London Borough of Waltham Forest

London Borough of Waltham Forest Reablement & Support at Home Team

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 23 and 24 January 2018 and was announced. The provider was given 48 hours notice of the inspection as they provide personal care to people in their own homes and we needed to be sure someone would be available in the office during the inspection.

The service was last inspected in July 2016 when we identified breaches of three regulations regarding person centred care, staff training and support and good governance. We asked the provider to complete an action plan to show what they would do by when to address these breaches and improve the key questions of Effective, Responsive and Well-Led to at least good.
Although the provider had taken action to address the concerns around staff training and support, breaches of regulations regarding person centred care and good governance continued. We found additional concerns regarding risk management and medicines and the service had not followed the action plan submitted to us.

The reablement and support at home team is registered to provide personal care to people in their own homes. They provide up to six weeks support to people to help them to regain their confidence and independence. At the time of our inspection in January 2018 they were providing support to approximately 100 people.

The registered manager had left the service in December 2017. 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. The service had just appointed a new team leader who told us they were going to apply to register as manager.

Risks to people during receipt of the service, and in particular in relation to their medicines, had not been appropriately identified or mitigated against. Risk assessments had been completed, but these delegated actions to mitigate risk to people's relatives and did not inform staff what they needed to do to keep people safe. There was insufficient information about people's medicines to ensure they were managed in a safe way.

People told us they felt staff had to rush, and did not attend at specific times. Staff told us they were unable to complete aspects of their work because they did not have capacity. Schedules for reablement officers were compiled in a way that meant it was impossible for them to deliver care on time. There were not enough staff deployed to ensure people's needs were met.

Care plans were not personalised and did not reflect people's needs and preferences. We saw generic templates were in use and people did not feel involved in the process of needs assessment and care planning. There was limited information about people's dietary needs and preferences, and care plans did not contain information about how people's healthcare conditions affected their support needs. There was some information about people's culture and background, but there was no information about the impact people's personal circumstances had on their experience of care.

The management and governance structures had not operated effectively to identify and address issues with the quality and safety of the service. Audits were not completed as scheduled and feedback about the quality of the service was not reviewed. There was no analysis completed of call monitoring data, complaints or incidents to ensure lessons were learnt.

People and staff told us their relationships were affected by inconsistent rotas, changing times and staff. People told us individual reablement officers were kind and treated them with respect.

Staff were recruited in a way that ensured they were suitable to work in a care setting. Improvements had been made to staff training and support. Staff received the training and supervision they needed to perform their roles.

The service worked well with other services to ensure people received multi-disciplinary support to meet their needs. The service made onward referrals to other services when people needed ongoing support. Staff had clear information about other services available to people and knew how to make referrals.

People provided consent to their care and treatment and the service worked within the principles of the Mental Capacity Act 2005.

The service was going through an organisational restructure and had clear plans in place for the future development and transformation of the service.

We found breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding person centred care, safe care and treatment, good governance and staffing. We found one breach of the CQC (Registration) Regulations 2009. We made a recommendation about ensuring people's personal characteristics were reflected in care planning. Details of our regulatory response are added to reports after all appeals and representations have been completed.

The overall rating for this service is 'inadequate' and the service is therefore in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risks to people had not been appropriately identified and measures in place to mitigate risk were insufficient.

The service did not have systems in place to ensure the effective and safe management of medicines.

There were not enough staff to meet people's needs.

Staff knew how to respond to allegations of abuse, and people felt safe with their staff.

Staff reported incidents, but it was not always clear what action was taken in response to incidents.

Staff were recruited in a safe way that ensured they were suitable to work in a care setting.

Is the service effective?

Requires Improvement

The service was not always effective. People's needs and choices were not assessed in a holistic or person centred way. Care plans lacked detail about how people should be supported to have their needs met.

There was insufficient information about people's dietary needs and preferences to ensure they were supported with meals in an appropriate way.

