Premier Nursing Limited

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Inspection report

2 Arun Street
Arundel
West Sussex
BN18 9DL

Tel: 01903883882
Website: www.premier-nursing.co.uk

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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

The inspection of Premier Nursing Services was on 12 September 2018 and was announced. We gave the provider two days' notice of the inspection. This ensured that staff were available in the office and people were prepared, to receive a telephone call, from the inspection team.

Premier Nursing Services is a domiciliary care agency. It provides personal care to people living in their own houses and flats, in the community. It provides a service to older people. At the time of the inspection the service was providing care to 22 people who lived in, or around Arundel. This service provided both planned visits to people's home and a live-in service.

At the last inspection, on 11 May 2017, Premier Nursing Services was rated as Requires Improvement. We had identified concerns relating to staff supervision and appraisals. We also found that systems, to check the effectiveness and safety of the service, were not always completed fully, or in a consistent manner. At the inspection before this, on 13 and 15 April 2015, we had identified concerns about the safe care and treatment of service users, and the oversight of the provider. More specifically, there had been concerns about risk assessments and the systems they had in place, for checking new staff, to ensure they were suitable for the job. We had also identified concerns relating to staff training. The concerns, relating to risk assessments and the suitability and training of staff, had been addressed at the inspection on the 11 May 2017. However, the oversight of the service had continued to require improvement.

Since the last inspection the provider had established a robust system, for ensuring staff received appropriate levels of support, with regular supervisions and appraisals. They had improved their method of reviewing the care people received, to ensure it was consistent and of an appropriate standard. However, processes to ensure the service was safe, and care was given in a consistent manner, continues to require improvement.

It is a requirement for providers to display their previous CQC rating in their registered premises and on their website. We reviewed the website, prior to the inspection, and the rating was not displayed. This was discussed with the provider, during the inspection. The provider has since ensured the rating is displayed, both within their office and on their website.

Not all care plans contained person-centred information. Some care plans were lacking specific details about the care people required.

There was a system for audits and quality reviews in place. However, documentation was not always robust, with omissions in the medication administration records and a variable amount of person-centred information in some care records. The quality assurance processes had not identified or corrected this.

Staff were involved in the management of medicines. Medicines were given appropriately, although we found omissions in some of the medication administration records. During the inspection the administrator

devised a medicine audit and devised a plan to incorporate this into their routine practice.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. On the day of the inspection the registered manager was away but we have spoken to them since the inspection.

People's care need were assessed, prior to the first care visit. Accessible information was considered during this initial assessment. Risk assessments were completed and reviewed as necessary. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. People were offered choices and felt respected by staff. Their privacy and dignity was maintained and practices were in place to ensure confidentiality.

There was sufficient staff available. People were informed of their planned visits a month in advance and could rely on the staff to arrive at the correct time. Staff were chosen to suit the needs of people. People could choose how much support they wanted and people's independence was maintained. We received many favourable comments from people and their relatives. People told us they felt able to raise any concerns and there was a complaints procedure in place.

The service had systems to ensure good infection control. Staff received training in food hygiene and were aware of people's nutritional and hydration needs. They worked well with other organisations and liaised effectively with health-care professionals. Some people received end of life care, which was caring and compassionate in nature.

New staff had sufficient back-ground checks, to ensure they were suitable for working in the care industry. There was a system for 'spot-checking' to ensure to care standards were maintained.

Since the last inspection the office team had sought to raise and maintain standards. There was a positive culture within the service and both people and staff felt the registered manager was approachable.

This is the third consecutive time the service has been 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?

Good

The service was safe.

People received their medicines, as necessary.

Risks to people had been assessed and managed appropriately.

There were sufficient staff available to provide continuity of care. Checks had been completed to ensure staff were suitable to work within the care industry.

Staff knew how to keep people safe and how to report any concerns.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training and supervision.

Staff worked within the principles of the Mental Capacity Act 2005.

People were supported to maintain their hydration and nutritional needs.

