Suffolk County Council

Mid Suffolk Home First

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

This inspection took place on 20, 24 and 27 July 2018 and was announced. This was to ensure someone would be available at the office to speak with us and to show us records.

Mid Suffolk Home First is provided by Suffolk County Council. The service provides two distinct services. Reablement and, since our last inspection, they now provide a longer term care service to support people to meet their needs. The reablement service concentrated on supporting predominantly older people following a hospital admission with the aim of helping the person to their optimal level of independence. After six weeks of reablement support people are assessed to see if the person should stay with this service or progress to longer term support..

At the time of the inspection, the service was providing support to 55 people in their own homes including 12 people needing longer term personal care.

The service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. Like 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.

Mid Suffolk Home First was last inspected by CQC in December 2015 and was rated Good. At this inspection we found the service had improved to Outstanding.

The service was very flexible and extremely responsive to people's needs. We saw and heard from people using the service and their relatives how staff went above and beyond their role.

People's care and support was planned proactively with them in a person-centred way. People's preferences and choices were clearly documented in their care records and people told us they were involved in planning the care they received.

The service had used case studies to review the support people had received and identify good practice or lessons learned. There were consistently high levels of constructive engagement with staff and people who used the service.

Staff felt supported by the registered manager and said there was an "open door policy" at the service. Policies and procedures were in place to keep staff safe, and management and office staff provided outstanding support to care staff.

Governance was well embedded into the management of the service. Service quality and improvement was measured through a variety of audits, satisfaction questionnaires and performance indicators. There was a strong emphasis on continually striving to improve the service for the service users.

As well as continuing to develop the reablement service in a difficult situation, the service had taken over the provision of longer care to people in need of a service to meet their needs. As well as attentive management to ensure the service was delivered well an assessment of need had been carried out and additional training was provided to staff.

There were sufficient members of staff employed by the service and no call visits had been missed and staff were not late for appointments. Staff had time to travel safely between care visits and people informed us the always stayed for the length of time agreed.
The staff received supervision and training and on-going support.

Staff respected people's privacy and dignity. People spoke positively about how staff respected their privacy and dignity while carrying out the support they received to help them regain their independence as well as during personal care.

Risk assessments were in place for people who used the service and described potential risks and the safeguards in place to mitigate these risks.
The registered manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.
Appropriate arrangements were in place to ensure the safe administration of medicines.

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.

There was a robust complaints process in operation.

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 remains Good.

Risk assessments were detailed regarding how to keep people safe.

There were sufficient staff employed to meet people's assessed needs.

Medicines were administered safely.

Is the service effective?

Good

The service remains Good.

People's needs were assessed and their choices recorded so that staff could deliver effective care.

Staff received support thorough supervision and training.

The service worked with other professionals to support people to meet their needs.

Is the service caring?

Good

The service remains Good.

People were treated with kindness and respect.

People using the service were encouraged to express their views.

People's privacy and dignity were respected by the staff.

Is the service responsive?

Outstanding

The service has improved to Outstanding.

The care plans are reviewed and changed as necessary to ensure they are accurate regarding people's needs and progress from week to week.

People considered staff had outstanding knowledge and skills to

support them with their reablement and knew them very well from working with them in a person-centred way.

The service staff understood the needs of different people using the service with regard to reablement and people with long term needs.

Staff had opportunities for learning development and reflective practice.

There was a robust complaints policy and compliments were recorded.

Staff had the knowledge and skills to support people in their last days while working with other professionals.

Is the service well-led?

Outstanding ☆

The service has improved to Outstanding.

Staff were proud to work for the service which had clear aims and objectives.

Governance is well-embedded into the running of the service to support the delivery of a high quality service based on outcomes of people's care.

Senior staff provided clear feedback to staff for their development.

Rigorous and constructive challenge was welcomed from other providers.

There was an emphasis upon continuous service improvement.

Mid Suffolk Home First

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 20, 24 and 27 July and was announced. This was to ensure someone would be available at the office to speak with and show us records. The inspection was carried out by one inspector.