People's healthcare needs were not clearly recorded in a way that was accessible to all staff.

The service had established close working relationships with other organisations that ensured people received multi-disciplinary input where this was required.

The service worked within the principles of the Mental Capacity Act 2005.

Staff received the training and support they needed to perform their roles.

Is the service caring?

Requires Improvement

The service was not always caring. People and staff told us the strength of their relationships was affected by frequently changing staff rotas and allocations.

Care plans contained information about people's religious belief and cultural background. However, people's sexuality and gender identity were not captured. There was no information about how people's background and personal characteristics affected their experience of care.

People told us the staff were kind and treated them with compassion and dignity.

Is the service responsive?

Inadequate

The service was not responsive. People did not receive personalised care and were told they could not have their preferences in terms of times of visits respected.

Care plans lacked detail and did not contain information about how to support people to achieve their goals.

People completed feedback questionnaires but the service did not complete any review or analysis of them.

People knew how to make complaints. Records showed complaints were responded to in line with the provider's policy.

The service did not support people who were identified as being at the end of their lives.

Is the service well-led?

Inadequate

The service was not well led. Systems and processes were not operating effectively to monitor and improve the quality and safety of the service.

The management team told us they did not have capacity to complete audits and quality assurance work.

There were detailed plans for transforming the service, but these did not focus on the quality of the experience for people currently receiving a service.

There were regular team meetings, but these were not used as a mechanism to improve the service.

London Borough of Waltham Forest Reablement & Support at Home Team

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.

The inspection was carried out on 23 and 24 January 2018 and was announced. The provider was given 48 hours' notice of the inspection as the service is largely provided in the community and we needed to ensure staff would be available to speak with us.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information and other information we held about the service in the form of notifications that had been submitted to us. Notifications are reports of incidents and events that providers are required to tell us about by law. We sought feedback from the local Healthwatch.

The inspection was completed by two inspectors and an expert-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.

During the inspection we spoke with 13 people who used the service. We also spoke with eight staff including the nominated individual, the service manager, two practice managers, a project manager, a social worker and a social work assistant who were embedded within the reablment and support at home team, and a triage reablement officer. After the inspection we spoke with five reablement officers. The service called staff who provided support to people in their homes reablement officers. During the inspection we reviewed 10 care files, including needs assessments, care plans, records of care delivered and visit monitoring information. We reviewed 10 staff files including recruitment, supervision and training records. We also viewed various policies, audits, meeting records and other documents relevant to the management of the service.

Inadequate

Is the service safe?

Our findings

Risks to people were identified during the referral and assessment process. However, the specific risks people faced were not always clear and measures in place to mitigate risk were not clear or effective. For example, risks to one person's mobility and ability to complete transfers were identified due to clutter in their home and a mobility trolley being used to store paper and books which meant the trolley was not in use. The risk assessment stated, "Bedroom is a little cluttered advised to keep walkways clear to reduce the risk of trips / falls. SU [sic] said she will ask her son to support with moving some of the items. SU [sic] has a kitchen trolley which is full of papers books etc. SU [sic] said she will ask her son to empty it so she can use it to transfer items to/from kitchen." The risk assessment stated risks would be managed by "S/u [sic] to request support from son to reduce clutter and clear trolley." This meant the plans in place to mitigate risk had been delegated to a family member.

There was no record that support had been offered to support this person to make their environment safe, and no record that the family member had been informed that risk mitigation had been delegated to them. This person's care plan stated the person should be using the trolley during each visit and care records showed that eight days after the service started the trolley was still not cleared. This meant the risk assessment had not effectively mitigated the risks for this person, and reablement officers were not able to support this person in line with their support plan as the equipment was not available.

