Morah Services Limited

Clarity Homecare Essex

Inspection report

The Old Courthouse, Unit 22
Orsett Road
Grays
Essex
RM17 5DD

Tel: 01375806129
Website: www.clarityhomecare.co.uk/

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
• Clarity Homecare Essex 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 adults, younger adults, people with physical disabilities, mental health needs, sensory impairments, learning disabilities and dementia.
• The provider had one domiciliary care agency within their registration.
• At the time of the inspection it was providing a service to three people.
• For more details, please see the full report which is on the CQC website at www.cqc.org.uk

People's experience of using this service:
• People were protected against avoidable harm, abuse, neglect and discrimination. The care they received was safe.
• People's risks were assessed and strategies put in place to reduce the risks.
• People's likes, preferences and dislikes were assessed and care packages met people's desired expectations.
• 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 supported this practice.
• Relatives provided consistently positive feedback about the care, staff and management. They said the service was caring, timely, effective and well-led.
• People's care was person-centred. The care was designed to ensure people's independence was encouraged and maintained.
• People and their relatives were involved in the care planning and review of their care.
• The service had a stable management structure. The provider had implemented systems to ensure they continuously measured the safety of people's care and quality of the service.

Rating at last inspection:
• This was the service's first inspection.

Why we inspected:
• This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Follow up:
• We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our Well-led findings below.

Clarity Homecare Essex

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team:
• The inspection team consisted of one inspector.

Service and service type:
• Clarity Homecare Essex is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community.
• The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection:
• Our inspection was announced.
• The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.
• Our inspection process commenced on 12 February 2019 and concluded on 12 February 2019. It included visiting the service's office and telephoning relatives of the people who used the service. We visited the office location on 12 February 2019 to see the registered manager and office staff, and to review care records and policies and procedures. We telephoned three relatives of the people who used the service during the inspection on 12 February 2019.

What we did:
• Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public and the local authority. We checked records held by Companies House.
• The provider had completed a Provider Information Return. This is information we require providers to

send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
• We spoke with three relatives of the people who used the service. We tried to speak to people who used the service however due to communication difficulties they were unable to provide us feedback.
• We spoke with the registered manager, the nominated individual, and two care workers. A nominated individual is someone who has been nominated by the provider and has responsibility for supervising the management of the regulated activity provided.
• We reviewed two people's care records, two staff personnel files, staff training documents, and other records about the management of the service.
• We requested additional evidence to be sent to us after our inspection. This was received and the information was used as part of our inspection.

Good

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

People were safe and protected from avoidable harm. Legal requirements were met.

• Relatives told us they felt the service was safe. One relative said, "There are certain things [staff] won't do for safety reasons." Another relative told us, "Yes, I do think [relative] is safe because I have met [staff] a few times and how they are with my [relative]. They are kind and considerate."

Systems and processes to safeguard people from the risk of abuse:
• People were protected from the risks of harm, abuse and discrimination.
• There was a safeguarding and whistleblowing policy in place which set out the types of abuse, how to raise referrals to local authorities and the expectations of staff.
• Staff and management we spoke with had a good understanding of their responsibilities. One member of staff said, "I would speak to my manager. I could take it further. You could go to the police and social services." Another staff member said, "We will report it to the office."
• Staff completed safeguarding training to provide them with knowledge of abuse and neglect.
• The registered manager was able to describe the actions they had taken when incidents had occurred which included reporting to the Care Quality Commission (CQC) and the local authority.
• The registered manager sent us statutory notifications to inform us of any events that placed people at risk.

Assessing risk, safety monitoring and management:
• The provider carried out detailed risk assessments to ensure the risks to people were identified, assessed and mitigated.
• The service aimed to obtain as much information about a person before a new care package commenced. Before admission to the service a 'care plan assessment' was undertaken to assess whether the service could meet the person's needs. This included assessments from commissioning bodies, and feedback from people and their relatives. One relative told us, "They came and did an assessment with us there. [Discussed] what [relative] could do and what he couldn't do."
• People's care files included risk assessments which had been conducted in relation to their support needs including guidance. Risk assessments covered areas such as the person's physical condition, physical abilities, walking, general safety awareness, skin integrity, medicines, lone working and manual handling.