We visited the service office on 20 July to speak with the registered manager, five staff providing support and to review care records, policies and procedures. On 24 July we visited the office again to look at further records and we visited three people who used the service in their own homes and one relative. On 27 July we spoke by telephone with a further two people who used the service and two relatives. We also spoke with six other professionals.

Before we visited the service we checked the information we held about the service including the inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law.

We used information the provider sent us in the 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.

Good

Is the service safe?

Our findings

At our last inspection of December 2015, the key question Safe was rated good. At this inspection we found Safe remained good.

People told us they felt safe with the staff from the service. One person told us, "I feel safe because they know me and they know what they are doing." A relative told us, "A safe service because they always come and have never let us down,"

All staff had received training in safeguarding people. Information and guidance about safeguarding people was clearly displayed in the office. Staff told us they felt supported by the management team and felt able to raise safeguarding matters with senior staff or to report directly to the local authority safeguarding team.

Staff informed us of the actions they would take should they not be able to access the people's homes at the allocated time of the call visit. This included a checklist for the member of staff to follow. For example, telephone the property, ensure people had time to answer, inform senior staff and/or the registered manager and to contact families and or the emergency services. Each person had a written risk assessment which described potential risks and actions for the staff to take to keep the person safe. The service also provided advice and guidance to ensure people's safety, such as the installation of equipment such as grab rails and raised lavatory seats.

The service continued to follow a robust recruitment process. This included checking references and checking with the disclosure and barring service (DBS) if potential staff were suitable to work with people receiving care and support. Each member of staff was required to complete an application form and provide references. We saw that where gaps in the person's employment history this had been explored with the recruiting staff to determine the person was suitable to work at the service. The registered manager had built up questions and scenarios which they used to test the suitability of potential staff to work in a care service.

The registered manager informed us they employed staff on a full-time and part-time basis. The service operated a flexible rostering system which meant that staff were allocated depending on the people's needs. Staff informed us they were allocated to provide support to people based on the person's interests or specific needs. Staff considered there were sufficient staff employed as they were not rushed from care visit to care visit and had time to write notes. Staff told us they had to be flexible with their appointment times as they were providing a reablement service. This meant that sometimes the care visit took longer than expected. Sometimes this was because the person was progressing and needed staff to be with them to keep them safe while trying to walk again. People who used the service told us staff always arrived within the designated time slot of the care visit and stayed as long as they needed to support them with the reablement plan for that care visit.

Medicine management remained safe. One person told us, "I do my own tablets but the staff always ask if I have taken them and is everything alright." Appropriate arrangements were in place to ensure the safe

administration of medicines. A medicines management policy was in place, staff were trained in medicines management and completed an annual competency check. A member of staff informed us that if they were ever unsure of anything they would speak to a senior member of staff or the person's doctor. We saw that medicine administration charts (MAR) had been completed accurately and the senior staff carried out audit checks to ensure people were receiving their medicines safely.

Staff were trained in infection control and personal protective equipment was provided for staff. People told us staff wore personal protective equipment such as gloves and aprons when they were supporting them. The service had an infection control operational policy in place. An audit of infection control was carried out which were rotated so all staff were included.

The registered manager was aware of the need for the service to learn lessons leading to improvements of the service. We saw that regular meetings were held to discuss events and actions recorded for staff to take and report upon at the next meeting. The service had reviewed how it had coped during the extreme winter weather. Actions included staff working close to their home, fourbyfour wheel drive vehicles and taxis being available for staff to use.

Good

Is the service effective?

Our findings

At our last inspection of December 2015, the key question Effective was rated good. At this inspection we found Effective remained good.

People's needs were assessed before they started using the service and continually evaluated in order to develop support plans. Initial assessments were carried out by one of the senior staff to ensure the person's needs were understood before staff were introduced to them.

The people who used the service received effective care and support from staff that were trained to meet peoples assessed needs. One person told us, "We spoke about what I wanted to do and how we would work together to sort things out." A relative told us, "Both myself and [my relative] know a lot about medical issues and we are very pleased with the understanding and knowledge of the staff.