Another person was identified as being at risk of falls. The mitigation was stated as being, "Reablement care package to assist and supervise 3 x visits per day." This did not explain to reablement officers what actions they should take to mitigate the risk of falls. A third person's file contained conflicting information about the risks they faced. Their assessment identified they were at risk of falls and their mobility was put at risk due to an unkempt and cluttered environment. The risk management plan stated, "[Relative] has agreed to help her sort through and dispose of. She agreed to be referred to [service] for help to employ support with domestic tasks." However, the support plan completed on the same day stated, "Clean environment with free space" and did not identify any risks or mitigation. This meant the identification and mitigation of risk was not clear and did not ensure that people were safe while receiving care and treatment.

Managers within the service told us staff did not administer medicines but did prompt people to take them where this was identified as a need by the referring agency. However, the information about what support people needed to take their medicines, and what medicines people took was not captured in the records. A senior practitioner told us reablement officers took medicines information from people's discharge summaries from hospital but this was not uploaded to the provider systems. This meant the only information about the medicines people took was within the person's home. They told us the information was copied into the paper records held in the person's home, but this was not reflected in the records viewed where the information about medicines was either blank or directed staff to refer to the discharge summary. This meant the provider did not have adequate information about people's medicines to ensure people were supported to take them in a safe way. For example, they did not know if medicines were time-critical and so were not able to ensure visits were scheduled appropriately.

One person's referral stated they required prompting with medicines at each of their three daily visits. Their assessment stated, "Client may need checking to see if she has taken medication, if not client may need prompting." However, support with medicines was not identified as a goal for this person and the only information for reablement officers visiting their home was, "For RO to check medication has been taken, if not prompt client with medication." As there was no information about which medicines the person was meant to be taking it was not clear how staff would check that the correct medicines had been taken.

Records showed staff recorded in daily notes whether they had prompted or assisted people to take their medicines, or if people had taken them independently. However, they did not specify which medicines had been taken. In addition, one set of care records recorded a person refused medicines but there was no information about what had been done to ensure the risks of this person refusing medicines had been mitigated. As the provider did not have information about what medicines this person was prescribed they were unable to evaluate these risks.

The provider sent us their medicines policy. This was dated August 2016 but was out of date and contained inaccurate information. For example, the policy referred to CQC regulations from 2010 rather than the current 2014 regulations. In addition, the policy had not been updated to reflect the guidance from the National Institute of Health and Care Excellence (NICE) regarding medicines in home care which was issued in March 2017. The policy stated that information about medicines would be captured in a risk assessment with information for staff about the level and nature of support to be provided. The provider had not followed this process as information was not captured in the records. This meant the provider was not ensuring the proper and safe management of medicines.

The above issues with risk assessments and medicines management are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment processes operated to ensure that staff who joined the service were suitable to work in a care setting. Records showed staff completed a robust selection process and were interviewed and assessed according to set criteria. The provider carried out checks of staff identity and right to work to ensure they were able to work in the UK. Employment references were collected and criminal records checks completed on starting employment and every three years following to ensure staff had a suitable character to work with people in their own homes.

Reablement officers told us they did not think there were enough staff. One reablement officer said, "Sometimes I have to rush. If the rotas are really quite busy seven people in four hours. I go over my time, nothing you can do about that. Sometimes we are rushed off our feet. It depends on holidays and people off sick. The weekends are unbelievable. We only have half the staff on the weekends, and we have standby, but you're called out anyway." Another reablement officer said, "I feel there isn't enough staff, because they will ask if I can cover visits as they haven't got enough staff to cover. So I think they should have more staff."

The provider used a system called CM2000 to schedule and monitor attendance at visits of care. We reviewed the CM2000 records for 10 staff. These showed staff were given schedules with little or no travel time between them and were scheduled to attend up to eight visits simultaneously. This meant the schedule was created in such a way that staff were unable to attend visits on time. In addition, some staff were scheduled a very high number of visits to complete within their shifts, which led to poor punctuality and affected people's experience of care. One person told us, "They come at various times. They never call you to let you know what is happening." Another person said, "The night times are a bit distressing for me as I have to wait and wait." A third person told us, "The staff are very good, but they don't have a lot of time. They do the best they can." A fourth person said staff couldn't arrive at a set time because, "They are too busy." This meant the service had not deployed sufficient staff to meet people's needs and staff had been given schedules that were impossible for them to complete.

