Apex Prime Care Ltd

Apex Prime Care - Hailsham

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
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
Apex Prime Care – Hailsham is a domiciliary care agency. The agency provides care to people living in their own homes. At the time of the inspection, care was being provided to 90 people. Some people lived with dementia and some people had support needs relating to their mobility or other health support needs.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The timings of people's care calls varied and did not consistently match the times recorded in people's weekly rotas. This had an impact on people with some people having to reschedule health appointments and social events. A person told us, "My morning call often comes so late I miss meeting up with my friends and I can't plan to see them." A system was in place for staff to call the office when running late however this system was not working. People told us that when raising issues or complaints, their calls were not well managed and that they felt 'fobbed off' when wanting to speak with managers.

Some care plans lacked risk assessments for people that had specific health needs for example, people living with epilepsy. Some other risk assessments lacked detail and only had general information about particular health conditions for example, Parkinson's disease. People told us they were unsure how to contact the registered manager and, in most cases, did not know who the registered manager was.

People's communication needs were met and people's care plans contained details of their likes, dislikes and daily routines. Some staff had completed end of life training and were able to tell us the important aspects of care and support for people at that time of their lives.

Systems were in place for auditing all key areas of the service and this was overseen by the registered manager. People had opportunities to provide feedback about the service. This was done each day to carers if needed and more formally through an annual questionnaire. The registered manger had developed positive working relationships with partners.

People were protected from harm by systems and processes that had been put in place to safeguard people. People told us they felt safe and staff were able to tell us the steps they would take if they felt a person was at risk and in need of protection. Risks to people had been assessed in most cases with clear guidelines in place for staff to follow if required. Staff had been recruited safely and there were enough staff to support all care calls. Some people needed support with their medicines and this was provided by trained staff with regular competency checks on staff, carried out by supervisors. Infection prevention and control measures were in place and staff had access to and correctly used, personal protective equipment (PPE). Accidents and incidents had been recorded and any themes or trends and lessons learned shared with all

staff.

The registered manager carried out pre-assessments for people and ensured that staff had the necessary skills and training to be able to support people. Pre-assessment paperwork formed the basis of people's care plans which were then subject to regular reviews. New staff received a comprehensive induction which was supported by ongoing supervision meetings, appraisals and regular training. People's nutrition and hydration needs were met. Staff sometimes supported people to meet health and social needs appointments. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People told us that staff were kind and treated them with respect and dignity. People were supported to make choices about their care and support needs and were encouraged to be impendent and to take positive risks with their daily routines.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for the service at the previous premises was good, published on 8 August 2018.

Why we inspected
This was the first inspection for this service following a change in office address.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 was safe. Details are in our safe findings below.	**Good**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Apex Prime Care - Hailsham

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we wanted to be sure there would be staff at the office available to speak with us.

Inspection activity started on 9 August 2022 and ended on 12 August 2022. We visited the location's office on 9 August 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke to 14 members of staff including, the registered manager, the supervisor, the training manager, two care co-ordinators, one senior carer and eight carers. We spoke with 14 people that used the service, eight relatives and seven professionals.

We looked at a range of documents including seven care plans and associated risk assessments. Medication administration records (MAR), six staff files, and documents relating to audits and quality assurance processes. We looked at safeguarding files, accident and incident records and policies about complaints, whistleblowing and contingency planning.

Good

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service that has moved office addresses. This key question has been rated good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of harm and abuse. There was a safeguarding policy in place and staff were able to tell us the steps they would take if they felt a person was being abused. A staff member told us, "Make safe, report to manager and document all. Can go higher up if serious and call 999."
- We spoke to people who told us they felt safe. A person told us, "I have a lot of different carers, but they are all good and know what they are doing." Similarly, relatives told us they were confident their loved ones were safe when supported by staff.
- We spoke with professionals who confirmed that the service always responded well to concerns and worked with partners to resolve issues. One professional said, "They do present with knowledge of risk and will raise concerns. They have at times provided additional support to ensure the individuals care support is managed safely."
- A whistleblowing policy was in place where staff could report concerns anonymously. Staff told us they know about the policy and would use it if they needed to.