Once employed by the service staff completed induction training to enable them to support people with their needs. We saw that staff training was up to date and further refresher training was booked for the coming months. A member of staff told us, "The training is well organised and very good. We will sometimes do training in small groups so that we can provide the care to someone who is admitted into our care." The member of staff further explained that this on-going training was interesting and boosted moral of the staff because of the new skills learnt.

Staff received supervision and an annual appraisal. Staff were also supported through staff meetings and spot checks of their practice. A spot check is when a senior member of staff checks upon a member of staff working in someone's home with the permission of the person receiving the care. The senior member of staff will be checking upon such things as the staff member being on time and their interaction with the person receiving the care.

People were supported to regain their independence with meals and drinks. Where people were assessed as nutritionally at risk, food and fluid charts were in place. Staff supported people with their dietary needs. For example, staff prepared meals for people who were not able to independently mobilise. People's food and drink preferences were recorded and people could make choices about what they had to eat and drink.

The service was committed to working collaboratively with other professionals to support the people using the service. The service had worked in conjunction with doctors regarding peoples on-going care and with other professionals so that people had exercises to do designed to improve their mobility and strength. People's care plans had a section for professionals to record information of their visits and consultation with the person. Staff told us that they always checked when visiting the person to ensure they were aware of the latest information.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. All of the people using the service at the time of the inspection visit were able to make their own choices. People had provided consent to their care and support and this was documented in care records.

The service staff we spoke with were knowledgeable about best interest meetings and lasting power of attorney and supporting people to access advocates should they wish to do so and it was felt to be in their best interest.

Good

Is the service caring?

Our findings

At our last inspection of December 2015, the key question Care was rated good. At this inspection we found Care remained good.

People who used the service were complimentary about the standard of care provided to them. One person told us, "I really cannot fault them they are kind and caring staff." Another person told us, "I shall be very sorry to lose them when I move onto another service because of the care and kindness they have shown towards me." A relative informed us the staff were kind, supportive and through coming on time and being there to help had shown care towards the whole family at a difficult time.

The service involved people in their care, communicating with them so they were listened to and valued. People's preferences and choices were clearly documented in their care records and people told us they were involved in planning the care they received. One person informed us that they sometimes liked tea and other times coffee. The staff never assumed and always asked what was their choice on that occasion.

People's care records demonstrated the service promoted dignified and respectful care practices and people spoke positively about how staff respected their privacy and dignity while carrying out personal care. A relative told us, "[My relative] due to frustration with their condition, can be annoyed with the staff when they provide personal care but the staff are great understanding and helpful." One person informed us about how the staff had helped them with putting shoes and stocking on and over time with the introductions of aids the person was now able to do this for themselves. They told us, "Never thought I would be able to do this again but marvellous that I can and have this increased independence."

The service supported people to help them regain their independence. Discussions had taken place with people about individual goals they wished to achieve. This meant people were proactively involved in planning their care and support. The majority of the goals were about supporting people to regain their independence following an admission to hospital following an injury or operation. For example, one person wanted to regain their independence so they could carry out their own personal care and dress themselves. Another person who had used the service before was confident with the staff support and through their own efforts they would once again achieve full independence of the service.

People who used the service told us how staff supported and encouraged them to regain their independence. One person told us, "The staff are very encouraging always positive and never put pressure on to you to do things too quickly or what you cannot do at present." Another person told us, "I just get one visit a day now and from their care I shall be discharged soon. I could not have done this without them."

A weekly feedback form was completed for each person that provided an update on the progress they were making towards their goals. This was shared with the person including if small steps were achieved or no progress at all so that the person was fully aware.

People's religious and spiritual needs were documented. We saw that discussions took place of how

people's needs would be achieved and this included setting goals that a person wanted to attend church. They saw attending a church service as an important marker in their recovery,

We saw that records were kept securely at the location office. This meant only care and management staff had access to them, ensuring the confidentiality of people's personal information as it could only be viewed by those who were authorised to look at records.

Outstanding ☆

Is the service responsive?