People were referred to health-care professionals as required

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and respect.

People were offered choices in their daily care.

Staff promoted people's independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not all care plans contained person-centred information.

There was a complaints procedure in place and people told us they felt able to raise any concerns.

Staff delivered compassionate end of life care.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The rating from the previous inspection was not displayed on their website.

The audit and quality assurance systems had not ensured care records were completed to an appropriate standard, for example the medication administration records and care plans.

There was a registered manager in post and staff told us they felt well supported.

The management team were continuously reviewing the service and introduced changes after feedback.

Premier Nursing Limited

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.

The inspection took place on 12 September 2018. We gave the service 2 days' notice of the inspection site visit, to ensure that people were aware of the planned inspection and prepared to receive contact from the inspection team. It also ensured that appropriate staff were available at the service's office. The inspection team consisted of an 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. The expert by experience had expertise in caring for older people.

Before the inspection visit we reviewed the information we held about the service. This included the notifications the provider had sent us. A notification is information about an event the provider is required to tell us by law. We also used the information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make.

The inspection involved a visit to the service's office, and telephone conversations with people who use the service, along with their relatives and a health care professional. During the inspection we spoke with two office administrators, three care staff and a health care professional. We also spoke with eight people and two relatives. We reviewed five care records. We looked at three staff files, training and supervision records and systems for monitoring the quality and safety of the service.

Good

Is the service safe?

Our findings

People told us they felt safe when receiving care from Premier Nursing Limited. One person stated, "Right from the word go I felt safe. I know they are in my home but my instinct just made me feel that everything was safe." Another commented, "I'm not worried about safety. I don't even think about it." One relative told us, "I feel my husband is very safe."

Medication was administered appropriately and safely. There was a medication policy in place. Each person had a medication assessment, as part of the initial assessment. This determined if the person was to remain independent with their medicines, or if the care staff were going to take on some, or all, of the management of the medicines. One person advised us, "They went through all the medication I take and how much I am able to do and not able to do." Medicine administration records (MARs) showed that some people were prescribed medicines to be taken when required (PRN), and we saw evidence that they were given appropriately. One person required pain killers before doing their exercises. The charts showed that these were being given at appropriate intervals.

Any accidents or incidents were recorded. These records included the actions taken by staff. We reviewed the documentation relating to one incident. The actions taken were both appropriate and timely. They were reviewed to look for trends relating to that person. The administrator assured us that as any incidents or accidents were discussed with the office staff they had a good oversight of the whole service.

People were safe-guarded from abuse. There was a safe-guarding and whistle-blowing policy. Staff discussed the need to keep people safe and free from abuse. They advised us that if they had any concerns they would talk to the manager. They had received relevant training on safe-guarding and talked through the actions they would take if they had any concerns about someone's safety. The administrator talked us through a recent situation, where they had worked closely with the local safe-guarding team, after raising a safe-guarding concern.

People also told us they did not need to worry about their personal belongings. One person commenting, "I feel our home and possessions are safe." There was a system in place for ensuring the staff documented any money they spent on behalf of the person.

There were sufficient staffing levels to cover the care visits. The care visits were planned a month in advance and a roster given to both people and staff in a timely manner. This was confirmed by one relative who stated, "We … know who is coming because I am sent a rota for the whole month." One member of staff similarly confirmed, "I know exactly what I am doing for the next month." Staff also advised us that they would ring people if they were going to arrive late. One person confirmed this stating, "Once…she was held up with another patient but they let me know." Staff told us they felt they had been allocated enough time, per visit, to provide person-centred care. One member of staff told us, "I do feel they have allocated enough time to be able to do that."

The service allocated a member of staff to each person, to ensure continuity of care. Every person we spoke

to advised us that they had the same regular member of staff. If a member of staff was unable to attend a visit, for example during annual leave of sickness, there was system for ensuring the care visits continued. The office staff aimed to send out an alternative carer, who had already had prior contact with the person. If this was not possible the administrator responsible for the quality reviews would complete the visit. This was confirmed by the people we spoke with. One person stated, "Is she can't make it, for some reason, they would ring me … and tell me who would be and ask if that was alright."

