Around The Clock Care Agency Ltd

# Around The Clock Care Agency

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

We inspected this service on 17 September 2018. The inspection was announced. The service is a domiciliary care agency. It provided personal care to people living in their own houses and flats in the community. The service is for older adults, including people living with dementia and people needing care at the end of their life.

The service was registered with the Care Quality Commission to provide regulated personal care in September 2017. This was their first inspection. At the time of the inspection, eight people were receiving personal care and support from this service. Some people were supported with a 'live-in' carer.

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.

There were sufficient staff to deliver all the care hours that were needed by people. The service was developing incrementally as new care staff were employed. There were safe recruitment practices in place and a service goal to always employ the right staff.

People were kept safe from abuse because there were safeguarding procedures in place and staff were aware of potential harm and knew how to report it. Risks to people in their homes were identified at the outset and kept under review. There were plans in place to reduce risks and staff knew about the actions to take. Incidents and accidents that did occur were recorded and reviewed, and learning was discussed with staff.

Where people were assisted to take their medicines, this was done safely. Staff were trained to administer medicines. There were weekly medicines checks in place. Staff followed safe practice to reduce the spread of infections and kept people's homes clean.

People received an assessment in line with good practice before any service was provided. This was completed thoroughly with the person and their family.

Staff had received a good induction and training before beginning their role. They shadowed a more experienced care worker in the home and given instructions on any equipment, special requirements or communication needs that the person had. Staff were supervised regularly and felt able to ask for support and advice at any time.

The service worked with other agencies to meet people's specific needs. Staff worked together and fed back to the registered manager any issues that needed to be addressed. People were enabled to access health and social care specialists and this improved the outcomes for people's health and well-being.

People's consent was sought in line with the principles of the Mental Capacity Act 2005. Staff were aware of their responsibilities and diligent in recording that consent was given before giving any care.

The care staff treated people with kindness and compassion. Staff had enough time to provide good care in a calm manner and to involve people in the way they liked. People's privacy was maintained and their independence was promoted. People told us they felt that they mattered to the staff and personal interest was taken in them. People's homes and belongings were respected and looked after by staff. The service was trusted by the people it supported.

People received care in a personal way that suited them. As far as possible, the timing of calls and choice of care worker was met. People's preferences were understood and there was a responsive approach to meeting individual requests.

People's concerns were responded to personally. People knew how to complain but there had been no formal complaints.

End of life care was provided by the service. Staff worked with other agencies to provide a dignified and comfortable experience for people. Relatives had fed back how pleased they were with the care given.

The registered manager was also one of the two directors of the company. This was a small service, still developing in its first year of operation. They had partnered with respected quality management companies to ensure they had the correct systems for governance and quality assurance in place.

The registered manager had created an open and caring culture and staff and people felt able to approach them with feedback. The service was building its reputation for quality. There was a vision to maintain high standards and person-centred care as the service expanded.

The provider wanted to improve the service to ensure sustainability. They were reviewing policies to better reflect practice and a new electronic scheduling system was in place to better plan and track the care delivery.

The registered manager service was developing partnerships with other agencies to improve the reach of the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People were protected from the risk of abuse.

Risks for people were assessed and instructions were available to staff to manage risks.

There were enough staff to meet people's needs.

Medicines were managed and administered safely.

People were protected from the spread of infection.

Incidents were reviewed to capture any learning and act on this.

### Is the service effective?

Good

The service was effective.

People's needs were assessed prior to receiving a care service.

Staff received a good induction, regular supervision and were up to date with training.

People were helped to eat healthily.

Staff worked together and with other agencies to meet people's needs.

People were helped to access health care when needed.

Consent to care was sought in line with legislation and guidance.

### Is the service caring?

Good

The service was caring.

People were treated kindly and with compassion by staff.

People were involved in planning their care and their views were heard.

People's privacy, dignity and independence were promoted.

## Is the service responsive?

Good

The service was responsive.

People's care was tailored and personalised to them.

People's concerns were responded to. A complaints procedure was in place.

