Raynsford Limited

Raynsford Domiciliary Care

Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 12 and 17 January 2017 and it was announced.

At the time of the inspection the service provided support to 11 people who lived with a learning disability and/or autism. People referred to the service as 'Raynsford' so this has been reflected throughout this report. People lived in one building and shared the communal facilities. They had their own private accommodation in the building which they rented through a tenancy agreement.

There was a registered manager in place although not present at the inspection. 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.

We made one recommendation for improvement related to guidelines for the administration of some medicines.

'Raynsford' had a warm and welcoming atmosphere. People looked relaxed and told us they liked living there.

People were kept safe and supported to help keep themselves safe when using the community.

Risks to people were identified and people were involved in deciding how these risks would be managed.

People received support to take their medicines.

People's support was provided by staff who had received training and support to be able to do this and who knew the people well.

People were supported to look after their health and to eat in a healthy way. They had access to appropriate health and social care professionals as needed.

People were supported to make their own decisions about their care and treatment. People's care and support was provided to them with their consent.

People unable to make decisions independently or who could not provide consent had their care and support provided in a way which protected their best interests.

People told us the staff cared for them and were kind towards them. Staff listened to what people had to say and genuinely wanted to improve their quality of life.

People were treated with respect and given privacy when appropriate. Information about people was kept confidential and secure. People's family members and friends were welcomed and also supported.

People were actively involved in planning their care and they had opportunities to review this and to make agreed alterations.

People were provided with support to go to work and take part in a full social life, if, this is what they wanted.

People's right to independence was respected, encouraged and supported where needed.

There were arrangements in place for people to make a complaint and have what was making them unhappy sorted out.

The service was well led but improvements were needed to how the registered provider and registered manager achieved planned improvements to the service. They were aware of this and plans to achieve this were underway.

Feedback from people and their relatives had been sought and all comments reviewed were positive. Health care professional made positive comments about the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Arrangements were in place to make sure people received their medicines safely. Additional guidance, for some medicines, was needed to ensure these particular medicines were always used appropriately.
People were supported to remain safe.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

There were enough staff to meet people's needs and good recruitment practices protected people from the employment of unsuitable staff.

Is the service effective?

Good

The service was effective. People received care and treatment from staff who had been trained to provide this.

People were supported to make decisions. Where people lacked mental capacity to provide consent or to make significant decisions they were protected under the Mental Capacity Act (2005).

People received appropriate support to maintain a healthy diet.

Staff ensured people's health care needs were met.

Is the service caring?

Good

The service was caring. People were cared for by staff who were kind and who had a genuine interest in the people they looked after.

People's preferences were met and their aspirations were explored and staff supported people to achieve these.

People were treated with respect and their privacy was upheld.

Staff helped people maintain relationships with those who mattered to them.

Is the service responsive?

Good

The service was able to be responsive. People's support plans were detailed and gave staff the information they needed to be able to respond to people's needs.

People had opportunities to work and socialise in a way which they enjoyed and which was meaningful to them.

There were arrangements in place for people to raise their complaints and to talk to someone if they needed to.

Is the service well-led?

Requires Improvement

The service was well-led but improvements were needed to the provider's quality monitoring arrangements to ensure these resulted in improvements to the service.

People were actively involved in decisions made about how the service should be run.

The views of people and their relatives were sought as part of the provider's quality monitoring processes. The management team encouraged people to express their ideas and suggestions on how the service could be improved for them.

Raynsford Domiciliary Care

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 17 January 2017 and was announced.

Prior to the inspection we reviewed the information we held about the service. This included a Provider Information Return (PIR). This form asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

The provider was given 48 hours' notice because the location provides a domiciliary care service for people with learning disabilities. People and staff are often out during the day so we needed to be sure that someone would be in. The inspection was carried out by one inspector.

During the inspection we spoke with four people who used the service and inspected various care records. These included, medicine records, support plans, risk assessments and behaviour management records. We spoke with two members of staff and the provider's representative. We also sought the views of two health and adult social care professionals.