Our findings

At our last inspection of December 2015, the key question Responsive was rated good. At this inspection we found Responsive had progressed to outstanding.

The registered manager informed us that person-centred care was the principle upon which the service was based and the staff had a passion for delivering care to support the person to meet their assessed individual needs. All of the people using the service and their relatives informed us the service was excellent because the rehabilitation goals were clear and the staff supported people to fulfil their maximum potential. The outcome of the service was that many of the people had been supported in their reablement and did not need to be referred for further social or healthcare services. For those people that required additional support after six weeks of the reablement service they had been supported in a smooth and caring process to move to another provider.

The registered manager told us about how the service had developed and improved since the last inspection. The senior staff had been trained so that they could recognise and order rehabilitation equipment for the person rather than have to refer to another professional. This has speeded up the process for the service, freed up valuable time of other professionals and reduced the frustrations experienced by all previously. The registered manager had attended meetings for the purpose of reducing delayed discharges from hospitals. They were now working with a wider group of professionals referring to the service and had taken self-referrals also from previous people using the service. The service aim was clear, to support people out of hospital as soon as possible but only when it was safe to do so. The service staff had not missed a care visits since our last inspection. The service had also stepped in and was continuing to provide long term care to people living in a geographical area of Suffolk because another service withdrew from providing care. This had resulted in a change to the statement of purpose and additional training for the staff.

The people we spoke with told us they had received their care from a small group of staff and this had helped with identifying any changes in their care and helped the staff to recognise peoples changing needs. We noted in a number of care plans that staff had requested a medicine review for the person as a result of their direct observations of their condition. This has also helped to ensure people were assisted in moving forward in their rehabilitation programme and to regain their independence as soon as possible.

People informed us they had planned their care jointly with the rehabilitation staff and also been part of the daily recording and feedback upon their progress. Referrals to the service were made via a 'single point of access'. Referrals were made by hospital, GP staff and health or social care professionals. Meetings were held to discuss and plan complex support packages. The registered manager had worked with all other services to prevent delayed discharges from hospital when the service had staff available and the person could be discharged home safely with the support of the service. Referrals were prioritised and those triaged as urgent were allocated to the senior staff and were responded to usually the same day or the day after. An initial visit was carried out by a senior member of staff trained in assessments for the reablement service and a comprehensive baseline assessment was carried out. The care and support provided by the service was scheduled for six weeks but did not stop until a new service was found and in place. A member of staff told

us, "Some people we discharge but if that is not possible we stay until something can be arranged."

Once the person was discharged home from hospital their care plan was checked, goals agreed and an initial assessment completed with the person in their home. One person told us, "It was wonderful to get home and to be clear upon how they were going to help me. This gave me the confidence I would be able to help myself and get my independence back." All of the people we spoke with told us how the service staff had supported them and each week they measured their progress towards the agreed goals. We saw that the care plans were reviewed and changed as necessary to ensure they were accurate regarding people's needs and progress from week to week.

People considered staff had outstanding knowledge and skills to support them with their reablement and knew them very well from working with them in a person-centred way. People told us they and their family, friends and other carers were involved in developing their care and support plans. People said they felt consulted with and listened to by knowledgeable and kind staff. One person told us, "We talked about the care plan it was a two-way conversation and we agreed it together." A relative told us, "We had a review of the care plan and the visits were reduced because [my relative] did not need as much support." Another relative told us, "This has all been so difficult for us as we have been in the medical profession. The staff have been marvellous always cheerful that helps, and the care plan is person-centred." They explained how the assessment of care had been discussed with them and their relative and they had been involved with the writing of the care plan.