Staff supported people at the end of life in a dignified and caring way

## Is the service well-led?

Good

The service was well-led.

There was a clear vision for the service and future. The registered manager created and open and transparent culture.

Staff and people had opportunities to feed back their views and engage with the service. Action was taken because of feedback.

There was a governance framework in place and statutory requirements were known.

Partnerships with local and national agencies had been formed.

# Around The Clock Care Agency

**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 17 September 2018 and was carried out by one inspector. The provider was given 48 hours' notice of the inspection visit because it is a small domiciliary care agency and we needed to be sure that they would be in the office. We also needed them to get people's consent for us to visit them at home or telephone them as part of the inspection.

Before the inspection, we reviewed the information we held about the service. This included the previous inspection report and notifications since the last inspection. Notifications are changes, events and incidents that the service must inform us about. We used 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 some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we visited two people in their own homes and spoke with two people and one relative by phone. We asked about their experience of the care they received. We also spoke with five of the care staff, with the administrator who also did care work, and the registered manager.

We received feedback from two health and social care professionals about the service.

Good

# Is the service safe?

## Our findings

People felt safe with the care they received. One person told us, "The carers are very good at keeping me safe." Another person said, "I can trust them. They always watch out for me." A relative said, "They are very safety conscious and very careful in everything."

The risks to people's personal safety within their home had been assessed and comprehensive plans were in place to minimise these. In the home, care staff acted with skill and care when moving and handling a person. Staff were also able to tell us about the risks people experienced, such as choking or nutritional risks. A relative told us that a new risk assessment had been completed when the person they cared for had been in hospital. They said, "The manager went to the hospital and then also when they were back at home. They made sure it was still safe to have one carer to assist."

The registered manager was introducing a new approach to the risk assessments in people's homes. They said that the current method was not "User friendly or easy for staff to navigate." People's individual issues, environmental hazards and care areas were identified. For example, one person was at risk of developing pressure sores as they were in bed most of the time. The risks with a person's mental health and orientation were covered where the person was living with dementia. For each risk area a score was given which corresponded to the level of risk, and the actions for the care staff to take were clear. One staff member said, "We are told what to look out for and the risks, for example [name of person] is at risk of falls. We have clear instructions and a handover before supporting a person." We saw that staff were provided with good information on the care tasks and any safety reminders on the electronic system that was used to plan and record all care provision.

People were protected from the risk of abuse. All staff had received safeguarding adults training as part of their induction and then completed an online course. One staff member said, "I would report safeguarding concerns to the manager, but I know I can escalate directly to the authorities if needed." In the office, there was clear information to support staff to make decisions, to escalate and help people if abuse was suspected. Safeguarding adults and whistle-blowing policies were in place. Staff refresher training was also being arranged with the local authorities who commissioned the care services. The registered manager said, "We will seek advice immediately on any safeguarding issue."

There were enough staff to provide people with the agreed level of care and support them safely. The registered manager explained that they would like to grow the service but at present they were keeping within the number of care hours they knew they could safely provide care for. This limited the number of people they could help, but maintaining good standards of safety and care was very important to the agency as they built their reputation. The service had no history of any missed care calls. People told us that the care staff always stayed for the time they needed. One relative also told us, "They always stay for the time requested. They phone ahead if running late and will make up the time or stay longer if it is needed."

The service had started to use a mobile electronic application to schedule and record all care visits. Staff were required to log in and out of the system when attending care visits. The agency could keep track of care

visits and act if there were delays. There was allocated travel time between visits. The instructions for the care to be given and any risks were also flagged on the system to remind and support staff.

There was safe and careful recruitment of the care staff. There were organised folders for each member of staff. These demonstrated that staff were suitable to work with people in their homes. There was evidence that the agency had obtained references, proof of identity, proof of address and a Disclosure and Barring Service (DBS) certificate before staff started work. A DBS check allows employers to see if an applicant has a police record for any convictions that may prevent them from working with people who use this type of service. The registered manager told us they recruited staff who displayed, "The right attitude and aptitude, to ensure the right staff are recruited who will keep people safe."

