk and action to be taken. Antiseptic hand gel was available in bathrooms, toilets and at other key points around the service. There was a housekeeping team who told us they had the training and equipment to keep the service clean and understood key issues for infection control. However there was an underlying odour in parts of the service. We shared this information with the registered manager. They told us action was being taken to remove the odour by replacing carpets in some rooms with cushion floor. A housekeeper told us the rooms which have had flooring replaced were much easier to manage.

All staff had infection control training as part of their induction. They then undertook refresher on-line training. A new in-house infection control course was being planned, to reflect the particular needs of the residents.

There was evidence of close liaison with the tissue viability nurse and GP concerning a person who was suffering from an infection. The plans advised by external agencies were being adhered to.

There was a safeguarding adults policy in place to support staff with guidelines to use if abuse might be suspected and to support them in the decision making process. Staff were aware of the safeguarding policies and procedures. Staff told us they were confident of the action to take and who to contact if they had any concerns. Staff had received safeguarding training and had regular updates on Safeguarding Adults.

Where necessary there was access to advocacy services so people had independent advice and support. There were body maps in place to record any injuries or wounds should they occur, with an explanation as to how they had been acquired. This provided a clear record to demonstrate any patterns or concerns. One staff member said, "It's important we know how to raise concerns and feel confident to do that."

Accidents, incidents and near misses were recorded, tracked and monitored by the management team to summarise what had occurred, outcomes and actions. The reviews included regular audits of events to identify possible trends or patterns to help minimise the risk of repeat occurrences. As a result of a recent audit to identify specific trends for falls and incidents, the service had introduced 'stand up' meetings during the day. These kept the staff team up to date with any changes and provide any essential information that might be needed to be shared to support peoples care and welfare and reduce incidents occurring.

People had assessments in place which identified risks in relation to their health, independence and wellbeing. There were assessments in place which considered the individual risks to people such as mobility, mood and emotional need, nutrition and hydration, and personal care. Where a risk had been identified, for example a falls risk, the assessment had looked at factors such the environment and whether current mobility aids remained suitable. Staff were able to tell us about people's individual risks and how they were being managed. Records were up to date to show where risk levels had changed. For example, a person's mobility had deteriorated with more falls occurring. Staff had responded to the changes by making the necessary referrals to ensure suitable equipment was in place to safely support the person.

Staff did not work in the service until all the necessary safety checks had taken place to ensure people were safe to work with people who may be vulnerable. Staff recruitment files contained all the relevant recruitment checks to show they were suitable and safe to work in a care environment, including Disclosure and Barring Service (DBS) checks.

We received information of concern prior to this inspection that the service was over reliant on agency staff. However we found that since the previous inspection staffing levels had been reviewed. There was now less use of agency staff which meant there was more continuity. The ratio of people requiring one to one support was limited to three. Staff told us this was more manageable. One staff member said, "It's much calmer now and we have more time to spend with residents on a one to one basis." We observed this to be the case and observed the service was being staffed in numbers which met people's individual needs. A family member told us "There always seems to be an adequate number of staff for my relative."

Call bells were responded to quickly. People were generally satisfied with how they were responded to. One relative told us, "They [staff] keep an eye on [person] every couple of hours." The level of support that each person required was assessed and used to determine staffing levels. The staffing rota showed there was a skills mix on each shift so that senior staff worked alongside care, domestic housekeeping and catering staff. Staff comments included, "I like it when we are fully staffed because we can spend time with people," "I am able to give people the time and care they need" and "There have been a lot of changes but it really has settled down recently and we work well as a team."

Each person had information held at the service which identified the action to be taken for them in the event of an emergency evacuation of the premises. Fire fighting equipment had been regularly serviced. Fire safety drills had been regularly completed by staff who were familiar with the emergency procedure at the service.

Equipment had been serviced and maintained as required. Records were available confirming gas, electric and fire systems were being maintained and were safe to use. Equipment including moving and handling equipment (hoist and slings) were safe for use and were being regularly serviced. We observed they were

clean and stored appropriately so people were safe when moving around the premises.

Requires Improvement

Is the service effective?

Our findings

Staff were knowledgeable about the people living at the service and had the skills to meet people's needs. People using the service and a relative told us they were confident that staff knew them well and understood how to meet their needs. A relative told us, "I visit a lot and the staff come and go but on the whole I have a lot of confidence in them."

