Islington Social Services

Reablement and Home Support Service

Inspection report

4th Floor
222 Upper Street
London
N1 1XR

Tel: 02075274435

Date of inspection visit:
13 December 2016
14 December 2016

Date of publication:
30 January 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13 and 14 December 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service. The Reablement and Home Support Service had recently moved location. This was the first inspection at the current address. However, the service was last inspected 10 February 2014 at the previous location and was meeting all the standards inspected.

There was a registered manager in post. A registered manger is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of law, as does the provider. The registered manager was present during the inspection.

The service currently offers five different types of support and works primarily with people aged 65 and over. The service offers home support which provides people with long term care within their own home. There are four types of reablement services: a rapid response service which helps prevent hospital admissions; a discharge service which assesses the support people need when leaving hospital; enhanced reablement services which provides 72 hours of 24-hour care assessment and support; and, reablement services which provides six weeks of care and support for people requiring rehabilitation. The service supported 68 people at the time of inspection. Nine people were receiving the home support service, while 59 people received care from the various reablement services.

Risk assessments were often a tick box format and did not give staff guidance on how to mitigate risks. Two people had no risk assessments in place despite there being known risks. Risk assessments failed to provide staff with appropriate information with regards to the people they were taking care of.

Care plans were not person centred and did not state people's likes, dislikes or how they wanted their care to be provided. Care plans were brief, often several sentences and did not provide staff with an appropriate level of knowledge to be able to work with people.

Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report it to if people were at risk of harm. Staff had an understanding of the systems in place to protect people who could not make decisions outlined in the Mental Capacity Act 2005.

The service did not administer medicines to any people that were supported. However, care workers did prompt people to take their medicines where necessary. Care workers were aware of the difference between prompting and administering medicines.

People received a continuity of care. The provider always tried to ensure that the same care workers looked after people. This promoted good working relationships with people who used the service.

There was an electronic monitoring system in place to monitor any missed visits. The service had not had any missed visits since January 2016.

People and relatives said that they were treated with dignity and respect. Staff were able to give examples of how they ensured that they promoted dignity. People were encouraged to be as independent as possible.

Staff received regular, effective supervision and attended monthly team meetings.

There were monthly monitoring visits and spot checks of all staff carried out by team leaders. The registered manager completed audits of staff training and supervisions. Quality of care was monitored through telephone calls to people that used the service and exit questionnaires when people stopped using the service. Where areas for improvement were identified, the registered manager used this as an opportunity for change to improve care for people.

At this inspection we found breaches of Regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is considering the appropriate regulatory response to address some of the concerns we found during this inspection. We will publish what action we have taken at a later date. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Risk assessments were brief and did not provide staff with guidance on how to mitigate risks.

The service provided prompting to ensure that people were taking their medicines. The service did not administer medicines.

Staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

There were sufficient staff to ensure people's needs were met. People experience a continuity of care and often had the same care workers visiting them.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role. People were supported by staff who reviewed their working practices as staff received regular supervision.

Staff understood their responsibilities in relation to meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Depravation of Liberty Safeguards (DOLS).

People told us that care workers knew their food and dietary preferences.

Peoples healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

Is the service caring?

Good

The service was caring. People were supported and staff understood people's needs.

People were treated with respect and staff maintained privacy and dignity.

Staff understood and were positive about equality and diversity.

People were supported to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care was not person centred and care plans were not detailed. People's likes and dislikes were not noted.

Staff were knowledgeable about individual support needs, their interests and preferences.

Complaints were responded to in an effective and timely manner. People and relatives knew how to complain.

Is the service well-led?

Good

The service was well led. There was an open and transparent culture where good practice was identified and encouraged. Staff were encouraged to review their working practice on an on-going basis.

Complaints were used as a learning opportunity to improve quality of care.

Audits and surveys were carried out to assess the standard of care.

Reablement and Home Support Service

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 13 and 14 December 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the registered manager was present. The inspection was carried out by one inspector and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts by experience contacted people that used the service and where appropriate, their relatives to gain their views on the care and support provided by the service.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We looked at 13 care records and risk assessments, eight staff files, and other paperwork related to the management of the service including staff training, quality assurance and rota systems. We spoke with 21 people who used the service, eight staff and two people's relatives.

Requires Improvement

Is the service safe?