The service was extremely flexible and responsive to people's individual needs. We saw and heard how staff went above and beyond their role. One person told, "Marvellous service, they have got me back on my feet and they always ask is there anything else we can do before they leave." A relative told us, "We were not looking forward to having strangers in our home, but through their kindness and professionalism we now look forward to them coming." The relative explained the staff had taken time to explain their roles and had worked with the family to support their relative. Another person informed us how the service staff had helped them to rearranged furniture in a number of rooms and also placed essential items they needed at a different level within their reach. The service staff were reported to us as innovative and empowering by the support they provided. As well as the above they had worked with other professionals in fitting ramps between rooms at different levels so that the person was able to self-propel themselves by wheelchair from room to room. They now through the support of the staff had the full use of their home again rather than be confined to one room. A professional informed us that the staff had focussed upon providing person-centred care with a excellent outcome.

During a period of bad weather and heavy snow we heard from the staff how they had worked together to ensure they visited people requiring their support to ensure they helped them with their reablement program. For example, staff informed us they covered calls near to where they lived to save staff having to try to drive long distances. The service arranged call visits up to four times per day depending upon the person's needs. The service staff had not missed a call visit since our last inspection or been late for any call visits.

The service worked with other professionals so that their assessment skills in reablement would be used to assess and plan care with the person. We saw that information from occupational therapists and physiotherapists were clearly recorded in people's care plans. The staff we spoke with were aware of the information and the role they played to help the person with their reablement. One person told us, "If it was not for this service, I would still be in hospital so much better for everyone I am now in my own home and making slow but steady progress." A relative informed us they were not able to support their relative on their own, but because of the support of the service staff their relative was able to return home. They told us,

"This is a marvellous outcome for us all." They explained the service staff had spoken with them and their relative about concerns and symptoms the person experienced about their health and the service staff had involved the GP to review the person's medicines. Since the review and change of medicines the person was starting to feel better. The relative was also highly impressed with the service staff working with them and not taking over. They explained to us about the option of a hospital bed but their relative was comfortable in their existing bed and did not want this option. The staff had worked with the family to rearrange the room's furniture to make it easier moving the person and they were happy to have kept their bed.

The service staff understood the needs of different people using the service with regard to reablement and people with long term needs. The registered manager explained to us how the service had stepped in to assist when a long-term care provider had withdrawn their service. This meant the registered manager had to utilise their resources in a different way and help to cover the gap in long term care. The registered manager had set up regular meetings to review every person using the service and to ensure a robust plan was in place for their current and long-term care needs. A member of staff explained to us how they had chosen to work in the longer-term care team although they still supported in reablement when the need arose. They informed us that they enjoyed having established a relationship with a person through reablement to continue to support them as the on-going need had been identified. They supported a person with dementia and over time had helped the person to do some washing and also gardening again. All staff did the same training so they were confident to move between the two services.

The registered manager and senior staff had recognised the frustrations people, their relatives and staff experienced when equipment was not available, such as grab rails, to aid peoples reablement. Some experienced staff had undergone training so that they could assess and order this equipment rather than have to wait for other, busy, professionals to become involved. The success of this approach resulted in reduced frustration for all and an increase in the staff's knowledge and skill. A professional supporting the service wrote to us with the following information. 'Professional mentoring of Trusted Assessors (TA) has effectively added value to the experience of people using the service by streamlining the process so that an individual's simple equipment needs can be identified, assessed for and ordered very early on in their Home First journey. For the reablement support worker who has progressed their knowledge and skills to become a Risk Assessor, the Trusted Assessor training is the next logical step in their professional development to enhancing competence and confidence to delivering meaningful interventions and embrace greater responsibility in achieving person centred outcomes. In my experience of mentoring two TA's both reported feeling more empowered to problem solve issues faced by service users. I, along with their respective team leaders observed a gradual change in the TA's confidence to propose changes, or highlight areas of deficit during team meetings in which cases are routinely discussed. It has been essential to ensure that in acting as the Mentor that the opportunity for two way dialogue is well established; and practical support and constructive feedback are always available to the TA's. The mantra is very clear that in whatever our role, we always act within our competencies. They informed us that a great deal of time of other professionals had been saved by the increase in skill of the staff to carry out these assessments,

People told us staff were exceptional at consulting them and involving them in their care. One person told us, "The staff were there for me to talk to and helped me regain my confidence." They also explained the service staff were reliable and never let them down. Another person told us they were consulted, "Right from the start and every step of the way." They explained that every week the staff discussed and recorded their progress with them on the goals they had agreed upon when first using the service. Further goals could be added and ticked off once achieved. Then further work and support agreed upon for other goals to be achieved. A member of staff told us, "It is so important to listen as good progress to one person may not be to another." They explained they listened and encouraged one person and it was very satisfying when they saw the difference. The person was out of hospital and improving. They further explained they took

satisfaction from that and that was why they enjoyed their job.