We observed some people's medicines being administered to them. We reviewed a selection of records relating to the Mental Capacity Act 2005 and some records relating to Deputyship arrangements under the Court Of Protection. We reviewed two staff recruitment files and the staff training record. We also reviewed a selection of audits, the registered manager's action plan and records which monitored incidents and accidents.

Good

Is the service safe?

Our findings

People received varying levels of support in relation to their medicines. Medicines were stored securely and each person had a medicine administration record (MAR). Records were also kept of those delivered to the service and returned to the Pharmacy. Staff who administered medicines or who supported people to take their own medicines had been assessed as competent to do this. We observed people receiving support to take their medicines and safe practice was followed. People's (MARs) were completed by the staff straight after administration in order to keep these records accurate and up to date. This process helped to prevent medicine errors. One medicine, required by one person, was administered daily by a visiting community nurse as staff had not received training or been assessed as competent to administer this particular medicine.

Some medicines had been prescribed to administer 'When Required'. For these medicines people's MARs clearly itemised the medicine and support plans made reference to them. To improve practice, guidance for existing staff and to ensure necessary information about when to use these medicines was to hand we recommended that guidance by the National Institute for Clinical Excellence (NICE) be reviewed and separate protocols for these medicines be placed along side the MARs. The registered provider's representative told us this would be done.

We recommend that the provider seek advice, from an appropriate source, regarding the relevant NICE Guidelines for medicines prescribed as 'When Required'.

People told us they felt safe and they were supported to use the local community safely. Risks were appropriately identified and managed so people could lead a good quality of life, safely. For those who had mobile phones, contact numbers were programmed into the phone for people to use if needed. All people were regularly reminded about the 'Keep Safe Scheme'. This meant people were able to identify shops and businesses that were part of this scheme and knew where to go for help if needed. People had received training on how to make an emergency call. All of these arrangements were checked from time to time with people to ensure they understood them and knew how to operate them. People who needed more support to use the community safely received this. One person told us how they felt much safer if a member of staff was with them when they went out.

People had continual access to staff where they lived and telephone numbers of other company staff who they could speak with if they had any concerns. When we asked one person if they felt able to do this they said, "I would speak to [name of staff], she's lovely." Records supported the fact that people had conversations with staff about things that worried or concerned them.

Arrangements were in place to help protect people from abuse. Staff had received training to help them recognise abuse and they knew how to report their concerns. The registered manager appropriately shared information with relevant agencies in relation to safeguarding matters. Any required alterations to how staff needed to work or how people needed to be supported, in relation to a safeguarding concern, were fully supported by the registered provider. To further protect people (and staff) a new professional boundaries

policy had been introduced in November 2016 and had been discussed with the staff.

There was a link with the local police who had spoken to people about what abuse is and how they can help to protect themselves. The police visited people when they made an allegation of abuse to talk through their allegation and ascertain the facts. People were due to be offered an opportunity to take part in training which would help them learn about safe sex and healthy relationships. This was to help people recognise what was acceptable and what was not acceptable within different types of relationships.

There were arrangements in place for staff to be able to report any concerns they may have, confidentially, about another member of staffs' behaviour or practice. One member of staff said, "I would be more than confident to whistle blow to [name of registered manager and name of registered provider's representative]. Such concerns were taken seriously by the registered manager and registered provider and managed appropriately and confidentially.

Care records contained risk assessments which identified particular risks for each individual and then what support was needed to reduce these. People had been involved in talking about what risks related to them. They had been involved in making decisions about how these would be managed. In one person's case this involved actions to prevent the person from falling. For another person, there were risks relating to not having access to food and drink, unless certain arrangements were in place. For others, there were risks relating to the management of bills and personal monies which had been identified and arrangements put in place to reduce these. For another person, a risk assessment was due to be reviewed, if, they confirmed they wished to travel further afield on their own. Where appropriate people's legal representatives were involved in this process and where people wanted it, their family members were also involved.