We 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. This enabled us to observe and record the day-to-day activity within the home and helped us to look at the interactions between staff and those who lived at Trengrouse. We observed staff positively engaged with people. For example some people chose to sit alone or did not engage with those around them. Staff were observed to stop and speak with the person to ask if they were comfortable or wanted something. Where a person required one to one support this was being carried out in a dignified and sensitive way, so that the rights of the person was respected by the care worker who gave them the space to move around unrestricted. During the SOFI observations we found that in general staff continuously engaging with people effectively and people appeared comfortable in the presence of staff members.

People's healthcare needs were being monitored and discussed with the person or relatives as part of the care planning process. Family members told us they were satisfied with the way they were informed about their relatives change in health and wellbeing. Care records showed visits from health professionals including general practitioners (GP's) and a range of other health professionals were involved with people when necessary. They included social workers, physiotherapists and dieticians amongst others.

The service worked closely with the Dementia Liaison Team who supported people with dementia conditions through specialist input and assessment to measure progress of the disease and to provide the service with any specific advice to enable them to effectively respond to peoples changing needs.

Some people's health needs meant they needed to have their food and drink intake monitored to ensure they received sufficient each day. We found the records for monitoring were not always complete. For example care plans had recorded a baseline fluid input for a 24 hours period. However this information had not always been transferred to monitoring records. Where a person's weight was being monitored due to a health condition the loss of weight had prompted a nutritional review of risk and changed accordingly. Records for monitoring this were not always consistent. If this was not now possible there was no record to reflect this.

We recommend the service ensures all information relating to the effective management of health conditions are completed to support staff in delivering care to people.

We observed positive behavioural support plans which provided staff with detailed information about people's fluctuating mental health needs and what people's coping strategies were. Staff were supported through behaviour training and restraint management strategies to effectively support people at times of

anxiety.

Staff were supported by the registered manager to have the appropriate resources to carry out their role effectively. This included a comprehensive induction at the organisations head office and once in post there was continuous training and support. The induction was in line with the Care Certificate which is designed to help ensure staff that are new to working in care had initial training that gave them a satisfactory understanding of good working practice within the care sector. Staff were positive that they were supported appropriately. One staff member said, "Training is really focussed on, I think what we receive is good." Staff received regular supervision and advice from the manager and attended meetings. This demonstrated staff were supported to understand their role and responsibilities.

Staff received training in equality and diversity which focused the Equality Act and ensured staff understood what discrimination meant and how to protect people from any type of discrimination.

There was some use of assistive technology to support people. This included pressure mats to alert staff when people were moving around. These were used only as necessary and identified as part of the risk assessment and mental capacity assessment.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The service held an appropriate MCA policy and staff had been provided with training in this legislation.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the 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. There were restrictions in place including locked entrance and exit doors with key pad codes and pressure mats to monitor movement. In all instances 'best Interest meeting's' had taken place and authorisations were being monitored and reviewed as required.

Staff were aware of the importance that people who lived at Trengrouse were able to consent to receive care and support. Where people did not have the mental capacity to agree to consent their legal representative acted on their behalf.

People were generally satisfied with the meals and choice of food options. Comments included, "Very good; there is a good variety, they [staff] have to support my relative with all meals. They are pureed meals, because [my relative] has swallowing problems. Even fluids have to be thickened so that it makes it easier for [my relative] to swallow." A resident told us, "I had a meal myself here one day and it was excellent; the special Valentine's Day meal last year was excellent. My relative has to be supported now and I presume [my relative] can have alternatives when [my relative] doesn't want one of the choices." There was a pictorial board with pictures of the meals to be serviced on the day. The chef had clear direction about special diets and meals which required softening. This list was constantly kept up to date and reflected the current needs of people using the service. For example, some people required food in a soft texture. The meal was presented with the ingredients being set out separately and looked appetising. The chef and kitchen staff were very proud of the way the kitchen was run. They said, "We think we do a good job."

We observed the lunchtime meal and found in general staff were very supportive where people needed assistance. However in one instance a staff member was observed providing little encouragement with limited communication to the person they were supporting. We shared this with the registered manager who had already identified this and was responding with additional supervision.