The service had used case studies to review the support people had received and identify good practice or lessons learned. For example, a relative was highly concerned about the safety of their relative and had decided to move in with the person or take them back to their home so that they could provide 24-hour care. They did not wish their relative to move into a residential home and were very concerned that due to a recent diagnosis of dementia the person would become lost when walking their dog. The service was able to advise and support in a number of ways including the use of assistive technology, so that the relative was aware of when the person went out on established dog walking route and returned home. The situation was reviewed regularly with the person, their family, referring social worker and service staff. The outcome was that the person stayed in their own home with their dog which was very important to them. The relative was reassured and no longer felt compelled to provide 24-hour care and support.

All of the people spoke positively about how responsive the service was and that without them they would have spent a longer time in hospital or full time care. One person told us, "I would have been in real trouble without them and would not have got back to my home." Another person told us, "From day one it all worked very well after I left hospital. I still need some help and sorry to be moving on but they have been great."

Care records described what activities were to take place at every visit and where risks had been identified, an appropriate risk assessment was in place. Every improvement in people's abilities was documented, no matter how small the improvement was. A staff member told us, "Can be difficult if no progress has been made, but so important then to talk about why and not to give up hope and focus on the positive." Records were kept up to date and were regularly reviewed. The senior service staff also telephoned people and their relatives regularly to check upon the progress made and to discuss any problems.

The service had supported people with their end of life care. Policies and procedures were in place to support people at this time, and staff had received appropriate training. The staff we spoke with told us how they enjoyed working for the reablement service with the emphasis upon working with a person for around six weeks and often they saw very good progress in that time. However, they also enjoyed providing care and working with people over a longer time. Staff told us they took satisfaction in making sure that people were comfortable and pain free during their last days.

The service worked with other organisations to help ensure people's social needs were met. The staff team were knowledgeable about what activities were available in the community and how people who used the service could access them. Staff had opportunities for learning development and reflective practice from on-going training and meetings arranged by the registered manager and senior staff.

People were encouraged by all staff to provide comments, compliments or concerns via telephone and to complete written information about the service during and after the service stopped. The service always planned a handover with the person to another service and this was also an opportunity for feedback. The service complaints policy was made available to every person who used the service. We saw one complaint had been reported to the service in the previous 12 months. We saw this had been appropriately investigated and resolved. People we spoke with told us they were regularly consulted but did not have any complaints to make. One person told us, "No complaints but full of praise." A relative told us, "I would give them eleven out of ten, they have been brilliant." They explained the staff were kind, understanding and nothing was too much trouble.

Outstanding ☆

Is the service well-led?

Our findings

At our last inspection of December 2015, the key question Well-Led was rated good. At this inspection we found Well-Led had progressed to outstanding.

We were informed by people who used the service it was very well led. This was confirmed by relatives and staff. This was because the management had clear objectives and committed to providing person-centred care and demonstrated these leadership values to the staff. The aim of the service was to support people to be independent and to lead a full and active life, whilst being in full control of what happened to them. Since registration with the CQC the service have always complied with regulations and shared any concerns they had with both the CQC and relevant authorities and have taken immediate steps to safeguard people's wellbeing when required.

The original ethos of the service was to provide short term care for people to enable them to regain their independence and assist them to return home from hospital. The reablement part of the service works with people for six weeks and should further support be necessary a smooth transfer involving the person is organised to another service. From our inspection it was clear the service had developed to provide longer term care as well because a service withdrew from providing care in a remotely populated part of Suffolk. The revised statement of purpose is clear while support people from a needs assessment to fulfil their individual potential through a person-centred approach based upon compassion and empathy. The service staff empowered people to make decisions about their care through setting goals with them which were reviewed as necessary and at set periods of time.