Assessing risk, safety monitoring and management

- We looked at several care plans and associated risk assessments. Most people had risk assessments in place specific to their support needs. (See our well-led section for more about risk.)
- Some risk assessments contained information about potential causes of risks and steps staff were to take if needed. For example, a falls risk assessment advised staff to clear obstacles when mobilising and to check the person was wearing appropriate footwear. If a person fell then staff would make the person as comfortable as possible and call for support.
- During the pre-assessment visit, managers considered all environmental risks within people's homes. This included for example, the presence of smoke alarms, facilities for storing medicines and whether or not people had pets.
- We were shown a risk matrix which prioritised care calls that would take place in the event of an emergency for example, the recent pandemic. The matrix prioritised people that lived alone or had time specific medication. This risk contingency was accessible to all staff and was effective during the recent pandemic with those that needed more support receiving it throughout that time.

Staffing and recruitment

- There were enough trained staff to cover care calls and to meet people's needs. Staff told us that they had enough time to carry out their tasks and that if there was a need to overrun then they would call the office to arrange cover for their next call. Staff told us that it was sometimes tight with travel time in-between calls. (See our responsive section for more about care calls.)

● Care notes were entered by staff onto a mobile phone application. Notes were timed and dated, and corresponding records were accessed by support staff working in the office. In the event of staff being late, this information was immediately available to support staff and managers.
● Staff recruitment was done safely. We looked at several staff files which contained all of the documents confirming that staff were safely recruited. For example, photographic identification, employment history with any gaps explained and referenced, employment references and disclosure and Barring Service (DBS) documents. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● People's support needs with medicines varied. Some were supported by family members and some were reminded during care calls by staff, to take their medicines. Some people needed staff to support them fully with medicines. Care plans showed clearly the level of support needed and medication administration records (MAR) were completed at people's homes. A person said, "They do my medication and it's fine. I haven't had any problems with it."
● MAR charts were recorded electronically and showed the date, time and name of the staff providing the medicines. Charts were coded to show if a person had refused or was unable to take their medicines and all of this information was remotely available to managers at the office.
● All staff were trained in the provision of medicines and we were shown training records that confirmed this. Staff were able to tell us what steps they would take if a person refused their medicines. A member of staff said, "Can't give if they refuse but would speak to them and family and if it persisted my manager and the GP." The registered manager carried out regular competency checks on staff to make ensure safe practice.
● Some people received time specific medicines for example, people living with Parkinson's disease. Care call schedules for staff prioritised people in need of their medicines at a certain time.
● Separate protocols were in place for staff for supporting people with 'as required,' PRN medicines.

Preventing and controlling infection
● Throughout the recent COVID-19 pandemic staff had received updated training in the use of personal protective equipment (PPE) including donning, doffing and the safe disposal of used PPE. Staff had received training in infection prevention and control and the registered manager kept all staff up to date with the latest government guidelines.
● The service had plentiful supplies of PPE and people and relatives told us that staff consistently wore PPE during care calls. People also told us that staff frequently washed their hands during visits to their homes.

Learning lessons when things go wrong
● Accidents and incidents were reported by staff with details being recorded electronically. This provided immediate access to the registered manager and office staff which would then provide additional support if needed. The registered manager told us they liaised with family members and loved ones and involved professionals for example, GP's, if necessary.
● A copy of the record remained on people's care plans and a weekly summary of events was produced and reviewed by a supervisor. In most cases no further action was needed but any trends and any learning from accidents and incidents was shared with all staff.

Good

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.