Our findings

Feedback from people and relatives around how safe they felt being supported by care workers from the Reablement and Home Support Service was generally positive and they felt that the care workers were dedicated and trustworthy. People said that they felt safe with the care staff that visited them. People told us, "Yes I feel safe, I don't think they [care workers] are any threat or anything like that", "Yes absolutely [I feel safe]" and "Yes, they are trustworthy, they have access to my keysafe and I am not worried about it." However, despite the positive feedback one aspect of the service was not safe.

For the reablement service, risk assessments were written by the staff referring people to the service. This was generally a social worker. The service did not write or update any of the risk assessments. For home support the registered manger told us that, "Home support risk assessments are completed by the team leaders [of the service]." For people using the home support service there were separate risk assessments. For people using the reablement service, the registered manager told us that any risks were incorporated into the care plan provided and written by the referrer.

Risk assessments were brief and did not provide staff with guidance on how to mitigate risks. Risk assessments were often a tick box format which provided little detail. Where there was information, this was often only one or two lines. For example; one person required two carers and the use of a hoist to safely transfer. The risk assessment just stated, 'two carers'. There was no clear guidance on what the risks were, how staff should use the hoist and no risk mitigation. Another person's initial reablement assessment noted that they were at high risk of falls. However, this risk had not been carried through into the care plan and there was no information for staff that this was a risk or how this risk could be mitigated. For another person, there was no risk assessment in place at all. There was no information available to show if there were any risks or if risks had been identified and not mitigated. Another person had risks identified. However, there was no risk assessment available. The registered manager told us, "There is a risk assessment but it is not on the file." Another person had a list of serious health conditions. However, there was no information on the risk assessment as to what risks these health conditions posed or how staff could recognise or mitigate the risks. Where people had been diagnosed with dementia or mental health conditions, there were no risk assessments on how this could affect behaviour and if there were any associated risks to the person or staff supporting them.

Care plans and risk assessments that had been competed were available in people's homes and staff confirmed that they had access to them. However, people's initial assessments were stored on a computer system which care workers did not have access to. Where a risk may have been identified at the assessment stage but not incorporated into the care plan, care workers had no way of knowing or understanding the risk. This potentially placed people and staff at risk of harm.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For every person that the service supported, an 'initial hazard assessment' was completed by the first care

worker that visited. This was an environmental risk assessment that ensured that the environment and equipment were safe and that there were no risks. Where any risks were identified these were mitigated and documented. One person told us, "Well it's alright when they were here they tested everything the gas, electric, they had a look round the flat for any dangers'.

All staff members that we spoke with were able to explain how they would keep people safe and understood how to report it if they felt people were at risk of harm. Staff were able to explain different types of abuse and how to recognise it. One staff member told us, "[Safeguarding] is to protect the service user. If we feel that the service user is at risk of abuse we need to report it and raise it as a safeguarding. I would report it to my manager or if necessary the CQC [Care Quality Commission]." Staff told us and records confirmed that they were trained in safeguarding adults during their induction.

Staff understood what 'whistleblowing' was and knew how to report concerns if necessary.

Care workers did not administer medicines to any people that the service supported. The registered manager told us, "We prompt and assist [medicines] we don't administer in any of the services that we offer. We don't have MAR [Medicine Administration Records] as we don't administer." Care workers that we spoke with understood the difference between prompting people with their medicines and administering medicines and confirmed that they did not administer medicines. The registered manager told us and we observed when we visited people in their own homes, that where a person required prompting with their medicines, a green sticker had been affixed to their care file within their home. This reminded staff that they needed to prompt the person with their medicines. People that we spoke with told us that they managed their medicines themselves, were supported by relatives or that staff reminded them to take their medicines. People's care plans noted if the person needed prompting with their medicines. However, care plans did not state how people should be prompted.

The service followed safe recruitment practices. Staff recruitment information including staff references and eligibility to work were held by local authority Human Resources (HR) department. During the inspection we requested to see this documentation but it was unavailable due to data protection and being held at a different office. Following the inspection the registered manager sent eight staff records which included proof of identification, eligibility to work in the UK and two references. This minimised the risk of people being cared for by staff who were inappropriate for the role. There had been no staff recruitment since the last inspection. However, the service had taken on three regular agency staff that had worked with the service.

There were records of accidents and incidents and staff knew what to do if someone had an accident or sustained an injury. There were two documented accidents or incidents since January 2016. Records were detailed and noted the issue, any follow up and the outcome. Accidents and incidents were used as a learning process to ensure better care practices for both staff and people.