The above issues with staff deployment are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they were able to access personal protective equipment in order to ensure people were protected by the prevention and control of infection. Referrals contained information about people's home environment in order to ensure that risks of infection were identified. Records showed that where staff had concerns that people's home environment posed an infection risk referrals were made to support them to improve their environment. However, records showed staff had asked for additional personal protective equipment for a specific situation where there had been extreme concerns about the person's home environment. Although the managers told us action had been taken to address these concerns, this was not clearly captured in the records.

People told us they felt safe while receiving a service. One person said, "Oh yes [I feel safe]." Another person told us, "I feel very safe and happy. They treat me like a normal person." Reablement officers told us they would report any concerns they had about people's safety or concerns that people may be being abused or neglected to senior staff or managers. One reablement officer said, "I'll phone the office as soon as I've left their house and feedback what has happened. I would expect the office to call the family or social worker would get involved." They continued, "Safeguarding is something we have to watch out for, that's very important in this job. We look for bruises, look at interactions between family members."

The service was run by the local authority and the team included social workers. This meant the service was able to initiate safeguarding processes quickly. Staff told us some issues were resolved by staff within the team, or where the situation was more complex people were referred to the local authority complex care team who would coordinate a safeguarding response. The service worked within the Pan-London Safeguarding Framework. This is a multi-agency policy which outlines best practice in safeguarding adults from abuse and harm. Records showed staff received training in safeguarding adults.

However, records regarding what actions were taken when reablement officers raised concerns about possible abuse or neglect were not always clear. For example, records showed one person had made an allegation of rough treatment and neglect by a reablement officer. Although the provider was later able to demonstrate appropriate investigations and actions had been taken, this was not clearly captured in the records. For another person, reablement officers had raised concerns through their supervisions about self-neglect and it was not clear what actions had been taken to address these concerns. The provider was later able to produce records that showed appropriate onward referrals had been made to put an appropriate package of care in place for this person. The team manager recognised the recording of the provider's response to incidents and allegations of abuse was not always clear. They submitted an action plan which included ensuring information about incidents and allegations of abuse was clearly captured and available for audit and monitoring by managers.

Reablement officers reported incidents and concerns to the office. The practice managers told us incidents were logged on individual case records along with any actions or onward referrals that were made. We saw that concerns were escalated and referrals made. However, as records were only held on individual records, there was no oversight or review of themes and the provider was not able to demonstrate that lessons were learnt to ensure incidents were not repeated. Likewise, records showed and people told us that sometimes visits were missed. Although some of the missed visits could be accounted for when emails were reviewed, others could not. As there was no systematic monitoring of the call monitoring information the provider was not able to identify when things were going wrong with the scheduling of visits.

Requires Improvement

Is the service effective?

Our findings

People gave us mixed feedback about whether or not they were involved in the process of having their needs and choices assessed. Seven of the 12 people who were asked about having their needs assessed and reviewed told us they had not been involved or the process had not been effective. One person said, "I was told [staff member] would come back to me about the assessment but I don't know what is happening."

The service provided up to six weeks support to people to support them to build their confidence and regain their independence following a change in their needs, usually following a hospital admission. Referrals were received from a range of sources, including internal social work teams and the local hospital discharge teams.

Referrals were screened by a triage reablement officer. They told us there were no set criteria for them to evaluate referrals against. They said, "We used to have referral criteria but not so much now as we are a front door team and it is often the route to long term services." They told us if a referral was complex they would discuss it with the practice managers who would help them decide if a referral was suitable. After the inspection we were sent a document which contained referral acceptance and refusal criteria. We were shown correspondence which demonstrated some referrals were refused if it was clear people did not have capacity to regain their independence within six weeks.