This is the first inspection of this newly registered service that has moved office addresses. This key question has been rated good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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

- Most new referrals came from the local authority. The registered manager first reviewed the local authority plans to ensure that the staff had the right skills and training to support the person. The registered manager then carried out a face to face assessment in people's homes where possible with relatives present.
- The documentation from the pre-assessment formed the background to the care plan. Any environmental risks or health or support needs were identified and documented. Staff were given time to read new care plans before starting to support people.
- Care plans and risk assessments were regularly reviewed. This was done by care co-ordinators and was overseen by the registered manager. Reviews were carried out after six weeks, six months and then annually or following a significant change in needs for example, following a hospital stay.

Staff support: induction, training, skills and experience

- Staff told us of a comprehensive induction which prepared them for working independently with people. Staff comments included, "I did three days of online training and then went out to shadow," "I'm new to care, I had a week going through everything" and "After the shadow shifts, I was shadowed to make sure I knew what I was doing. I could ask for more days if I need them."
- Staff continued to be supported by the registered manager and senior staff. Competency checks were carried out several times each year, unannounced practical supervision sessions in people's homes to ensure safe practice. Staff had supervision meetings every three months and annual appraisals. A staff member told us, "I'm supported well and I'm confident to talk about anything with supervisors."
- We were shown the staff training matrix which was colour coded to show when training sessions were completed, due and in a small number of cases overdue. The registered manager assured us that overdue training was recorded only for staff who were absent on maternity leave. Staff told us the training covered all of their needs and they could ask for additional training if needed.
- All staff had achieved or were working toward the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

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

- Most people were able to prepare their own food and drink or were supported by relatives or loved ones. Some people, however, did require some support. Details of support needed was recorded on care plans and people's nutrition and hydration needs were met.

● Some people lived with diabetes that was diet controlled. Risk assessments were in place and care plans clearly indicated the type of food and drink for staff to offer. Staff had been trained in diabetes management. If staff had concerns about people's weight a diet and nutrition monitoring plan was put in place where weights were recorded, and specialist advice was sought in the event of significant changes.
● People told us staff supported them with food and drink. One person said, "I can't eat a lot of things and they always ask me what I want and do their best to prepare it." Another added, "They always give me a choice and are happy to prepare what I want."

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● Some people were supported to make and attend health and social care appointments. This was not a routine task done by staff but they did support people in some cases when needed. A person told us, "I had a doctor's appointment and couldn't manage to go on my own. They went with me which was over and above what they are supposed to do." A staff member said, "I have taken people to their GP. It's rare and pre-arranged."
● The registered manager had established positive working relationships with other professionals and worked well together to help support people. A professional said, "They have a caring approach and are open to collaborating with other services."

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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

● One care plan contained a generic MCA which was not decision specific. We spoke with the registered manager who took immediate steps to update the document and clearly describe the decision being supported.
● Most people supported by the service were able to make their own decisions about their day to day care needs. Some were supported by relatives. Some people did lack capacity and the service had a mental capacity 'code of practice' which supported staff to understand the principles of the MCA. In addition all staff had received MCA training.
● Reference was made in all care plans to people's capacity and for those people who needed support in making decisions, mental capacity assessments were completed and where required, best interests meetings were held with people and their relatives.
● Staff understood the importance of gaining consent from people. Comments for staff included, "I reassure and support, give them a couple of minutes and go back," "Assess the mood. I talk to them but know I can't make them do things. I don't give too many options" and "Most people consent. I'll encourage people, slow down and explain reasons why it's safer to do things."

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.

This is the first inspection of this newly registered service that has moved office addresses. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- The registered manager told us that they try to provide people with the same team of carers but sometimes, to cover sickness and leave, different carers do have to be used. A person told us, "We get the same man most mornings and he comes at 7.50. He is very prompt." However, a relative told us, "We have a list of who is coming but it often changes."
- People and relatives told us they felt the care they received was of a high standard and that staff were kind, caring and attentive. One person told us, "They have made my life more bearable. I'm so glad I have them, they are the only people I see."
- People's backgrounds were documented in care plans including a section called, 'what is important to me.' These sections included information about any cultural or faith needs that people had including and support they may need to practice their faith.