People were protected, as far as possible, by a safe recruitment process. New staff went through a series of checks, to ensure they were able and appropriate, to work within the care industry. The checks included a Disclosure and Barring Service (DBS) check, two references and an identity check. They also had to complete an application form, an interview and provide a full history of their previous employment, including explanations of any breaks in their work history. If a member of staff had not been employed by the service, for a period of time, these checks were repeated.

Personal risk assessments were completed, prior to the first visit, and were reviewed on a yearly basis. If a person's condition changed the risk assessments were reviewed and updated. These assessments included the risk of developing pressure area damage and the risk of the person becoming malnourished. One person, with highly complex needs, had very specific individual risk assessments, covering a wide range of potential risks. These included the risk associated with them using public transport and public toilets. There was also an assessment relating to any risk to staff, when they were visiting different homes. If any potential risk was identified appropriate actions were taken to reduce that risk. For example, if a person was assessed as being at high risk of developing pressure damage, appropriate actions were taken and pressure relieving devices introduced.

Staff were aware of the principle of good infection control. They advised us they had ready access to personal protective equipment (PPE), for example gloves and aprons. People told us that that they were happy with the level of hygiene. One person commented, when asked about cleanliness, that the member of staff, "does it to the standard I want."

Good

Is the service effective?

Our findings

At the last inspection on 11 May 2017 we had identified that there the service did not have a consistent approach to staff supervision and appraisals. At this inspection we found this had improved. Staff received regular supervisions, every six months. The staff also had annual appraisals. Staff told us that they found these helpful. One member of staff had supervision from an external person, due to the area that they worked within. The quality lead also did spot-checks on staff, to ensure they were working at a high standard.

People were confident that the staff had sufficient training and knowledge to fill their needs. One relative stated, "I know that they're all professional and well trained." Another person, when asked if they thought staff had sufficient training, advised us, "Much more that I've ever seen through any of the other agencies I've used." People expressed confidence in the care provided, with one person reassuring us, "I'm confident in her care."

There was a comprehensive training programme for staff. This included a range of topics including food hygiene and infection control. Training was delivered in different formats, including face to face and online. One member of staff advised us that they had updates via texts providing details of available training courses. We asked staff if they felt the training was helpful. One member of staff stated, "It is really good actually." Staff felt involved in the training programme, with one member of staff telling us that the service was arranging some additional training for them, at their request.

The service also sourced specialist training, dependent on the needs of the different people they were caring for. One recent example was training to support a person living with epilepsy. All the care staff, responsible for visiting the person, received specialist training and their knowledge was checked, prior to them being allocated to the care of that person.

New members of staff had a period of orientation to the role. This included shadowing more established staff. The length of the orientation was dependent on the prior experience of the new member of staff and they did not work on their own until they were competent and confident to do so.

Each person's needs were assessed, prior to the service providing any care. One person confirmed, "The agency sent round someone to assess me and she asked me what I wanted and she looked at everything." These assessments were conducted by a small number of staff, who were experienced in assessing people's needs. These assessments were then checked by the administrator responsible for the quality of the service provided. After the initial assessment a member of staff was allocated to the care visits. Prior to the first care visit, the member of staff then met the person and their family. One member of staff informed us, "In all cases I have gone to meet the client before I had to go in (to perform care)."

The care staff liaised with other health-care professionals and were happy to make suggestions and referrals as necessary. One member of staff, when talking about their relationship with the local health-care professionals, described it as, "A real team." We contacted a local health-care provider and they told us that

they felt confident they would be updated and consulted, as necessary. Staff told us of a recent example of how they detected a change in a person's continence. The carers had spoken to the GP who had arranged further diagnostic tests for the person. They had also arranged for another health-care professional to visit the person and assess the change in their needs. They also made recommendations about specialist equipment, giving an example of their sourcing a specialist chair to increase one person's mobility.