There were adequate staffing arrangements and enough staff were employed to ensure that people using the service were supported. Care workers told us that they had enough time at visits to complete care tasks. The registered manager said that continuity of care was important for the people that used the service and that the service always ensured that people had regular carers that they got to know. Staff and people told us, and rotas confirmed, that people often had the same care workers visiting them, which enabled people to experience continuity of care. One person told us, "I have the same carer all the time." Another person said, "They're fantastic. The carer comes every day, it's always the same ones although it's different ones at the weekend and I don't know all of them."

Good

Is the service effective?

Our findings

People were supported by staff that were able to meet their needs. Staff told us and records confirmed they were supported through regular supervisions to look at people's on-going care needs and identify staff training and development needs. Staff had input into their supervisions and told us that they had monthly supervision that helped them be clear about the best way to support people. Staff were positive about the process and told us that they felt supported by their supervisions.

All staff received yearly appraisals that identified training needs and reviewed performance. Where training was noted, we saw that this had been provided.

Staff had a comprehensive induction when they started to work to ensure that they understood people's needs prior to working alone. As well as the local authority employing their own staff, they also outsourced work to several other staff agencies. The local authority employees received a full induction including all mandatory training and understanding the needs of the people they would be working with. New staff shadowed more experienced staff before being allowed to work on their own. Agency staff received an induction to the service and an introduction to the people they would be working with. The registered manager told us that they used the same agency staff, where possible, to maintain continuity of care. Although agency staff were not supervised by staff at the service. the registered manager told us that the service had good inter-agency working with the care agencies that were used and any issues were shared and discussed.

Records were kept of monitoring visits [spot checks] for care staff. Team leaders completed monthly visits to all care workers and looked at all aspects of how the person's care was being delivered including; medicines prompting, if the person was treated with dignity and as well as moving and handling techniques. . The registered manager told us that if an issue was identified it would be addressed with the staff member as soon as possible and in supervision.

Staff training records showed when staff had completed training and when it needed to be renewed. All staff had received mandatory training in areas such as, manual handling, Mental Capacity Act 2005 and health and safety.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the 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.

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

Staff had received training in the Deprivation of Liberty Safeguards (DoLS) and The Mental Capacity Act 2005 (MCA). One staff member said, "If service users are not able to make decisions for themselves, the Act [MCA] is to establish if they lack capacity and whether they are able to make decisions for themselves in their day to day lives. If we are in doubt, there would need to be an assessment and someone appointed to help with their decisions." All staff that we spoke with were able to explain how the MCA could impact on the care that they delivered. The registered manager told us that the majority of people that the service supported had capacity. If there were any issues regarding a person's capacity, this would be identified by the referrer at the point of assessment and included in people's care plans.

Care plans showed if people required help with meal preparation when care staff visited. The majority of the people that the service supported were able to prepare their own meals. However, some people were supported to cook meals and others required prompting to eat regularly. People told us, "I do everything myself I use a microwave to cook', "They help prepare breakfast for me" and "I do it all myself." Care plans documented where people needed support with eating although their likes and dislikes had not been documented. However, people and relatives told us that where care workers prepared meals, they offered choice and knew what they or their relative enjoyed eating. One person commented, "They cook what's in the freezer, they take it out and heat it up in the oven. They ask what I want."

People and staff told us that the service did not attend healthcare appointments with people and that this was generally managed by relatives. However, staff told us that if a person required support they would ensure that this was provided. The registered manager told us that any healthcare visits were recorded in people's daily logs.

Good

Is the service caring?

Our findings

We asked people if they thought that staff were kind and caring. People told us, "Absolutely fantastic, haven't got a bad thing to say about any of them", "Yes always, the way they talk to me [is kind]", "Very kind and they are very compassionate" and "They do [speak kindly] to me. Very nice bunch of people."

The team leaders and care workers told us about the importance of treating people with dignity and respect and making sure people were seen as individuals and had their needs met in a person centred way. People commented, "Yes things like closing the doors and curtains when I am getting changed", If I need to go to the toilet they will help me in and then wait outside" and "I think they care about my privacy more than I do." One care worker told us, "When you go into people's homes you've got to respect their wishes and treat them with respect. You ask them what they want. How they want things done and treat them with dignity."