Staffing and recruitment:
• Through our discussions with the registered manager, staff and relatives of the people who used the service, we found there were enough staff to meet the needs of people who used the service.
• Staffing levels were determined by the number of people using the service and their needs, and could be adjusted accordingly. Relatives told us people's needs were met by the staff. One relative said, "The same regular [staff]. There is a pool of about five. They come in every day. Normally the same. Most of the time they are there give or take five minutes. They give us a call if running late or [registered manager] will call us." Another relative told us, "They only missed a call once and that was due to a traffic incident. Always spot on.

If they are late they will ring me and say they are really sorry and that [they] are coming. We know what is going on all the time."
• Staff told us there were sufficient staffing levels and their shifts were covered when they were on sick and annual leave. One staff member told us, "Yes [enough staff], if there is a traffic [delay] we let the office know and they tell [people who used the service]. If we are sick we have to ring to give enough time to get cover."
• The provider followed safe recruitment practices.
• Staff recruitment records showed relevant checks had been completed before staff worked unsupervised at the service. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records.

Using medicines safely:
• People's medicines were administered safely.
• The service had a medicines policy in place which covered the recording and administration of medicines.
• Records showed staff were up to date with medicines training.
• Staff shadowed an experienced staff member and then were supervised with giving medicines.
• Medicine competency checks of staff were undertaken. This ensured they remained safe to continue to administer medicines.
• People who were supported with medicines had a medication administration record (MAR). We found these were accurately completed and showed that people received their medicines as prescribed. One relative told us, "[Staff] are very strict how they administer the medicines. If they have any queries they phone me or follow up with GP surgery. They keep comprehensive records of what they administer."
• MAR records were returned to the office monthly and audited.
• People who required PRN medicines had guidelines in place. PRN medicines are those used as and when needed for specific situations.

Preventing and controlling infection:
• People were protected by the prevention and control of infection.
• Staff completed training in infection prevention and control on a regular basis. Records confirmed this.
• Staff had access to personal protective equipment (PPE) such as gloves, aprons and hand sanitizer. One staff member told us, "I have aprons and gloves. Make sure you wash your hands before and after [giving personal care]." Another staff member said, "You change your gloves and aprons every time you do things"
• A relative told us, "[Staff] wear gloves and they throw the gloves [away]. Everything is clean each time."
• Staff were required to complete training in food hygiene, so that they could safely make and serve meals and clean up after preparation. Records confirmed this.

Learning lessons when things go wrong:
• When staff members became aware of any accidents and incidents, they called the office and details were recorded on an incident form.
• The forms were passed onto the registered manager for review and, where necessary, investigation.
• A log of incidents was kept, to tally up the number and analyse any trends or themes on people who used the service.
• Where necessary, incidents and accidents were reported to third parties.

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.

People's outcomes were consistently good, and people's feedback confirmed this.

• One relative said, "The [staff] seem to be good. I think [staff] do quite well." Another relative told us, "[Staff] have been really good with [relative]. They have really looked after [relative].".

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• Assessments of people's needs we saw were comprehensive, expected outcomes were identified, and care and support regularly reviewed.
• Staff applied learning effectively in line with best practice, which led to good outcomes for people and supported a good quality of life.
• Staff knew people's preferences, interests, likes and dislikes. Information available included meal choices, and personal hygiene routines.

Staff skills, knowledge and experience:
• When new staff joined the service, they completed an induction programme which included shadowing more experienced staff. One staff member said, "We did some shadowing. I went out with the other [staff] to get to know the [people]. They watched me do some of the care and signed me off. When they felt I was ready they let [registered manager] know."
• Training was provided in subjects including moving and handling, food hygiene, communication, duty of care, basic life support awareness, privacy and dignity, fire awareness, fluid and nutrition, equality and diversity, safeguarding adults, medicines, moving and handling, health and safety, person-centred care, infection control, confidentiality, and the Mental Capacity Act 2005.
• Training was specific to the needs of the people staff were caring for. This included dementia care, pressure care, and continence care.
• Staff told us the training provided helped them to perform their role. One staff member told us, "I think [training] is really good. Recently just had a bit more training. We have online training we can do at home. [When] we have a new [person] we are able to refresh our training." Another staff member said, "The training is good. It goes into depth."
• Staff felt supported and received supervision and annual appraisals. One staff member said, "Supervision is every three months. We [are] asked how we are finding the job, if any issues, if anything could be done differently. There is a benefit to it because sometimes it's nice to speak to someone if you are not sure."
• Records confirmed staff received supervision and appraisals.