After a referral had been accepted reablement officers started visiting people in their homes to provide support. A senior reablement officer aimed to visit people within 48 hours of their referral being accepted in order to complete an assessment and write their support plan. Records showed this was usually completed within two working days. However, reablement officers told us and records confirmed, people were supported by reablement officers prior to assessments being completed, particularly when they needed the service to start over the weekend or during public holidays. A reablement officer explained, "Sometimes we do walk in blind. You have to look at the person and see what you can do. I went to two people just before Christmas who hadn't got any food or anything in the house. I phoned the office and gave them feedback to get in touch with the social worker to try and get stuff in place as soon as possible. Sometimes we just have to do what we have to do. I'll go and get bread and butter, milk and eggs. You can't leave someone without any food."

The assessments completed by senior reablement officers considered people's abilities and established their goals. The service used a system called goal attainment scoring to set goals and measure progress. This meant senior reablement officers established and scored people's current abilities as "-1." If people achieved their goal within the set timescales they scored "0" and if they exceeded their goals they would score "+1" or "+2" depending on how far they exceeded their goals by.

Records showed that each person was set very similar goals and there was a lack of personalisation. For example, of the 10 care files viewed, five had identical goals set, and the other five were only slightly different in terms of the phrasing used. Two people's goals and goal attainment scores had been pre-populated into the assessment form. The senior practitioners told us they had identified this poor practice and showed us meeting minutes that showed this had been addressed with the staff member concerned.

Assessments reviewed were also not always completed. For example, information about people's functional ability with tasks, or their height and weight were not always completed. Records showed that upon an occupational therapy review one person was found to be unable to use the original equipment in their home as it was not large enough for them. The person required bariatric equipment. Bariatric equipment is equipment that is larger and stronger than standard equipment to be used by people who are obese. The section of their assessment regarding their height and weight had not been completed. This meant staff attending did not have full information about the person's needs. The lack of clarity around referral acceptance criteria combined with the lack of personalisation in goal setting meant people were not having their needs assessed in line with person centred practice.

The above issues are a breach of Regulation 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in July 2016 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received the training and support they needed to perform their roles. The provider had taken action to address these issues and staff now received the training and support they needed to perform their roles.

New staff received a comprehensive induction to the service, including training on key policy areas, ways of working, classroom based training in specific topics and shadowing of more experienced colleagues. One member of staff explained, "There was induction for one week, going through policies and procedures, our behaviours, how to treat people. I've been for lots of training. It's really good in that respect. Then there was serious shadowing which I really appreciated. That's how you learn about dealing with people, it's their lives and that can be delicate."

Records showed staff had received training in areas relevant to their role, including dignity in care, safeguarding, infection prevention and control, risk assessment awareness, first aid and fire safety. Staff received regular supervision from staff who had received training in how to deliver effective supervisions. Staff told us they found supervision useful to discuss issues and concerns about the people they supported. Records showed supervisions followed a set agenda, including a discussion of people's needs as well as training and any issues with staff teams. However, it was not always clear that issues raised by staff in supervisions had been addressed. For example, records showed staff had raised concerns about people's welfare but it was not clear what actions had been taken and the issues were not discussed at the next meeting. The practice manager was able to locate records that showed actions had been taken but these were not located within the supervision record.

People who used the service were mostly independent in ensuring they ate and drank enough to maintain a balanced diet. However, some people did require support to regain their confidence and independence in preparing their meals. One person told us, "Sometimes they help me [prepare meals]. They watch me cook." The information within people's care plans regarding the level of support they needed to prepare meals was very limited. There was no information in any of the care files viewed about people's dietary preferences. Care plans stated whether or not people's goals included meal preparation, but did not include information about the type of support people needed to achieve this goal.