Staff sought people's consent to provide care and understood how this impacted on people's welfare. Care workers said, "We will ask, do you want me to do this? Can you do this? We encourage people to do what they can but we ask for their consent before we do anything." Staff were positive about encouraging people to do what they could for themselves and had a good understanding of reablement service. One staff member said, "It's about getting them to do things for themselves and encouraging their recovery."

People receiving home support services were also positive about the support that they received. Home support could be providing care for a number of years. On person said, "They [care workers] encourage me to do things in the morning like clean my teeth and pay my bills and I can do things on my own but the carers help me with bits and bobs. They always ask though."

People told us that they were involved in assessments and reviews of their care. Although these were completed by staff external to the service, people were positive about their involvement in planning their care. One person told us, "Yes, I will tell them anything and we have a review every so often."

People's beliefs were noted in their care plans. One care worker said, "We always take their [people's] faith and culture into account. If they want shopping and that want halal food, we will ensure we get this."

Staff were positive about working with transgender, lesbian, gay and bisexual people. One staff member told us, "Makes no difference, people need care and that is what we are there to do. The only time it may make a difference was if the service user requested something specific regarding their care and sexuality."

During the inspection, we visited two people in their own homes and were accompanied by one of the services team leaders. We observed friendly interactions and people knew the team leader well, greeting them and asking how they were. Staff that we spoke with knew people well, including their likes and dislikes. Another person commented, "We get on really well and I think they know me. We're always chatting away."

Requires Improvement

Is the service responsive?

Our findings

The registered manager told us, "We are a providing service, we do not write any of the care plans. We don't have any input into the care plans as it is done from the assessment of needs. If a care plan needs updating, we feed back to the care manager to get it updated."

Care plans that we looked at were not person centred and did not include details of people's likes and dislikes. Information contained within care plans was often very brief, consisting of only a few lines. Information from people's initial needs assessments that were completed and detailed at the point of referral had not always been transferred into the care plan. All care plans were task focused and although they informed staff of what tasks to complete at visits, they failed to state how care should be delivered. For example, one person's care plan stated 'Give [person] a wash'. There was no further information. Some care plans noted that people had a diagnosis of dementia or a mental health condition. However, there was no information on how these conditions affected the people, or if there were any behaviours associated with their conditions that care workers needed to be aware of.

Where care plans stated that a care worker should prepare a meal for people, there was no further information. People's likes and dislikes were not documented. However, care workers and people told us that they knew people well and knew their preferences.

For people receiving a six week reablement service, care plans stated the goals such as, 'to become mobile', to make a simple meal'. However, there was no information on how this was going to be achieved. There was no guidance for care staff on how to enable people to become independent with the identified goals. We discussed this with the registered manager who acknowledged that the reablement care plans failed to provide guidance for care workers. The service employed several healthcare professionals, including occupational therapists and a physiotherapist. However, there was no information in the care plans as to what role these staff had in the person's reablement.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans noted whether English was the person's second language and if the person needed a translator. The registered manager told us that where people spoke a different language the service would try to engage a translator where necessary. The registered manager also gave an example of matching a staff member with a person that spoke the same language and said that where possible the service tried to ensure that people were able to communicate effectively and provided with appropriate care and support. If the service was unable to meet the person's needs with regards to communication, they would source a care worker form an agency that the service used that could meet the person's needs.

We asked relatives and people if carers stayed for the correct amount of time that had been agreed at the assessment stage. One person said, "Yes, they always stay the time they are supposed to." People had no concerns about care workers staying the correct amount of time.

People told us that staff were sometimes late for visits but this was usually because of traffic. One person said, "Sometimes it can't be helped. Someone usually calls to tell me if they [care workers] will be a little late." Rotas and care staff that we spoke with confirmed that the service ensured that there was adequate travel time to enable staff to get to their visits in a timely manner.

People and relatives told us that they thought the service met their needs. People told us, "[The service] is very flexible. They are willing to work with me." Another person said, "If anything changes they will deal with it right away. Like when I changed the time they come around they sorted it out for me."

The service had installed an electronic monitoring system to ensure that care workers attended visits. Carers logged on to the monitoring system when they arrived and logged out as they left via their mobile phones. This allowed the provider to monitor whether that care workers were on time and spending the correct amount of time supporting the person. If a care worker had not logged in for a visit, an automatic alert was sent through to the office after 30 minutes. The registered manager told us that since January 2016, when the electronic monitoring system had been brought in, there had been no missed visits. People that we spoke with confirmed that they had not experience any missed visits.