The practice for supporting people with their medicines was safe. Staff who were going to administer medicines had to be trained and signed off as competent by the registered manager. Their skills were reviewed annually. The registered manager said, "If there was an error we would re-train them and then re-assess for competency. There haven't been any errors so far." The medicines administration records (MAR) we saw in people's homes and the office were up to date and signed off clearly. Where medicines could be given 'as required' there was information in place to support staff. The MAR was marked that the person was offered and refused 'as required' medicines. Where medicines were administered directly into a person's stomach, via percutaneous endoscopic gastrostomy (PEG), this was clearly documented and staff were proficient and able to tell us about what they did. The service also supported people who managed their own medicines but who needed a reminder. They worked with the pharmacist to ensure the person had an easy to use system. The MAR records included when the person took their medicines themselves and what help was given. One person said, "I know what I'm taking but I need physical help to open things. They always check everything with me."

People were protected from the spread of infection due to safe staff practices. The provider upheld strict guidelines for hand washing and infection control. A relative told us, "They always use the aprons and gloves to give any care and to apply creams." In a person's home we saw that care staff were wearing a uniform and protective equipment (aprons and gloves) which they then disposed of safely. There was a record that staff had received induction training and regular online updates about safe practices in the community setting. People's homes were respected and kept clean by staff. Information about people's homes, and how they liked things to be maintained, was covered in the initial assessment and care plan. Any risks in the home, for the person and for staff were assessed. Health and safety guidelines were followed and there was provision made for the safe disposal of any soiled items.

Learning from accidents and incidents was in place. Any incidents that had occurred in the home were recorded. Any learning was immediately conveyed to staff by the registered manager. The provider had said, in their PIR, that analysis of trends and prevention strategies would be developed. This was still in progress as the numbers of incidents was too small. The registered manager told us they were learning to engage with family members in managing risks, after one specific incident. The family had taken a risk with the person, but it was explained to them that the carers were not able to do the same and the reasons why had been documented. The registered manager said, "We now discuss everything with the family first." In another situation, a person's husband was struggling to manage with the care they gave. The incidents were logged and enabled the service to refer them for more help and support.

Good

# Is the service effective?

## Our findings

People had their needs assessed prior to receiving a care service to ensure staff could provide the care they needed. The initial assessment was carried out by the registered manager. The care plan was then developed using this information. The essential information was provided to staff to ensure effective care and support could be provide from the outset. The assessment covered the person's medical conditions, medicines, allergies, mental health, mobility, continence, communication, sensory impairment as well as how much care at home would be required and special interests and activities the person engaged with.

Staff had the knowledge and skills they needed to deliver good care and support. There was a four-day induction process in place for all new staff. This covered essentials such as moving and handling theory and practice, infection control, communication and person-centred care, consent issues and basic first aid. Following this, staff had access to online refresher training and were required to complete this within a prescribed time frame. We saw training certificates that had been issued as staff completed courses and there was a plan to ensure staff remained up to date.

Staff also shadowed a more experienced care worker in a person's home and go through together any use of equipment and a checklist of all that is expected of them. We saw a copy of the checklist that includes how they greeted the person, asked for consent, checked care records, recorded their observations and actions, and ensured the home was left securely and safely.

The registered manager told us that staff new to social care would compete the Care Certificate within their first 12 weeks. The Care Certificate has been introduced nationally to help new care workers develop the key skills, knowledge, values and behaviours they need to provide people with safe, high-quality care. The service had recruited some experienced care staff in the first year of operating. The registered manager was exploring ways of retaining good care staff as the service grew, such as developing a staff structure to enable promotion and professional development. One staff member told us, "Personal development is good, and from the start I knew what was expected of me."

Staff were receiving regular supervision from a manager and had support to continue in their role. Staff told us the registered manager was approachable and they could access advice whenever needed. One staff member told us, "When I have called for advice, when a person was unwell for example, I felt confident that the manager was there." Supervision records showed that issues covered with staff were a reminder to log on when they arrived at the person's home, time-keeping, using a person-centred care approach, and development opportunities. Staff folders contained their supervision notes and a performance review.