The service was staffed in a way, both during the day and at night, which ensured people's needs were met and they were kept safe. Staff on duty had a varied mix of knowledge and experience. 'On-call' arrangements were in place so staff always had access to help or advice. Staff recruitment files showed staff had been recruited in a way which helped to protect people from those who may not be suitable. For example, checks had been carried out before staff started work. These included clearances from the Disclosure and Barring Service (DBS). A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had been obtained from the staff member's previous employer where this was still possible. The registered provider's representative explained that staff experience was considered when someone applied for a job, but more importantly they wanted to be reassured that the person was a caring and compassionate person and willing to learn. They said, "It's really important we get the right staff." People were involved in the recruitment process. They joined staff on the interview panel to assist with pre agreed questions, discussions and decision making.

Good

Is the service effective?

Our findings

People's assessed needs were met by staff who received support and training to do this. Many staff had several years experience in supporting people who lived with a learning disability or/and autism. Training records showed that all had received relevant training to help them perform their duties safely. One member of staff talked to us about their role and the support they received to carry this out. They said, "I do not need to worry, I can always get help." Another member of staff described the support they had received as "good". They told us they had been provided with one to one support sessions where they had been able to discuss their learning needs and progress. They told us they had personally found this to be a positive process with "constructive feedback" provided. Paper and electronic records showed staff had received support sessions. Staff also received an annual appraisal. The registered manager had identified that this process needed to become a more meaningful process for staff and they had included this in their action plan for the new year.

All staff completed induction training when they started work. During this time they were introduced to the registered provider's policies, procedures and expectations. There was an expectation that staff kept themselves updated with these. The induction training gave staff an introduction to all subjects the registered provider considered necessary to complete in order to work safely. Updates in these subjects were provided from then onwards and staff could request particular training and learning experiences as part of their on-going professional development. The training record showed that all staff had also completed the care certificate's basic modules. The certificate is a framework of training and support which staff new to care and others can receive. Its aim is that staff who are new to care will be able to deliver safe and effective care to a recognised standard once completed. Two staff had completed additional training in caring for those who live with autism.

Staff were supported to gain further qualifications in care. The majority of staff had all obtained further health and social care qualifications (NVQ - National Vocational Award now known as QCF- Qualifications and Credit Framework) at various levels. Staff with management responsibilities had also completed appropriate additional qualifications in management and leadership. One member of staff held a diploma in cognitive behaviour and counselling which was relevant to their work.

People's rights were protected and they were supported to make decisions about their care and treatment. A section in people's care records was headed "How I make decisions" and went through what support each person needed to do this. People received care for which they had provided consent. People's records also recorded when they had provided consent for information about their health and care needs to be appropriately shared with other professionals.

Where people had been unable to provide consent or make a specific decision about their care and treatment, the principles of the Mental Capacity Act 2005 had been applied. Where needed people had legal representatives to support them and to help them make significant decisions. For example, one person required regular treatment to maintain good health. The person had been supported to make a decision about this. Although the person did not object to receiving the treatment they were unable to retain and weigh up the additional information which they needed to make a fully informed decision about this. For example, information about the treatment's side effects and risks. A mental capacity assessment therefore recorded the person as lacking capacity to make this specific decision. Therefore, relevant and involved

professionals had made a decision on the person's behalf and in the person's best interests that the treatment should be given. In another case important decisions needed to be made about a person's accommodation and what kind of care they received in the future. Discussions about this had already involved professionals, a family member (who was the person appointed deputy under the Court of Protection) and the person to ensure their best interests were protected.

Staff supported behaviour which could be perceived as challenging in the least restrictive way. The Provider Information Return (PIR) stated staff were to receive further training on how to do this. The staff training record showed that several staff had completed this and others were booked to do this. Staff worked proactively to identify and manage situations which could act as triggers for these behaviours. Their aim was to work closely enough with people so they knew them well and knew what the triggers were. Staff could then provide the appropriate support and environment which would help to prevent such situations from arising. Staff worked closely with specialist health care professionals to support people with behaviours which could be perceived as challenging. One health care specialist said, "There is a consistent staff team which helps" and "They have some really good things happening there."