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 can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. Staff had received training in the MCA. When asked if the staff considered consent, one relative stated, "they ask permission before they do anything." Staff discussed the need to obtain people's consent before giving care. One member of staff advised us they were, "always asking," giving the example of checking if they were ready to receive personal care.

Some of the people had help with shopping and others required assistance with eating and drinking. The care documents documented people's food preferences and if they had any specific requirements relating to eating and drinking. Staff discussed strategies they used to ensure people stayed hydrated, advising us how they offered people a drink, on each visit and ensured they had a drink available when they left. One person had been on a fluid restriction. Very specific advice had been clearly recorded in their care records, to ensure the person did not become dehydrated in hot weather.

Good

Is the service caring?

Our findings

People commented on the caring attitude of the staff. One person stated, "My carer is perfectly caring and charming." Another told us, "The carers are wonderful." One relative told us, "Their manner is excellent. They seem caring and compassionate." Another commented, "It makes me feel really good… (the manager) has made a big effort to find somebody suitable."

The member of staff was chosen to suit the needs of each person and the provider took pride in matching the right member of staff to the right person. One person advised us, "I couldn't have hand-picked them better." A relative told us that "(the manager,) is absolutely very good at marrying her client with the carers. She is good at judging who will get on with us or vice versa."

Staff spoke respectfully and caringly about the people they supported. One member of staff commented they were, "fond of them all." Another stated, "You do build up a relationship/friendship as you get to know the person." Staff could tell us personal information about the people they support, including their social history and likes and dislikes. They commented about the benefit of, "Chatting to them and getting to know them."

The care of the person also extended to caring for the family. One member of staff stated, "We are not just there for (name), we are there for his wife too." We were told of one relative who had been keen to take a more active role in caring for their loved one. With the help of the carers and physiotherapists the relative had been guided in the use of the hoist. The administrator told us, "It's so nice to see we are not just empowering the clients but also the carers."

People were involved in planning their care and making choices, around when they wanted visits and what they wanted the member of staff to do. One member of staff told us, "We do what the service user wants, as we are in their home." People could specify if they wanted staff to be in uniform or not. They could also request the visit to be at a particular time. One person preferred a late start at weekends. Their visits were arranged earlier during the week and later at the weekends to accommodate this request. Staff told us they routinely offered people choices about the care they received. One member of staff gave examples, which included, "bath today or hair wash today? Choices over meals and things. Choice of who goes into their house."

Staff promoted people's independence. One person told us of the importance of remaining active and independent, "I'm getting my morning walk every other day and feel that I'm still belonging to the world." Another person told us, "When I first came out of hospital I could barely get upstairs. The care I've had has really helped me improve a lot, much quicker, I am sure, than without it." One member of staff stated, "It's important to encourage independence." Within the initial assessment, there were goals that people aimed to achieve. These covered a range of topics, for example improving mobility, with the aim of enabling a person's social interactions. Strategies were listed in the care documentation, for example, one care assessment read, "Make bed with (name)," going onto state, "Encourage (name) to do more, for example washing up." One member of staff told us how this was a continuous process, stating, "The stronger he is

getting physically, the more we are asking him to do." They went on to comment about the impact independence had on a person's well-being, stating, "His quality of life is all about doing as much as he can."

Staff respected people's confidentiality. The service had a confidentiality policy which detailed how staff should manage and destroy any records containing personal information. We asked staff how they maintained people's confidentiality. We were advised that information about a person's care needs was only shared with the carers who would be doing the care visits. The administrator informed us, "We only disclose information to those who need it." There was also a system in place for the care staff to return any confidential information they had, to the office, to ensure it was disposed of appropriately.

Staff described how they treated people with respect. People confirmed that they felt staff respected them and their opinions. One stated, "they allow me to have a point of view. I like people to treat me as a person." Staff told us that they respected everyone, with one commenting, "We wouldn't discriminate."