Supporting people to eat and drink enough to maintain a balanced diet:
• People were supported to eat and drink enough.
• Some people required support with their meals. Care records showed how people's dietary needs were assessed and personalised, such as their food preferences and how they should be assisted with their meals.

For example, one care plan stated, "Breakfast is usually a chocolate spread sandwich made with 2 slices of bread, buttered with a thin layer of butter, and a layer of chocolate spread. I have a small glass (about 50mls) of prune juice with my breakfast. I like this in the small glass. I have a fresh glass of refrigerated water in the medium glass which has the leaf pattern around the bottom. I don't have any hot drink with my meals."
• A relative said, "[Staff] reheat ready meals. But [staff] now they know [relative's] likes and dislikes." Another relative told us, "[Staff] prepare [relative's food]. They will ask what she wants"

Staff working with other agencies to provide consistent, effective, timely care:
• The service worked with other agencies and professionals to ensure people received effective care.
• Relatives told us the agency worked with other health and social care professionals. One relative said, "If anything comes up [registered manager] will contact other people like [occupational health] people [about] electric beds. [Registered manager] gets in contact with them and says [relative] needs this and that. [Relative] just got an electric bed and new wheelchair and [registered manager] was involved with that. The [occupational therapist] liaises with [the service]."
• Where people required support from other professionals this was supported and staff followed guidance provided by such professionals. Information was shared with other agencies if people needed to access other services such as GPs, health services, social services, community services and palliative care agencies.

Supporting people to live healthier lives, access healthcare services and support:
• Staff were aware of what action to take if people were unwell or had an accident. They told us they would contact people's GP or phone for an ambulance as necessary and inform people's next of kin. One staff member told us, "I would phone an ambulance. Doctor information [is] in the care plan book. In the care plan has the doctor's surgery number and next of kin."
• A relative told us, "[Staff] have really looked after [relative]. Doctor and hospice is really pleased with the care. [Staff] are genuinely on top of it. They contact nurses if any issues. They go the extra mile."
• Records showed the service worked with other agencies to promote people's health such as district nurses, GPs, occupational therapists and pharmacists.

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 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.

• Staff ensured that people were involved in decisions about their care, and understood the procedures to make sure decisions were taken in people's best interests. One staff member told us, "We have to ask [people] before we do anything like with personal care. You can't just surmise they will say yes." Another staff member said, "With [person] I am there to make her dinner but I will always say are you having something to eat today. [Person] has her kitchen window open and I will ask if it is alright to close the window. I won't just shut up."
• A relative told us, "[Staff] ask if [relative] is ready to go to the bathroom. They ask her what she wants for her evening meal." Another relative said, "[Staff] will always say to [relative] if she wants a drink or what she wants for lunch. They will ask if she wants a full wash or semi wash. They just don't barge in and off they go."
• Mental capacity assessments were completed when there was any question of a person's capacity to independently make important decisions.
• We spoke to staff and found they had a good understanding of the principles of the MCA.
• Records showed that people had agreed to their care plan by signing a consent to care agreement form.

Records confirmed the service had copies of Lasting Power of Attorney documents when people were unable to make their own decisions and relatives were involved in making decisions for them.

Good

Is the service caring?

Our findings

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

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:
• Relatives told us that staff were caring. One relative told us, "I think [staff] are genuinely interested in [relative] and what they do for him. They stay there and have a chat with him. They have got a good banter with him. [Staff] are cheery when they come in." Another relative said, "[Staff] really do care. They are great. They have a chat, laugh and joke. [Relative] needs that social interaction. She loves them. She wouldn't want anyone else to care for her."
• Staff showed a good awareness of people's individual needs and preferences. Staff talked about people in a caring and respectful way. One staff member said, "I think I have a good relationship with all the [people who used the service]. [Person] loves music so when we go in we put on old music. He loves it." Another staff member told us, "I have a good relationship with all [people who used the service]. They are all nice. You have a laugh and joke with them. Have a chat to see how they are. It's a rewarding job."
• We saw the service recorded compliments about the care provided. Comments included, "I love them [staff] all. They make me feel safe and feel well, and we have a laugh now and then" and "just a note to say we really appreciate how caring you are towards [person] and [person] and all their needs. Especially keeping us updated regarding any issues. We consider what you are doing is first class."
• Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service. The registered manager told us, "Everyone is an individual it doesn't matter what [your sexual orientation is]. We would talk to them about their needs and plan their care around them. They shouldn't be treated any differently from anyone else." A staff member said, "Just the same as anybody else. Your sexuality shouldn't mean you get different care. I wouldn't treat anyone different because of their sexuality."
• Training records showed staff had completed equality and diversity training.