Trengrouse is a purpose built single storey service. There was a maintenance plan in place to update, decorate and replace carpets and furniture in the next year. One chair in a lounge was badly stained. We were told it was due to be removed but agreed this should be done with immediate effect. A recent inspection by an assistant operational director identified the need for removal of 'clutter' in two storage rooms. The decoration and signage was designed to support people with dementia to move around the service and identify with different areas and rooms.

The organisation had a maintenance team to address general maintenance with contractors undertaking any specialist work. There was a central hub with access to a garden are and where people were safe. Another garden area had been introduced and staff supported people to access it.

Good

Is the service caring?

Our findings

People had developed positive and caring relationships with the staff that supported them. People made positive comments about the approach of staff saying they were kind and caring. One person told us," Generally, everyone's ok'. Another person said "They [staff] are always very good'. Family members told us, "They [staff] are brilliant, nothing is too much trouble; some are exceptional," "Visiting is never a problem; I can come anytime, which is very nice" and "No restrictions on visiting times, only if there is an illness or a bug."

There was an equality and diversity policy in place and staff received training on this topic. Staff demonstrated that they were aware of their responsibility to help protect people from any type of discrimination in the way they provided care for people. They were able to describe the importance of acknowledging people's individual characters and helping to protect people from any type of discrimination and ensure people's rights were protected. For example, respecting the person for who they were, asking people sensitively if they needed assistance. There was a sensitive and caring approach observed throughout the inspection visit. The service respected the diverse needs of staff. For example, where a condition was affecting the skills of a staff member, they received additional support and supervision from the management and staff team.

Throughout the inspection visit we observed staff responded to people's needs in a caring manner and treated people with dignity. They were polite and attentive and quick to respond to people who required their assistance. Staff demonstrated they knew and understood people's life history, likes, dislikes, needs and wishes. They knew and responded to each person's diverse cultural and spiritual needs and treated people with respect and patience.

Staff had a good understanding of protecting and respecting people's human rights. Staff members and people who lived at Trengrouse were observed throughout the inspection to have easy and friendly relationships. People told us that staff listened to them, respected and considered their wishes and choices. Staff ensured they were at the same level as people and gained eye contact when communicating with them so that people could clearly understand them. Staff took time to talk with people and put them at ease if they appeared confused or distressed. For example where people had limited communication due to an advanced condition. One person was non-verbal. We observed staff used facial expressions to support communication such as whether they were hungry or sleepy. The person responded positively to this approach. This demonstrated the staff understood how to use individual prompts to effectively communicate with people.

People told us their privacy and dignity was always respected and this was observed during the inspection. We observed staff members knocking on bedroom doors and waiting to be invited in before they entered. Family members told us they felt staff treated their relative with dignity and their privacy was respected and their independence promoted.

People were at the centre of the service and routines were flexible. There were some restrictions in place for

some people as part of their health and welfare plan. Staff understood this and supported those people in a way which meant it was the least restrictive way possible. For example, some people liked to walk around the service. They were not restricted from doing this as and when they chose to. Staff supporting them were discreet. Staff were observed encouraging those people to think about what they wanted to do or talk about. In one instance a person wanted to be quiet and the staff member supporting them respected this. It was clear that the culture of the service was one where each person was treated as an individual rather than being defined by the type of service they were living in.

Where necessary people had access to advocacy services which provided independent advice and support. The service had information details for people and their families if this was required. This ensured people's interests would be represented and they could access appropriate services outside of the service to act on their behalf if needed.

Care files and information related to people who used the service was stored securely and accessible by staff when needed. This meant people's confidential information was protected appropriately in accordance with data protection guidelines.

Good

Is the service responsive?

Our findings

Most people did not have the mental capacity to comment on their personal care due to health conditions. However some people and their families told us they were confident the service responded to their relative's needs. They told us, "My relative has power of attorney and is involved and checks up on all of this, so I leave them to all of that and "The carers go through it [the care plan] with me and review it roughly every 3 to 4 months. They [the carers] keep me informed of any changes; and I'm made aware of any medication changes immediately."

We observed call bells were answered quickly and people did not have to wait long for a response. The design of the service meant some rooms were at a distance from the main hub; however this did not affect response times. A relative told us that staff were always visible, although due to the layout and size of the service they said it might not look as if there were many [staff] around. They said, "It's a big place but as soon as someone needs something they are on it." We observed staff members undertaking their duties and responding to requests for assistance in a timely manner.