People told us that the staff respected their privacy. One commented, "They are professional and friendly but not too intrusive." Another person told us, "Very much so, always discreet." One relative also said "They do respect his privacy and maintain his dignity." One member of staff advised us of the need to maintain people's dignity, stating, "If helping with personal care I would always make sure they are covered up." This attitude also extended to people's possessions. One person told us, "I'm what is known as a tidy freak and she puts things back exactly where I've left them."

Requires Improvement

Is the service responsive?

Our findings

Some documentation, relating to the care needs of people, did not contain clear guidance or person-centred information. People had a wide range of care needs. These needs were recorded in care records, which documented the person's daily routine and the care required on each visit. The documentation we reviewed contained a variable amount of information and detail. One person had very limited mobility and a range of complex needs. The assessment had an area to record their psychological wellbeing. Within this section the assessor had written "N/A," for not applicable. In the section for communication, it stated, "All excellent," whilst elsewhere in the records, there were comments about the person requiring glasses and being unable to write. Some of the care plans were similarly lacking in detail. One care plan recorded the 'problem' as the person's medical condition. The nursing actions, within the care plan, simply stated, "Full nursing care." This care plan was not person-centred and the specific care the person required was not recorded. The impact of the lack of person-centred care plans was small, due to the service's practice of ensuring staff were aware of people's care needs, prior to their first care visit, and of ensuring continuity of care. However, if another member of staff had to provide care, there was a risk that people may receive inappropriate or inadequate support, due to the lack of person-centred and specific information within the written records. This is an area that needs improvement.

There was evidence that the care plans had been reviewed, and agreed, with the person or their family, as appropriate. One person told us, "I was involved in the care plan, we went over everything very thoroughly, much more so than I've ever done previously." Care plans were sent out to the relevant staff, prior to the first care visit. One member of staff told us, "It's nice to have that before you visit, so that you are prepared before you go in."

Staff also told us how they would communicate, with their colleagues, about the care someone had received each visit. They referred to the records kept in the person's home. The staff told us that when they arrived at someone's house they always read through the care records, to check what had happened since their last visit. This was confirmed by the people. One stated, "There's a book here, that she fills in every day, to say she's been and I have to sign it. It says what she has done whilst she's been here." The office staff were also kept informed of any change, with one member of staff stating, "Any change we would ring it in (to the office)."

The service assessed people's need for accessible information. There was a form in the pack people received, prior to their first care visit, which asked details about any information needs. They also provided key documents, in a larger font, if required.

The service provided end of life care, working closely with other members of the health-care team. Staff received training on end of life care. Part of this was acknowledging and addressing the impact caring for people, as they approach the end of their lives, can have on staff. One member of staff told us, "I've done many palliative…it's lovely." They described the depth of the relationship they established at this time, both with the person and the family. They described how the caring relationship did not stop when someone died, or was admitted to a hospice. They referred to instances of meeting relatives, after someone's death

and taking the time to reminisce with them about their loved one. They also mentioned visiting a person in the local hospice, commenting, "I promised her I would." We were shown cards from bereaved relatives thanking the team for the care their loved ones had received, as they approached the end of their lives.

The service had a complaints procedure. People and relatives told us they would be happy to raise any concerns. One person advised us, "I would pick up the phone and call. I have a wonderful relationship." One person stated, "I'd have no hesitation telling the agency." However, people felt they did not have cause to complain. One person stated, "They come on time and do what I ask them. I've absolutely nothing to complain about."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 11 May 2017, we identified that the provider had made changes to improve the oversight of the service. However, some of the planned improvement had not been fully implemented. At this inspection we found the service had continued to improve, but there were still some areas that required better oversight, to ensure care was given safely and to a consistent standard.

It is a requirement under the Health and Social Care Act (2014) that providers must ensure that their rating is displayed conspicuously and legibly at each location delivering registered service and on their website. We observed that the rating from the previous inspection was prominently displayed in the office. However, on review, the website did not display their previous rating. After the inspection the provider changed their website and the rating is now displayed.