Supporting people to express their views and be involved in making decisions about their care:
• People and their relatives were supported to express their views and to be involved, as far as possible, in making decisions about the care and support they received.
• Records showed people who used the service and relatives were involved in care planning and reviews. One relative told us, "They did [care plan review] about two weeks ago and [nominated individual] and [registered manager] reviewed the care plan. Went through everything with me and [relative]." Another relative said, "They talk to me quite a lot to see if anything needs to be reviewed."

Respecting and promoting people's privacy, dignity and independence:
• Relatives told us privacy and dignity were respected. One relative said, "[Relative] can be hard work due to her illness. [Staff] treat her with a lot respect and very kindly." Another relative told us, "[Staff] speak to [relative] as an adult not a child. They give her time to respond as she has got a dementia."

• Staff we spoke with gave examples about how they respected people's privacy. One staff member told us, "We always knock. You knock and open door slightly and call out and say it's [staff member's name]. We go out of the room when [person] goes to the toilet. When she is ready she will call us back in." Another staff member said, "[When giving personal care] you cover [people] up so they are not exposed."
• The service promoted people to live as independently as possible. Staff gave us examples about how they involved people doing certain aspects of their own personal care which supported them to maintain their independence. One staff member said, "Most [people] do things themselves. Some can wash certain parts of their body." Another staff member told us, "I give [person] more encouragement and a bit more time."
• Relatives told us the service supported people to maintain their independence. A relative told us, "[Relative] is independently minded. [Staff] would never stop her. They let her do stuff but keep a close eye on her to make sure she is not in danger." Another person said, "[Staff] took her off to the bathroom and let her do things she wants to do herself. She is a very independent [person]."
• Promoting independence was reflected in people's care plans. One care plan stated, "Please apply the body wash to the flannel for me and give me the flannel to allow me to wash the area's I can reach."

Good

Is the service responsive?

Our findings

Responsive – this means that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• Staff showed us they knew people's likes, dislikes and preferences. They used this detail to care for people in the way they wanted. For example, care plans had clear details around how a person preferred to be supported with personal care and day to day tasks necessary to obtain desired outcomes. One care plan stated, "I like to have a banana peeled but not cut up, and a cereal bar unwrapped and put on my special non-slip plate. Take a yoghurt drink from the fridge open it and put a straw in it. Make a cup of tea with milk and put a straw in it. Place both on the kitchen table with my breakfast. (Straws are kept in the kitchen drawer to the right of the sink)."
• Relatives were positive about the person-centred care provided. One relative told us, "[Staff] take [relative] out if he asks. I can't say anything against them. They are quite good." Another relative said, "[Relative] gets distressed sometimes due to her illness. [Staff] are very calming. They are good at calming her."
• All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements.
• The care documentation clearly showed that the service identified and recorded communication impairments. One care plan stated, "I use a touch writer to communicate as I am unable to communicate effectively verbally. Ask questions that require a yes/no answer, as I raise or lower my left thumb to answer these types of questions. I also blink my eyes and look at objects that I am trying to describe to you. I will also spell words out on my leg using my thumb when I don't have my writing machine."
• The service supported people with communication impairments. One relative said, "[Person] is non-vocal and he gives a thumbs up. They will ask what he wants to drink."
• Staff could describe how they would communicate with people they supported. One staff member said, "With [person], when I first started going in he would use the speech machine, but we hardly use the machine. We communicate more. He can talk but you give him a bit more time. You give him that time and don't rush him. With [person] there is eye movements and gives a thumbs up for a yes. His face says an awful lot."
• People's cultural and religious needs were respected when planning and delivering care. Records showed people had discussions of their spiritual faith during the care planning process. One care plan stated, "I am a practising [spiritual faith] and have [spiritual service] at home on a Saturday afternoon."