All of the staff we met were highly motivated and enjoyed working for the service. Staff informed us this was because the service was very well led by experienced staff. The registered manager informed us about how they had reviewed the service and continued to do so by a variety of means. This involved listening to people that were and had used the service, relatives, other professionals and the service staff. They emphasised to us the importance of the staff induction to be comprehensive to support people whether this was for reablement or long-term care. The induction developed staff's observation skills and to recognise people's emotions of fatigue, frustration and up to a few weeks previous had not considered they would be in need of care support. Hence coming to terms with the situation required the staff to be sensitive, understanding and empathic.

Staff were proud to work for the service which had clear aims and objectives. Staff meetings were an opportunity to discuss and review how the service was performing regarding the aims and objectives. A member of staff told us, "I am proud to work here because we help people out of hospital back into their own homes."

Staff received exceptional support from the registered manager and senior staff responsible for organising the care delivery and managing the service while planning longer term activity. A member of staff told us, "I work alone but I am never alone." They explained they enjoyed working with the people using the service and their relatives. Before working with the person, they were briefed with important information and they

could always ask for support from senior staff. Systems were in place if staff needed urgent assistance and an out of hours emergency assistance protocol was in use. A manager was always on call and available.

Staff told us there was an "open door policy" at the service and they received "outstanding and understanding support" from the registered manager, senior staff and the business manager. A member of staff told us, "We are welcome to call in at the office at any time." They explained the registered manager was approachable and a problem solver. They further explained that as well as taking care of day to day matters the registered manager had involved staff with the major change of providing long term care as well as a reablement service. Some staff moved between the service functions while others preferred to work in one or the other and this was recognised and supported by the registered manager. All staff undertook the same training so that if required they would be able to work in any part of the service providing the assessed care to people as specified in their care plan.

Direct observations of staff were regularly carried out looking at how staff supported people in their own homes. We viewed samples of these and saw that if the registered manager or senior staff noted any issues with these monitoring visits these were addressed immediately. Staff told us they found these observed visit useful and valued the feedback they received. Medicines were also audited by senior staff to make sure people were supported appropriately with their medicines.

A member of staff explained to us that sometimes matters could not be resolved on the spot and told us. "If the manager cannot sort things out there and then, they will get back to you with a solution." Staff told us they were consulted and involved in the running of the service and the staff meetings were where information was shared and their ideas sought. The registered manager informed us they liked to ensure the team meetings were interesting and an opportunity to increase knowledge and learning together. We saw that, as part of the meeting, quizzes were organised and staff looked at case studies to discuss how difficult care issues could be resolved. A member of staff told us, "Key information is delivered to us through team meetings and we have actions to achieve so we all know what each other is doing."

People who used the service were extremely positive about the service. One person told us, "I cannot praise them enough, they have helped me no end and I have got my confidence back." Another person told us, "I would not like to think how much it would have cost keeping me in hospital in a bed I did not need but someone else did, so pleased they got me out."

We found the services' philosophy was to facilitate hospital discharges safely without delay, to help avoid unnecessary hospital admissions and reduced the number of people requiring long term care by supporting people to regain their independence. The service staff communicated effectively with other health care professionals such as doctors, occupational therapists and social workers. This meant that the service continued to involve other professionals for advice and support in the person's care to support the goals of reablement for the individual.

Governance is well-embedded into the running of the service to support the delivery of a high quality service based on outcomes of people's care. We looked at what the service did to check the quality of the service, and to seek people's views about it. The registered manager told us service quality and improvement was measured through a variety of audits, satisfaction questionnaires and performance indicators. These included risk assessments, service review, staff supervision, governance, development initiatives and service specific training. For all of these key performance indicators a number of measures were in place to gauge their effectiveness. To ensure people received effective care and support, staff performance was monitored and fed back via supervisions. The supervision of staff was provided both formally and informally and there were clear links between the supervision sessions to staff appraisals and further training for staff

development. A member of staff told us, "One of the reasons I work here is the support and I feel I am developing my skills."