Despite this, sometimes, challenging situations had occurred which staff had been trained to manage. The use of safe minimal physical intervention was only ever entertained if people were going to harm themselves or others. One person said, "When people get upset the staff are brilliant." They went on to tell us about what staff sometimes did to support people. This involved talking to the person, distracting them and changing activities. People we spoke with about this told us they left the immediate vicinity if someone else was upset. One person's behaviour management plan gave staff clear guidance on what acted as potential triggers. It also gave detailed information about positive behaviours the person may exhibit and then behaviours that may be seen if the person was not managing a particular situation. It then gave detail about how each step of behaviour should be managed.

People were supported to look after their health. One person's care records recorded the planned support they received related to their concerns about their mental health potentially deteriorating. Included in the support plan was help for the person to be able to identify and manage situations that may have an impact on this. The plan went through "what worked well" and what needed altering. Records showed people had access to a GP and that sometimes they arranged their own appointments. The GP sometimes visited people in their own accommodation as was the case for one person who had become poorly. Staff supported people to attend appointments at the GP surgery and to be assessed by therapists and community nurses as needed. People's care records recorded appointments attended with a dentist, optician and chiropodist (foot care).

People were supported to eat and drink in a way which helped maintain their health. People kept a weekly food diary which they went through with a member of staff. This gave staff information about the types of food people were eating and they could advise them if their diet needed to improve. Staff supported most people to shop and cook but some liked to do this independently. Most people contributed an amount of money towards an evening meal which they preferred to eat together. We spoke to a member of staff who was involved in preparing these meals with those who wished to help. They told us some people enjoyed the experience of cooking. Other meals such as breakfast and lunch were organised on a more individual basis. One person told us they preferred to have their main meal cooked for them and eat with others. Another person told us they also liked to do this but sometimes enjoyed the freedom to be able to buy their own food and prepare it. Another person told us they ate out sometimes and other times they ate at home. We observed people able to make their own hot drinks and prepare snacks for themselves.

Good

Is the service caring?

Our findings

People told us how the staff were caring towards them. When talking with us about how the staff looked after them one person said, "I like it here, [name of staff] is lovely and they help me to have a shower." Another person said, "[Name of staff] is brilliant, they have a heart of gold, we have a laugh." Another person said, "I loves it here, I don't want to move, they help me with my washing." Another person said, "I really likes it here, it's better than some places I've lived, they [staff] are kind." We also observed and heard people show their affection towards staff. One person entered the room and put their arms around a member of staff and another spoke fondly of the registered manager who was not present at the time. They asked after her and said, "Bless her, she's lovely she is." Comments given as feedback about the service from relatives included: "The residents' welfare is uppermost and in the end it is truly made to be their home." Another relative had returned a comment about whether they considered staff to be thoughtful towards the needs of family members. They had commented, "Extremely, the team at Raynsford are very caring."

Throughout the inspection we saw people coming and going and encouraged to be independent. People looked extremely relaxed in the company of the staff. They were keen to tell staff about their day and what they had been doing or planned to do. Staff in return showed a genuine interest in what people had to tell them. People were spoken to in a respectful way. Information about people was kept secure. Conversations with people about their care were carried out in private. The registered manager had identified in their action plan that because people and staff had lived and worked with each other, in some cases, for many years, people's individual right to privacy and confidentiality needed to be consciously remembered by all.

People's care records and support plans recorded a lot of detail about people's likes, dislikes, preferences, things that worked well for them and things that did not. In one person care records a form called "All About Me" contained information about the person's life. We could see that staff knew people well and tailored their support to meet the person's needs and preferences. Staff were genuinely interested and motivated in meeting people's preferences and aspirations. People discussed these with the registered manager on a monthly basis and plans were drawn up to help people achieve their goals. The care and support people received was therefore personalised. Staff were sometimes designated to work with people because the person responded well to them or the person chose them to be their support worker.

People's records also showed the service made sure people had other opportunities to discuss the support they were receiving. The registered manager was very keen that people were in control of their own decision making, where this was possible. Where appropriate people had access to those who could support them with this. Family and friends (where appropriate) were communicated with and encouraged to be involved in people's lives. People were helped to obtain support from formal advocacy services when this was needed. Those who mattered to people were made welcome and updated appropriately about people's health and progress. People's wishes not to have family involvement were also respected. People's friends were made welcome and they were supported to maintain friendships.