Improving care quality in response to complaints or concerns:
• People's feedback, concerns, complaints and compliments were recorded.
• Staff knew how to provide feedback to the management team about their experiences which included supervision sessions and team meetings.
• Relatives were aware of how to make a complaint. A relative said, "We would inform [registered manager].

Never had to do a formal complaint." Another relative told us, "Initially I would ring [registered manager] first, and if it wasn't resolved I would put it in writing."
• Records showed the service had received one complaint since they had been registered. We found the complaint was investigated appropriately and the service had provided an explanation to the complaint in a timely manner.

End of life care and support:
• The registered manager told us one person was preparing for end of life care support at the time of our inspection. The registered manager and the relative of the person told us palliative care specialists were involved with the person's care.
• People were supported to make decisions about their preferences and staff supported people and relatives in developing end of life care plans. Other healthcare professionals such as GPs, district nurses and palliative care nurses were involved as appropriate.
• Staff gave us examples of how they supported people with end of life care. One staff member said, "[Person] has [hospice] who go in on a Tuesday and chat with [person]. They make sure [person] is alright."
• The service had an end of life care policy which was appropriate for people who used the service.

Good

Is the service well-led?

Our findings

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

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on duty of candour responsibility:
• Relatives told us they felt the service was well run and responsive to their concerns and needs. One relative told us, "[Registered manager] is good. [Relative] has a lot of time for her. Most of the time available if not [nominated individual]." Another relative said, "[Registered manager] is very effective manager. She knows her stuff. She makes an effort to know [people who used the service]."
• The registered manager understood her role with duty of candour. Duty of candour is intended to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf). It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
• The registered manager told us, "It is about being open and honest. To make sure everyone has got the information they need to have by following the legislation. To make sure people are protected and working with multi-disciplinary organisations."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• Staff spoke positively about the registered manager. One staff member said, "[Registered manager] is great. She is approachable. She is good to talk to. [Nominated individual] is nice as well." Another staff member told us, "[Registered manager] is really nice and so is [nominated individual]."
• Staff were very positive about working for the service. One staff member told us, "Being a small company, you get a family environment feel." Another staff member said, "I get job satisfaction and I get great support. Great company to work for."
• The registered manager had a clear understanding of her role and the organisation. The registered manager told us, "I would like to think I am caring for my staff and the people I look after. I am fair and honest. I don't like blowing my own trumpet. I do my best."
• Effective communication systems were in place to ensure that staff were kept up to date with any changes to people's care and support systems. For example, staff meetings were held on regular basis. One staff member said, "We have a staff meeting. [Registered manager] will have an agenda what she wants to talk about. Then we all have an opportunity to say anything we need to talk about."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• The registered manager and the staff team knew people and their relatives well which enabled positive

relationships to develop and good outcomes for people using the service
• The service had a number of quality monitoring systems in place. These were used to continually review and improve the service.
• The registered manager told us they conducted regular audits on the service. The audit looked at people's daily records, medicine records, and people's finances.
• Spot checks were regularly conducted. The spot checks looked at punctuality, uniform and badge, respect, choices, equipment used safely, personal protection equipment, paperwork, medicines, feedback from people. Staff members and records confirmed this. One relative told us, "They have done spot checks on the [staff] and with [relative]." A staff member said, "I have had a spot check recently. It is unannounced to see whether if wearing correct uniform, our aprons and gloves, if care we are giving is correct. They will talk to the [person] to see if they are happy."
• Telephone reviews were conducted regularly. The telephone reviews looked at satisfaction with the service, call times, happy with staff, punctuality, availability of the registered manager, and any suggestions for improvement.
• The franchise provider had completed an audit on the service September 2018. The audit looked at records, recruitment, training, supervision, and quality assurance. The audit had not identified any issues with the service.
• The provider was planning to send an annual survey in February 2019 to people who used the service and their relatives.

Continuous learning and improving care:
• Throughout our inspection we saw evidence the nominated individual and the registered manager were committed to drive continuous improvement.
• There was a quality assurance programme in place.
• They told us the service was always trying to improve the way they provided care. The registered manager said, "Always want to improve where you can. It's about people knowing we exist. Trying to get on spot purchase. We've been to the council and CCG (clinical commissioning group.

Working in partnership with others:
• The service worked in partnership with key organisations to support care provision, service development and joined-up care. For example, the registered manager told us the service had worked with health services, pharmacist, palliative care services, and the local authority.