People were supported to have a balanced diet and their nutrition was closely monitored. The service supported people who received nutrition and hydration via a PEG feed. This allowed nutritional food to be transferred directly to the person's stomach. We visited one person in their home and saw there was a strict feeding regime documented in the care plan from a dietitian. The staff said they were confident in following this. One care worker said, "Every person is different so we need guidance from a dietitian each time." The fluid and bowel charts were completed thoroughly by staff. If there was a problem there was access to

support and any problems resolved within the hour when reported. Fluid and bowel charts were in place for any person where their needs warranted this monitoring. A person who needed help to prepare their meals told us, "I am much healthier now. I am taken shopping once a week and I eat less bread and more fruit and fresh vegetables."
Staff worked together and with other professionals to meet people's needs. In people's homes staff used the daily notes to record anything of significance so that continuity of care was maintained. One person was known to the palliative care team. The person was unable to communicate verbally, but staff said, "We know when [person] is in more pain. We can see the change even if they cannot say it, and we will record this." This was reported back to the registered manager who asked for a review by the palliative care team. In another situation, the service communicated with a GP and social services about a person whose family carer was not managing their medicines well and there was concern about the person's health.

People were supported to have their health needs met and access services when needed. One person told us, "Once when I felt ill and my blood pressure was low, the carer called the doctor and the paramedics came out to me. I don't know what I would have done without her." A referral was also made for the person to see an occupational therapist to explore options to use their shower and toilet more independently. Another person, who had been discharged home from hospital was refusing to open the door to the care workers, and this was reported back to the social services. A member of staff went to the home once more to offer help. They saw the person was lying on the floor inside their home, and they called the emergency services. The paramedics who gained access praised the care staff for their actions as the person was in a diabetic coma and might have died. The registered manager said, "We knew the person was vulnerable even though they refused our support and we wanted to do all we could."

People's consent was sought before care was provided. Staff had received training and understood the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so or 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In the daily notes staff always recorded that the person's consent had been gained. One relative told us, "Staff always ask for permission before doing anything in our home." One person said, "They always ask me. I have a choice." The registered manager told us that a person's relative had wanted to decide things, such as how often the person had a shower. The person had the mental capacity to decide for themselves, but communication was difficult. Consent and communication issues had been discussed with the relative so that the person's wishes could be met. The relative had also signed the consent for care form on behalf of the person without any legal authority. The registered manager said they would check for evidence of any legal authority from now on if a family member was involved, and record the reasons if a consent form was signed off by someone other than the person who needed care.

Good

# Is the service caring?

## Our findings

People were treated with kindness, care and compassion. A relative said about the staff, "They are unfailingly kind, good and attentive." We observed two care workers in a person's home and saw how they spoke kindly and calmly to the person. They also explained what was happening and why we were visiting them. Staff were described as "Calm and considerate" by two different people.

People were involved in their care and able to express their views. We heard how people had been involved in their assessment and care plan. One person said, "I met the manager and we did the assessment together." The registered manager told us, "The assessment is always completed with the person and their family. We also review the care plan as we get to know the person." Staff helped a person who had difficulty with speech to communicate their wishes by providing a letter board which they used to spell out words. A relative who provided care for a person said they felt involved through the daily notes in the home. They said, "Nothing is secret, we have access to the same information." They added their own comments to the daily notes which meant that all those caring for the person had the full picture.

There was enough time allowed for staff to give good care and involve people. One person told us, "Nothing is too much trouble. They don't rush you, they give you the time you need." People felt that they mattered to the staff and that the care was focused on them and their needs. Another person said, "They take an interest in me and my family." We also heard from a person who said, "I really appreciate that they take the time to do what I ask."

People's wishes, their belongings and home were respected by staff. One person said, "They treat my home with respect and keep things the way I like." Another said, "The carers left the place immaculate." A relative told us that care workers, "Make sure [person] has choices and talk to him all the time. If they have to talk to me, they are respectful and make sure [person] is included." In one person's home we heard one care worker call the person by a shortened version of their name. The other care worker corrected them and told us what the person preferred to be called.