Good

Is the service responsive?

Our findings

People were actively involved in planning their care. They had designated time with staff to review their support plans and future goals they may have. One person showed us their support file which contained their care records and support plans. People had access to information about them. They told us they went through their support file once a month with their designated member of staff called a keyworker.

The Provider Information Return (PIR) told us a consultant was used to formulate personalised support plans. This arrangement was still in place and the registered manager wanted to further support staff so they could also update support plans in a personalised way. Care information was detailed and centred on the person who was receiving the support. It recorded what people's views were, their decisions, preferences, interests, goals and aspirations. It showed that people's challenges in life were discussed with them and it clearly outlined the support people required to address these challenges. The information provided a month to month evaluation of what went well and what did not go so well. The reviews identified what needed altering and what people wanted altered. People's care was therefore evaluated and adjusted according to the person's needs, abilities and wishes. The information gave staff the information they needed to deliver personalised care which was tailored to people's individual needs and circumstances. Additional records relating to specific areas of support, such as behaviour management records, were maintained and gave visiting professionals the information they needed to further help support the person.

People's work and social activities were organised and supported around their abilities, preferences and aspirations. Different people required different levels of support to live a meaningful life. We observed people going out and coming back independently from work and from social activities. We also observed others receiving staff support to achieve their activities. One person told us about their work activity, which they said they "really enjoyed". They also had a full programme of social activities which was also important to them and which they also enjoyed. Each person we spoke with took part in some form of meaningful activity during the day.

People's diverse needs, behaviours and circumstances were responded to without discrimination or judgement. One person with a physical disability was spoken to and treated with the same respect as others around them. Their individual needs were responded to by the staff, who addressed these as they arose, without hesitation and in a way which was familiar to the person. People's ages also varied considerably and the needs of those who were older were also understood and accommodated without judgement.

People were given the time they had been assessed as needing (by their funding authority) to meet their personal care needs as well as their work and social needs. We observed the local county council's electronic call monitoring system in use. Staff logged in and out when starting and completing a person's funded support. People's funded one to one time was protected and they had decided how they wanted this time provided. For example, one person preferred their funded support to be provided in shorter periods of time each day, across the week. This electronic system allowed the local authority to monitor the contract it had in place with the registered provider.

At Raynsford there was usually always additional staff in the building on top of people's funded support time. For example, the registered manager was employed by the registered provider and was based in the building. Although employed to manage the service they were experienced in meeting people's needs and able to respond to people when other staff were providing people's funded support. This provided support for people which was over and above that paid for by their funding authorities. This cost was absorbed by the registered provider.

People, relatives and other visitors were able to raise a complaint if they needed to. A complaints file was in place but we were told no formal complaints had been received. We were told people were given opportunities to express complaints or talk about anything they were unhappy about. The last provider representative's monitoring report recorded there had been no formal complaints but people shared areas of minor dissatisfaction/complaint in 'resident meetings'. The report stated that in these meetings they were "encouraged to make complaints, concerns, comments and compliments known". It stated that these would be followed up, for example with the maintenance team or with individual staff or other residents if appropriate. People told us if they felt able to tell someone about things they were not happy about. A representative of the registered provider visited Raynsford on a weekly basis; sometimes more frequently. We observed them to have a relaxed relationship with people and people talked freely to them. They told us as part of their visits to the service they speak to people and make sure they are happy and have no concerns they wish to talk to them about. People knew the representative and told us they would feel alright talking with them about anything they were unhappy about.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was unable to be present for the inspection so the provider's representative was present instead. People spoke fondly about the registered manager in their absence. One health care professional spoke highly of them and told us they were "impressed with the service". They also said, "I have a good feeling about the place when I visit." During the inspection Raynsford had a friendly and welcoming atmosphere.