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

- People were offered choice when being supported by staff. People decided what clothes to wear, in some cases what food they wanted and whether or not they wanted to shower or bathe each day. Staff told us they offered people choices and respected the decisions they made.
- People's care plans were regularly reviewed. Reviews were carried out at six weeks, six months and then annually or following a significant change in needs, for example, following an accident or after returning home after a stay in hospital. Reviews were carried out with people and where appropriate, their relatives. Advice from professionals was sought when required.

Respecting and promoting people's privacy, dignity and independence

- People told us that staff respected their privacy and dignity, took their time and were patient with them. Staff confirmed that they never rushed people and that it was important to respect them at all times. Comments from staff included, "Respect and dignity are important, we are in their homes," "Treating people with dignity is common sense. I treat them like I'd like my mother to be treated" and "100% dignity, includes everyone I've worked with."
- People's personal information was updated and kept on computers that could only be accessed by trained staff. Documents were kept in a locked cupboard within a locked office.
- People were encouraged by staff to be as independent as possible and to take positive risks to maintain their independence, without compromising safety. Staff told us, "If they want to be independent, I encourage them" and "It's right that they are encouraged to do some things themselves."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection of this newly registered service that has moved office addresses. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences. Improving care quality in response to complaints or concerns

- People told us that the times of their care calls varied, did not keep to the times on their weekly rotas provided by the service and had an impact on other aspects of their lives and daily routines. Comments from people included, "I used to get regular calls but now it's different times," "It's the timing that's the problem" and "The calls vary all the time." A staff member said, "We have enough time at calls but travel time is an issue."
- Comments from people about the impact included, "The times keep changing, they used to come at 8am but now it can be anytime up to 11am which is difficult because I sometimes have a hospital appointment and I have had to cancel it before now." Another person told us, "I am getting very depressed because I need help in the morning and sometimes, they don't come till after 10am."
- People told us they understood that sometimes carers would run late but they also told us they were never told when this happened. A person said, "I speak to them about it most weeks, but nothing happens." The registered manager told us that there was a protocol for staff to inform the office if running more than 15 minutes late and then for office staff to call the people who were affected. In practice, this was not happening.
- Staff rotas showed that there were enough staff on duty each day to cover all calls with a contingency plan to use office staff if there was unexpected sickness. People consistently told us that calls were late, and they were not informed of delays.
- People told us they did not think complaints were well managed. One person said, "Only one complaint, we wanted to have the same person on shower day. When I rang the office, they were quite rude." Another person told us, "When I ring the office about the time of my calls I get fobbed off when I want to speak to the manager."

The daily communication with people about the timing of their care calls and the accuracy of the schedules provided to people and the service response to complaints were areas that required improvement.

- The registered manager told us that they had to prioritise people who required support with time specific medication. During care calls people were supported in a person-centred way. Staff told us they spent time with people, getting to know them and the ways they wanted to be supported. A staff member said, "We mostly have enough time with people, I'd stay longer if I was needed."
- A complaints policy was in place and was accessible to people and their relatives.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the

Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Most people were able to communicate their needs verbally but some required support. Some care plans had 'accessible information assessments' which gave detail of support needs and the best way to communicate with people. For example, some people used boards for messages to be written down so that people and carers could communicate. Some people had weekly rotas provided in a large print version.

● Some people lived with dementia and required more time to process information and respond when asked questions. Staff were aware of peoples different needs and told us they took time with people, explaining the tasks they wanted to support them with and only carrying out tasks when people fully understood.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Most people did not need support with their social activities however staff told us that with enough notice they could help people to visit local shops, cafes and places of worship.

● People's care plans gave detail of peoples' likes, dislikes and daily routines. Staff respected people's routines.

End of life care and support

● Care plans had a section called, 'my advanced care plan.' The registered manager told us this section was discussed with people but not everyone was prepared to provide details. This section included end of life arrangements, people's preferences and contact details of relatives and loved ones involved.