People's privacy, dignity and independence were promoted. One person said, "They always knock first and call out when letting themselves in." We noticed that the care workers drew the curtains before delivering personal care to a person who was in a downstairs room. Another person told us their mobility had improved, "Since they have looked after me." They went on to talk about how the care workers encouraged them to keep active and to do things for themselves, saying, "They give me confidence."

The staff had built up relationships and trust with the people they were caring for. The registered manager had helped a person work out how much care they needed, and given them different options. The person said that, "My care costs were cut back, they worked it out for me and it was very helpful." A social care professional also told us that the agency had worked with a person who challenged care services. They said, "They are very accommodating and understanding."

Good

# Is the service responsive?

## Our findings

People received care in a personalised way that responded to their assessed and day-to-day needs. The provider had said in their PIR that they were committed to supporting people, "To live according to their preferred lifestyle." The care plans reflected an individual approach, recording and tailoring the care to suit each person. The registered manager had started to review all care plans, to become more person-centred and reflect people's strengths as well as needs. These were written in the person's own words as far as possible. A key focus was on the 'Outcomes I would like from my support visits and how I will achieve this.' Other headings were, 'Things that are important to me about my life,' and 'How best to support me.' The registered manager said they preferred to talk about support, rather than care, as this was more empowering for people and promoted their independence and choice.

People's preferences and choices were heard and understood and there was a responsive approach. One person had specific instructions about how they liked their pillows when they went to bed. A person who enjoyed going out to activities had their support tailored around when they wanted to be going out. One person told us how they were supported to attend the funeral of a friend and were helped to maintain their lifelong interests. Another person said, "They always give me the choice about what to eat." The provider understood and noted details about people's lives, their interests and working life, as well as how they wished to receive their care.

People's specific needs for equality and dignity were recognised. People were asked about their preference of the gender of staff coming into their home. Where a person had a visual or hearing impairment this was understood and large print documentation could be provided. The provider said, "We treat everyone as individuals and ensure that staff and clients are treated fairly and with respect."

Initial care plans were developed and then reviewed after the first two weeks with the person and their family. After this, the registered manager aimed to review before eight weeks and then every three months, or if a person's needs changed. People were introduced to their care workers before any care started. People were given some say in the choice of care worker, ensuring that the staff chosen had some knowledge of the person's condition. One relative had given feedback to say that the service provided a higher level of care than other agencies. They said, "Because they think very carefully about the person and continuously adjust their approach to improve the experience."

The provider had a complaints process in place. This was made available to people at the start of their care and was made accessible by being placed in their home. The registered manager said they welcomed feedback and complaints as learning opportunities. There had not been any formal complaints. People told us they knew how to complain. One person said, "I know how to do it, but I have nothing to complain about." Another person who had raised some concerns about timekeeping said, "I would take it up verbally first." They were satisfied that their issues had been addressed.

People were supported at the end of their life in a personal and dignified way. The service worked with other agencies and services to give seamless care. The service had recently cared for four people at the end of

their life. One person received their care four times a day alongside another care agency who delivered care at other times. The service also worked with the community health services to enable the person to die in their home as they wished in a peaceful way. We saw a letter of appreciation from the family. They said, "We have so much praise for the care given, your staff have been truly amazing."

People's wishes at end of life were recorded and upheld. One staff member who had cared for a person at the end of their life said, "It was important for them that they were comfortable and always looked presentable for any visitors." Another person who was coming to the end of their life was religious. The staff accommodated their spiritual needs which included saying a prayer with them. The registered manager told us they would develop their role and expertise and engage more widely with other services to get extra training for staff.

Good

# Is the service well-led?

## Our findings

There was a clear vision for the development of the service to provide high quality care and meet people's needs in a personalised way. The provider was putting the foundations in place whilst delivering care to a relatively small number of people. The service was building its reputation and gaining trust by ensuring that some complex and larger care packages were covered in a professional way. The registered manager led by example demonstrating the, "Open and transparent culture" that was stated in their PIR and by the way people and families were respected as partners in the service delivery.