People who wished to move into the service had their needs assessed to ensure the service was able to meet those needs and expectations. Care plans were in place for people and were accurate and up to date to reflect current nursing and care needs. The care plans were detailed and included information about people's nursing care needs as well as their emotional and social support needs would be met. For example, end of life care, positioning charts and dementia care. Care plans were clear where people required additional nursing care, for example with medical interventions.
This information was shared with other relevant health professionals to ensure they had information about individual nursing needs. This ensured people received care that was provided with a person-centred approach. Staff were knowledgeable about the support people in their care required.

The service took account of individual communication and support needs of people with a disability, impairment or sensory loss. Care plans confirmed the services assessment procedures identified information about whether the person had communication needs and how they should be met. For example, where people had sensory needs the service had links with community support in order to arrange service and equipment for the person.

The service had a complaints procedure which was on display at the entrance of the service. The procedure was clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. Contact details for external organisations including social services and CQC had been provided should people wish to refer their concerns to those organisations. Where complaints had been raised the registered manager had responded in accordance with the organisations protocol. Responses seen were open and transparent and following complaints they were reviewed to identify any areas where lessons could be learnt. Some people told us they did not always get told of the outcome of any complaints. We shared this with the registered manager to ensure communication was more effective in the future.

There was a dedicated activity co-ordinator who supported the diverse range of needs of people living at

the service. Throughout the day the activity co-ordinator was delivering a range of activities for small groups and on an individual basis. There were quizzes, crafts, exercises and use of music to engage with people. Where people were unable to join in the group activities the activities coordinator and care staff spend time each day with them on an individual basis. Specific calendar dates were celebrated for example, Easter, Christmas and Valentine's Day amongst other events. Relatives told us, [Person's name] will respond to music. Tapping their hand and always has a radio on too" and "Someone with bongo drums comes to the home, it's very infectious when he comes; some of the residents love that and enjoy it; others, it's not for them."

The service responded to people's needs as they were entering the final stages of their life. Supporting people and their families through end of life was seen as an essential and continuing part of care by the service. The service had arranged for medicines to be used if necessary to keep people comfortable. The registered manager and staff gathered as much information during the assessment and review process to record information that would support the person and their family when entering the final stage of their life. For example, choice of funeral and informing people who were significant in the person's life.

Good

Is the service well-led?

Our findings

A registered manager was in place. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

The service had the latest CQC rating on display where people could see it.

Services are required to notify CQC of various events and incidents to allow us to monitor the service. The service was notifying CQC of any incidents as required, for example expected and unexpected deaths.

There were clear lines of accountability and responsibility within the service. Changes to senior management structures were communicated to the registered manager through regular organisational engagement meetings.

The management team consisted of a registered manager, deputy manager and senior nurse. Each had responsibility for specific care and clinical audits. For example the senior nurse had responsibility for all clinical audits.

There were systems in place to support all groups of staff. There was consistent daily communication between the registered manager and staff as well as staff meetings for all staff groups working at Trengrouse. These were an opportunity to keep staff informed of any operational changes. For example, reminding staff to be vigilant regarding infection control by ensuring disposal of incontinence pads and gloves to be removed from all rooms after use. The meetings also gave an opportunity for staff to voice their opinions or concerns regarding any changes.

As part of the provider's internal quality assurance checks they invited people who used the service, relatives, representatives and professionals to complete an annual survey about the service. The most recent recorded comments including, "Thank you for all the care and support," "They [staff team] are all brilliant with [my relative] they really are." The registered manager also held quarterly family meetings. One person told us they really appreciated that these meetings were held in the evening as they work during the day. They told us the meetings were really useful and they felt they were able to speak up about any topic that might be mothering them.

Staff told us they were supported by the management team and enjoyed working at the service. Comments included, "We work well as a team. It has improved a lot. Staffing levels are a lot better," "They [managers] have been really supportive of my condition. I have lots of supervisions" and "I feel really supported by the managers and nurses. It's a great team very supportive at all levels." This demonstrated the provider's commitment to supporting the staff team who told us they all felt what they did at the service was valued by the management team.

There were audits taking place to review and manage the operation of the service regularly. This included incidents/ accidents analysis and the environment.

The service worked in partnership with other organisations to make sure they were following current practice, providing a quality service and to ensure the people in their care were safe. These included working collaboratively with social services and healthcare professionals including general practitioners and district nurses.