The reablement service healthcare professionals that were employed by the service including two senior occupational therapists, a physiotherapist, pharmacist, four reablement officers and one team leader held a weekly multi-disciplinary meeting. All people receiving six-week reablement were discussed. People's progress and what further input may be required was agreed and documented. However, care plans were not updated to reflect what care and treatment should be received.

There were reviews of care. The registered manager told us that these were usually carried out and documented by the staff that referred the people and the Home Support and Reablement Service was invited to attend. Where reviews resulted in a change to the care plan, the registered manager told us that the referrers would write a new care plan and this would be placed into people's home for care workers to read.

The service had a complaints policy. The complaints policy was given to people when they began using the service. The registered manager told us that people had a copy of the complaints procedure in their folder located within their home. We saw that a large font guide on how to complain was in both people's homes that we visited. However, the complaints policy was a general one that was used for the local authority to register formal complaints. There was no separate complaints policy for the service. There were no documented complaints through the local authority system. However, the service had received 19 informal complaints since April 2015. The registered manager kept a record of complaints received, how they had been addressed and any actions or learning arising from the complaints. People and relatives told us that they knew how to complain. One person said, "Yes, I know how but I have nothing to complain about. No problems with them" Another person said, "I'd just call the office."

Good

Is the service well-led?

Our findings

Staff were positive and said that the registered manager promoted an open and inclusive environment. One staff member said, "[The registered manager] is fine. Very easy to talk to. No matter how busy he is he will always take time to talk to you. Any problem, you can take it to him." Another staff member said, "[The registered manager] is very fair. He's a good manager and he tries to listen and can bend over backwards for people but can be firm when needed. He's well liked." People that we spoke with were not sure who the registered manager was as most of their contact was with the team leaders. However, people were positive about the overall management of the service.

Regular team meetings were held. Staff told us that they felt they could raise any issues and that the registered manager would listen to them. One staff care worker said, "We have regular team meetings. It is very open and they [the management] allow us time to voice our concerns or issues. It's often the only time we get to see other staff as we often work on our own." There were also regular management meeting involving the management within the office. These were designed to discuss the direction of the service, new developments and any issues arising. All staff that we spoke with said that they felt supported by their managers.

There were systems in place to ensure that staff training was up to date. Training records showed when staff needed to refresh training. Supervision records showed that staff were able to identify and request training. We saw that where a staff member identified training that would improve their care practices, this was provided. Quarterly training audits were completed by the registered manager to ensure that staff training was up to date.

The registered manager maintained an overview of supervisions that staff received and monitored when staff were due their supervision meetings. Staff were positive about the support that they received from management during their supervision.

The office was open and staffed by team leaders on a rota basis, seven days a week from 07:00 until 22:00 every day of the year. As such there was no on-call system. However, in the event of an emergency a manager was allocated as on call and was able to address any issues. People and relatives told us that there was always someone available if they needed to contact the office. People were positive about the support they received when they did make contact with the office. One person said, "They are always so helpful."

The service completed exit questionnaires for people at the end of their six-week reablement care package. Any comments or concerns were taken to the registered manager to be addressed. The registered manager gave an example of where several people had highlighted that they had not been happy with the timings of visits. This was discussed with the assessment team and the four new coordinators within the reablement team now discuss timings with people and ensure that they are happy with the times of care visits.

There were records of regular telephone monitoring. This was where office staff would contact people by phone and ask questions regarding the quality of the service that they were receiving. Monitoring visits

carried out by team leader for all staff on a monthly basis were reviewed and audited by the registered manager. Where issues were identified the registered manager used these to make improvements to the service. Results were also discussed at team meetings if necessary.

Where a recent safeguarding had been raised and investigated, the service was using the outcome of this as a learning experience and conducting a review of the service to ensure better working practices and provision of care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred and failed to reflect people's preferences. The provider failed to ensure that people's likes and dislikes and how they wished their care to be delivered were documented. Regulation 9(1)(a)(b)(c)3(b)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments did not ensure that care and treatment was provided in a safe way for service users. Risks were not always identified and mitigated. Risk assessments were brief and failed to ensure that staff were provided with sufficient guidance to mitigate risks. regulation 12(1)(2)(a)(b)

The enforcement action we took:

Warning Notice