● Some staff had completed end of life training and only those who had successfully completed the course would be used to support people at that time of their lives. Trained staff were able to tell us about the important aspects of care provision at that time. A staff member said, "dignity and respect are important as well as involving family." Another staff member told us, "It does vary with some needing more help and others less. Making people comfortable is important."

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.

This is the first inspection of this newly registered service that has moved office addresses. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

- Not all care plans contained detailed risk assessments for people's specific health and support needs. For example, some people lived with epilepsy. A description of the condition was included in care plans with some guidance for staff in the event of a seizure but no indication of what may trigger a seizure or when seizures were more likely to occur.
- Other people lived with Parkinson's disease. Similarly, there was a generic description of the disease but no bespoke risk assessment within the care plan. People living with Parkinson's disease were at greater risk of falls.
- Several people and relatives were unsure of who the registered manager was and were unclear how to contact the manager if they needed to. A person was asked about who they would contact to raise a concern and they answered, "I don't know." People who were able to name the registered manager told us they had had no contact with them. Following the inspection, the provider informed us they had provided everyone with the registered managers details'.
- Some people and relatives told us that they had not been given formal opportunities to feedback about the service.

Some risk assessments needed more detail and guidance for staff. Some risk assessment reviews needed updating. And lines of communication between the registered manager and people and relatives were areas that required improvement

- Staff told us that the registered manager was supportive. A member of staff said, "No issues. Approachable and would deal with my issues."
- Staff used handheld devices to input their actions during care calls. This enabled managers and office staff to immediately see when and what support had been provided, monitor any incidents and to respond if told that staff were running late.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager was aware of their responsibilities under the duty of candour. Registered managers have a legal obligation to inform CQC of certain significant events that have affected their service.

This obligation had been met.

● The staffing team covered a large geographic area and were split into teams to ensure best use of time. Contingencies were in place to cover staff absence through unexpected sickness or vehicle breakdown with trained office staff being sent out to cover in the first instance.

● Office staff and seniors operated an out of hours on call system to support carers if they need advice. The registered manager was not part of that on call system but was available to be contacted out of office hours for advice and support if needed.

● Auditing processes were in place and were carried out by office staff with oversight from the registered manager. Auditing covered all aspects of the service including, training, accidents and incidents, medicines and safeguarding. Most trends and themes were identified with any learning or changes to practice being shared with all staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and relatives told us that they had not been given formal opportunities to feedback about the service. However, the registered manager showed us annual surveys that had been completed and offered assurances that people's immediate feedback and concerns were followed up every day.

● Staff had informal and formal ways of providing feedback to managers about the service. During the recent pandemic team meetings had been held via video links however face to face meetings were due to start again. Staff told us they could speak to supervisors and managers whenever they needed to and could use the in-call system if they needed urgent advice. A member of staff told us, "I can approach anytime for help."

● Staff had regular supervision meetings which provided a further, regular opportunity to raise any issues and discuss concerns with supervisors.

● People's equality characteristics were recorded in care plans where appropriate. Care plans had sections called 'About Me' and "What I important to me." People's faith and cultural needs were supported.

Continuous learning and improving care

● The registered manager showed us contingency and continuity plans that had come into force during the recent pandemic. Apex is a large domiciliary care provider in the south east with a vision of expansion to support local people and provide care in people's homes. Locally the registered manager was keen to learn, to match staff experience with people's needs and to continue to improve the service provided.

● The registered manager had monitored and complied with the government guidelines throughout the pandemic and continued to keep up to date with bulletins circulated by the CQC, local authority and the UK Health Security Agency.

Working in partnership with others

● The registered manager had developed positive working relationships with professionals and statutory partners who were involved in aspects of people's care. Professionals told us that the registered manager and their team kept them informed about people's health and social care needs. Comments from professionals included, "I have spoken to several members of the care team and found them all helpful," "They spotted some inconsistencies in a pre-assessment and chased us for an update," "In general, always very good and communication is clear."