For example, one person was assessed as needing support to achieve their goal of preparing meals independently, but the only information available for staff stated, "To be independent warming up a microwave meal whilst standing." Another person's plan simply stated, "To be independent preparing breakfast and microwave meal sat on a perching stool." This meant staff had limited information about what support people required with meal preparation. Records of care delivered captured whether or not people had required support to prepare their meals, but did not capture whether or not people had eaten. This meant there was a risk that people were not supported to prepare and eat meals in line with their needs and preferences.

The reablement and support at home team was integrated into the local authority and worked closely with the local hospital and healthcare teams. There were social workers, physiotherapists and occupational therapists within the team. This meant people receiving a service could receive support and be referred to on-going care teams smoothly and easily as referral processes were internal and well established. Records showed reablement officers would alert the office if people needed the input of healthcare professionals who would then visit people to complete assessments and provide additional input and support. This meant people received effective multi-disciplinary support from the service.

Care plans contained information about people's recent and current healthcare needs. However, this was often copied directly from referral forms where the information was recorded in medical terminology. For example, one person's medical history was captured as, "Osteoarthritis, CCF, AF, HTN, HC and Diabetes" another person's medical history was recorded as, "S/u was admitted into hospital following a fall at home and confusion. She was diagnosed of wall + LT orbit floor fracture and UTI." Even where the full terminology was used in care files, there was no explanation for staff regarding how people's health conditions impacted on their experience of care or care preferences. In relation to people who were diagnosed with diabetes, there was no information for reablement officers regarding the indicators of hypo-or-hyperglycaemia to guide them in how to respond to people's presentation. Records showed only two staff had received training in diabetes awareness. This meant the service had insufficient information regarding people's healthcare needs to ensure they were met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision 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 interest and as least restrictive as possible. Staff told us, and the service criteria information sent to us after the inspection confirmed, the service only provided support to people who had capacity to consent to their care and treatment. Staff recorded in their systems that people had given consent to receiving a service and stated this was captured in the paper records held in people's homes. Where staff had concerns about people's capacity to consent to their care or to engage in the reablement process they made internal referrals for qualified professionals to complete capacity assessments and make arrangements for long term packages of care. This meant the service was working within the principles of the MCA.

Requires Improvement

Is the service caring?

Our findings

People told us they thought the reablement officers who visited them displayed a caring attitude and treated them with kindness and respect. One person said, "They are like friends to me." Another person said, "They treat me with respect all the time. I can't find any fault." Reablement officers described how they attempted to put people at ease and build relationships with them. One reablement officer said, "You have to know how to speak to them, a little smile, talk about weather, if I see a painting or embroidery I ask a question about that, did they do it themselves? I don't just go in and sit down and do my report. I like to have a conversation. A lot of people are on their own and enjoy a little chat." Staff described how they promoted people's dignity by taking steps to ensure they were covered during care tasks, and that windows and curtains were closed.

However, people and reablement officers told us the quality of relationships was affected by frequent changes to the rota. One reablement officer explained, "Building up relationships is better if you've got consistency. When they come out of hospital they are very frail, they don't know what to expect and whether to trust us. The more we go there the more we build up a rapport, that's for all the staff. I think the rota does affect the relationship. Someone will say, 'I thought you said it was you yesterday', I have to apologise that the rota changed." Another reablement officer said, "The service user gets used to us, and then all of a sudden they change us. I don't think it's fair for the service user. I think they should have the same person. Some of the family get annoyed. It helps to build up the relationship if you're with the same person. They don't want different faces every day."

Records showed the service collected information about people's cultural and ethnic background, preferred language and religious beliefs. However, there was no detail about whether this information affected their care preferences. For example, there was no information about whether someone's religious beliefs affected whether or not they needed to complete their personal care at specific times or in specific ways. There was no information regarding whether it would be culturally appropriate for reablement officers to remove their shoes when visiting people's homes.