Quality monitoring processes by the provider needed some improvement to ensure planned improvements to the service were followed up and completed. Visits to the service were carried out by the provider's representative on a weekly basis and sometimes more frequently. They also received a weekly report from the service which helped to keep them up to date. The provider's representative was therefore well informed about how the service was functioning and what sort of support it needed. In addition to these visits they also carried out a monthly quality monitoring visit. The format for this visit followed the five main questions assessed by the Care Quality Commission and as seen in this report. This visit enabled the provider to check the service's performance and compliance with the Health and Social Care Act 2005 and relevant regulations and with the provider's own expectations. Due to unforeseen circumstances in 2016, the last recorded quality monitoring visit had been August 2016 and we reviewed this report. Since then the provider's representative had carried on visiting the service and supporting it as described above.

In 2016 the registered manager had written an action plan which recorded actions which they had identified as needing to be completed moving forward. We were given a copy of this to read. This included reviews of and various improvements to systems, processes and records to improve the management and performance of the service. This demonstrated that the registered manager had clearly given consideration to how the service could be improved and what needed to be done to achieve this. The actions on the plan however did not have recorded dates for completion but the provider's representative was aware that progress with the actions needed to start. To support the registered manager to be able to focus on management tasks and the action plan we were informed of changes which were planned to achieve this.

At the time of the inspection the quality monitoring arrangements undertaken by the provider needed to be fully reinstated, clear dates for completing actions needed to be put in place, robust follow ups and the signing off of these actions, when completed, would enable to the service to demonstrate that the quality monitoring system in place was effective and led to improvements being achieved.

However, audits were completed by the registered manager and deputy manager and had led to actions for improvement being identified, recorded on the action plan or addressed immediately. We saw a selection of audits which included an audit of the care files, completed in November 2016. This identified reviews with people, of their goals and aspirations, were "behind" and this had been added to the action plan as needing to be addressed. A medicine audit had been completed on what medicines individual people took and of their medicine administration record (MAR). A full audit of the medicine system had also been completed by the supplying pharmacy service. This had identified that people's medicines had not been recorded as received into the service when delivered. A review of the MARs after this audit date, by us, showed this action

had been addressed. Accidents and incidents were audited so that trends and frequencies could be analysed and appropriate actions taken to try and prevent recurrences.

The registered manager promoted an open and inclusive culture. Many people had lived at Raynsford for several years so it had been their 'home' for a significant amount of time. People had lived with each other, in some cases for many years. We were greeted by one person who was the service's ambassador and who was very proud to be this. They said, "We [meaning the people and staff] work as a team in collaboration". We could see people were actively involved in making collective decisions with the staff. This included when people planned to go out and what they wanted to eat as a group for supper. Another collective decision had been made to the lead up to Christmas 2016. People had decided that they wanted a real Christmas Tree instead of the usual artificial one. The provider's representative said, "So we went out and brought one".

Staff meeting dates were to be planned in for 2017 and according to the action plan, more importance given to these meetings. These would be used by the registered manager to communicate their plans and expectations for 2017 but also to receive feedback, ideas and suggestions collectively from the staff. Regular meetings were also held with people to pass on information which was relevant to them and to hear what their ideas and suggestions were for taking the service forward.

The Provider Information Return (PIR) told us how the registered manager kept herself up to date with best practice and current legislation. They attended various meetings, forums and learning exchange groups. They brought back what they learnt to the service and helped other registered managers in the provider group keep up to date. The registered manager also used this knowledge to update and strengthen certain provider policies, procedures and processes.

People's feedback and feedback from their relatives had been sought. Questionnaires had been sent out in order to gather this in August and September 2016. People had been asked to give their views on areas such as: care, staff approach, the facilities, choices and security. We reviewed the questionnaires returned from people who used the service which were 10 in total. All contained positive comments. Relatives were asked to feedback on: the atmosphere and the service's family values. One comment stated, "Our family believes that Raynsford has a good atmosphere and is a great place to live". Relatives were also asked to comment on areas which included: communication, privacy, staff skills, return of telephone calls and the ability to discuss complaints. These also all had positive comments. One relative had written that they "very much" considered staff to have the necessary skills and training to look after their relative. There were no areas for improvement fed back.