There were audits and quality assurance processes in place. However, these had not always identified areas that needed further improvement. One example was some gaps we identified in the medication administration records. From reviewing people's care documents we were satisfied that people were being given their medicines safely. However, at the time of the inspection the service did not have a process in place, to review the MARs and ensure they were completed accurately. This would mean that errors and possible trends may not have been detected. The quality assurance processes had also not detected the variation in the person-specific information, within the care documentation. If another member of care staff was required to take over someone's care, at short notice, this could impact on the care the person received. Ensuring a robust quality assurance process, to maintain high standards across all care documentation, is an area that requires improvement.

People told us they were very happy with the care they received. One person stated, "I tried three other agencies, before this one. This one is so much better." Another person told us, "I think it is a well organised organisation…From my point of view I can't see anything that can be done better." We also received positive comments about how the service was run. One person stated, "They turn up on time, stay and do what they have to do. Whole thing works like clockwork." These positive comments were echoed by staff. One member of staff told us, "I do think it's a very professional company, that strives towards high standards." Another member of staff commented, "The best thing is just feeling relaxed at work and looking forward to work."

There was a registered manager in post, who was keen to continue to improve and develop the service. There were two administrators who had taken on different roles within the company, to ensure good standards of care. One of the administrators was tasked with business development and the other was employed to monitor and improve the care provided. They advised us that it had been, "A good year," and they were proud of the changes that had been introduced. They showed me a list of the objectives they had devised for 2017-2018. The objectives included the introduction of the spot check system. These were now completed every four months, or more frequently if indicated. These checks involved one of the senior team going out to a person's home, to ensure that care was being delivered, in an appropriate manner. There was a checklist which was completed at these visits. These included checking the time that carers arrived, whether the carers were appropriately dressed and how they ensured personal information was kept

confidential. When these were introduced, it was noted that the times of planned visits, were not always recorded accurately. This had been addressed and the times were now reliably documented.

The administrators expressed determination, to continue to improve the standards of care, within the service. When we discussed the gaps in the MARs, with one of the administrators, they immediately created a medication audit. They went on to identify how often they would perform the audit, and how they would capture and use the information it provided. We were also shown a list of objectives for the coming year. These included a mix of topics, for example the aim to have a key worker system established by October 2018. The aim of the key-worker was to have one identified carer to co-ordinate a person's care, for example having the overall responsibility for ensuring health-care appointments were arranged at appropriate intervals.

The service had a comprehensive list of policies. These had all been reviewed and updated over the last year. Care staff were notified when policies were updated so that they could either request a copy, or arrange a time to come into the office to review them.

People told us they had a good relationship with the registered manager. One commented, "The manager has been more responsive than any other agency I have been with…I feel I could call her up and ask her anything. She has set up the relationship that way." Another person commented, "If I send her an email, or call the office, there is an immediate response." The service was keen to get feedback from people and relatives, to help improve the service they offered. The spot-checks involved talking to people and relatives, to check that all care was given to their satisfaction. They also had forms, which they sent out to people, asking them to evaluate the care they received.

The office team liked to have an open-door policy for the carers. We were told, "They know they can just pick up the phone." The staff told us that they appreciated this and advised us they would not hesitate to speak the registered manager if they had any concerns. One member of staff stated, "If I had a worry, I would just tell her (registered manager)." Another member of staff advised us the manager had, "Always been supportive."

There was a regular programme of staff meetings. The office staff also sent out email updates to the team and there was a regular newsletter for all staff. Within this newsletter was relevant information the staff should know, for example the summer edition had details about the recommendations from the Meteorological (Met) Office, regarding staying hydrated, during the hot weather. It also had information that was important for the staff when planning their visits, for example details of the parking restrictions during the Arundel festival.

The service communicated closely with other organisations. They gave an example of handing over one person's care to another care agency. This handover was conducted face to face, as they wanted to ensure a smooth transition of care.