The culture of the organisation was noticed by the staff and they were supported and valued. Staff told us they enjoyed working for the service. All the staff we spoke to said that the registered manager was, "Approachable" and that they could talk to them at any time for advice. One of the care workers said, "It is a good organisation and the manager and has helped me a lot." Another care worker told us that they were supported with good handovers before looking after anyone new.

Staff were given an opportunity to meet with the registered manager and discuss care issues. At the most recent meeting, staff had been thanked for their hard work and team spirit. The reporting of accidents and incidents was on the agenda and staff were thanked for, "Their comprehensive documentation." Following a recent incident, the importance of good working relationships being established with people and families was discussed. The recording of medicines was raised, including the correct symbols to use on the MAR charts. One staff member told us their view was, "Appreciated" and they were helped to do their job. The registered manager said they would explore more ways to help with staff communication, for example on a group email or with a mobile group chat.

People who used the service and their relatives were encouraged to provide feedback. This was often done personally and directly. One relative told us, "I give feedback verbally." A person said, "I was able to tell the manager my views when they came to check on the carers at my home." A questionnaire was in place to seek people's views. However, only two had been completed so far.

The registered manager demonstrated they wanted to improve the service, based on feedback. We heard mostly positive feedback from people and relatives. However, there had been some feedback about a care worker arriving late. An immediate apology was issued. Care workers now telephoned ahead if they were delayed and the electronic scheduling system was now in place following this feedback. This gave an alert if the carer was ten minutes late or left a home ten minutes early. There was also a fob in the person's home that the care worker would use to communicate with the office. This would enable the registered manager to oversee and keep track of staff and address any lateness.

The provider wanted to improve the service and ensure sustainability. The use of technology to schedule care and staff training was one example where efficiency could improve as the service expanded. The registered manager had also attended training on person-centred and strengths-based care and was now implementing this learning in the new care plans. They also talked about supporting staff mandatory training, by using a recognised 'train the trainer' model to ensure future updates could be done in-house.

One person told us, "They are improving the service all the time."

The provider worked with an external quality assurance company who conducted a review once a year. They came in July 2018 and focused on paperwork and the quality assurance systems being used. They advised the registered manager to keep a register of all the forms that were in use. This was being implemented. They also advised changing the proposed staff structure to include a compliance manager, within next 12 months as the service grows. The registered manager said this would be included in the annual business plan.

There was a governance framework in place. Policies and paperwork had been developed with support from a compliance company at the outset. These covered the full range of standards and practice for safe and effective social care delivery, including health and safety, medicines and risk management, business continuity and administration. We saw that the safeguarding and confidentiality policies were in a different format, using the Around the Clock logo, but were undated. The whistleblowing policy also needed a review. The registered manager said they were now reviewing all their policies to make them more relevant to domiciliary care and meet the needs of the agency. They were now working with another company to develop new policies and aim to switch completely by the end of the year.

Service risks and performance were managed effectively. The registered manager conducted their own spot checks in people's homes to ensure care was delivered as expected. This included a medicines audit which was currently being done each week. These checks would be monthly as the service grew. The registered manager was aware of the circumstances of when to send in notifications to the CQC.

The registered manager told us, "We aim to deliver a high standard of care and make sure people are happy." They recognised that as the service grew they would not be able to visit people each week, but said, "I do not want to compromise on the quality of care." There was a business plan in place, dated September 2017, detailing the start-up of the service and projections. This demonstrated that the provider was meeting their intended aim of growing the service and staffing as demand increased and to be able to support ten people by the end of 2018.

The service was creating good links with other agencies to work in partnership. A recent tender for a local authority preferred providers list and contract was successful. Good links had already been established with the local hospital and some care had been commissioned through the NHS. The registered manager was also in contact with a local rapid response team, where people at home received therapies to improve their independence. The provider was a member of the UK Home Care Association. They maintained contact with the local authority safeguarding bodies to ensure they received any best practice guidance and training opportunities