There was a strong emphasis on continually striving to improve the service. The registered manager regularly met with their manager for supervision and to discuss the current issues of the service and future planning. Managers' meetings reviewed the quality of the service and considered what could be improved upon. The service also looked to improve through collecting and listening to the views of people using the service. Quality assurance checklists were completed by staff during visits to people's homes. These included seeking feedback from people about their experiences and the monitoring of records kept in people's homes. All informal or formal feedback was recorded and this was shared with staff during team meetings.

The registered manager informed us that they valued the people using the service and staff considered it a privilege to work with people at a difficult time of their life. They also valued and trusted their staff and had built into operation effective systems to support them. We saw guidance and policies were in place to support staff and to keep them safe. Staying safe on social media, driving safely at work, severe weather and lone working guidance was provided for staff.

There were opportunities for staff to progress and develop leadership skills. One member of staff informed us about how they had worked for the service and developed their skills, which had prepared them to apply for and being promoted to a senior position in the service. They used their knowledge of their previous role to support staff through supervision and working alongside them when the person needed the support of two staff. Members of staff informed us how well supported they were by experienced and knowledgeable colleagues. One member of staff who was new to working in care informed us how well they had been supported and the service had given them training while recognising the transferrable skills they had from their previous work.

The service was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

Rigorous and constructive challenge was welcomed from other providers by the service. The registered manager spoke with other providers at set times through meetings and as the need arose regarding discharging people from hospital. The registered manager prioritised that people were discharge safely but understood the pressure other professionals worked under to ensure there were beds available at the hospital for people to be admitted. The registered manager ensured this happened effectively and had sufficient staff trained to undertake assessments quickly. They worked with individual professionals to arrange discharges rather than wait for meetings. They had also arranged for people living in Suffolk to return home with the support of the service from hospitals outside of Suffolk.

The service had a procedure in place to work with the person to identify another provider and to hand their care over to after six weeks of reablement from the service. Although there was a clear process in place things did not always run smoothly and hence it could take longer to discharge the person to another service. The registered manager had built a failsafe into the system to ensure staff would continue to work with the person to keep them safe until the new service commenced.

The registered manager regularly reviewed the quality of the service to see what could be improved. Meetings were held to discuss lessons learned from case studies, complaints and surveys, and best practice was shared and discussed. For example, it had been recognised that lessons could be learned from the bad

winter weather and how the service ensured the most vulnerable people they supported were prioritised. An action plan had been put in place to support this with detailed information of what the service would do as soon as bad weather was forecast in the future. A professional informed us about how the service staff always helped them with supporting people out of hospital whenever they could do so. They told us, "During the bad weather, I am convinced by their commitment and management organisation they helped to prevent emergency readmissions."

During the inspection the registered manager was able to show that they had maintained accurate records and demonstrated how they efficiently and effectively ensured that the quality of the service was monitored and any shortfalls identified and action taken to address. The records had been completed to a high standard and information could be easily accessed to support their compliance with regulations and the CQC five key questions. The service had not missed any planned care visits since our last inspection and also had quality monitoring procedures in place for the auditing of medicines, staff training and supervision plus any lessons that could be learnt from complaints and safeguarding referrals.

The service had developed and improved from the quality assurance process in place which was continually reviewed for improvement. The senior staff of the service carried out observations of the staff they managed. Feedback from these observations are given to the staff member and any issues raised form part of the development plan for the staff which is discussed in supervision. A new observation form was completed since our last inspection and was implemented to further improve quality of observations and ensure on-going compliance with Care Certificate Standards.

We saw that 70 telephone questionnaires were completed in last 12 months with Mid Suffolk customers. All customers said they were happy with the service being provided and that there were no improvements required. All long-term customers are visited at start of service and six monthly. A professional informed us they had been involved in people's care reviews. They said, I am confident not only does the service help people out of hospital safely and prevent delays whenever they can they also work effectively to prevent unnecessary readmissions.