Reablement officers told us people were asked what their preference was for the gender of their reablement officer, but this was not captured in the care files viewed. People told us they did not feel they had been asked about their views about their care. For example, one person said, "They rarely ask me what I want." Another person said, "I don't have much choice dear, but they are good when they come." Care records stated whether or not people had family members or neighbours involved with their care.

However, this was limited to stating what, if any, support these people were able to provide. The care files contained no information regarding people's sexual orientation or gender identity. We asked staff if they provided support to anyone who identified as Lesbian, Gay, Bisexual or Transgender (LGBT). One reablement officer said they had in the past. Reablement officers told us someone's sexual or gender identity would not affect how they delivered care.

However, they did not demonstrate an understanding that sexual and gender identity can affect someone's experience of care. For example, one member of staff was asked if they thought identifying as LGBT might affect people's experience of care. They said, "We ask if they have a preference of whether they want a male or female carer. There is no section on the paper that asks about sexuality." Another member of staff said, "It's not something we'd ask, I shouldn't think for one moment it would be in the care plan because that's personal. I wouldn't treat them any differently. I don't think it would affect their experience. We as females we go into men and women, the male reablement officers only go to the males. I can't see how it would affect it. A person is a person." As questions about sexual and gender identity were not included in assessment there was a risk that people did not feel safe to disclose this information and the impact it might have of their experience of care.

We recommend the service seeks and follows best practice guidance from a reputable source about ensuring people's religious beliefs, cultural background and sexual orientation and gender identity are included as part of a holistic care package.

Inadequate

Is the service responsive?

Our findings

At the last inspection in July 2016 we identified a breach of Regulation 9(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans lacked detail and were not personalised. The service had not addressed this breach and issues with the detail and personalisation of care plans remained widespread.

Care files contained statements of people's reablement goals and a separate action plan to inform staff how to support people to achieve their goals. However, the action plans lacked detail on the support to be provided. For example, one person's action plan stated for each visit of care, "Reablement staff to assist her to get out of bed supervise her mobility to the bathroom, assist her to wash and dress her whole body while sitting on a perching stool. Assist her to make breakfast." There were no descriptions of what assistance meant or what reablement officers were meant to do to provide assistance. Another person's action plan stated, "Single cover 30min AM visit to be assisted and supervised to complete personal care: strip washing/ undress/dressing lower body and preparing b/fast to be supervised to negotiate the stair to go down the stairs." There was no further information to describe whether staff should be assisting or supervising or to describe what assistance was required.

Reablement officers told us that the terms "assist," "prompt," and "supervise" were known and understood by them to mean specific levels of support. However, some care plans were unclear about what level of support they should be providing. For example, a third care plan stated, "AMx7 30 mins. R/O [reablement officer] to support and encourage s/user to go into the bathroom to sit on the perching stool at the bathroom sink and wash her upper body. R/Os to assist with lower body washing. R/os to support and encourage s/user to go into the bedroom to sit on the bed and dress her upper body. R/os to assist su with her lower body dressing." There were no details to inform staff when the person moved from needing support, to assistance to encouragement. In addition, people were referred to as "service user" or "s/u" throughout the documentation. This added to the task focussed nature of plans as people were not presented as individuals, but "service users" for whom tasks required completion.

People told us, and the records of care delivered confirmed, there was no continuity in terms of the reablement officers visiting people in their homes. Records showed people received support from between seven and 17 different staff members during their time with the reablement service. One person was seen by nine different staff in their first 10 visits. In addition, people were told they were not able to instruct what time staff came to visit them. One person said, "They are supposed to come at any time so I am told. The office told me if I went private I could get a specific time." Another person said, "I can't order them to what time I want them." A third person said, "They arrive between 08:00 and 10:30 but I am not really sure. Sometimes they have come at midday."

Schedules showed that people had no continuity of the time scheduled. For example, one person had their morning visit scheduled at 10:10, 07:30, 08:00, 09:10, 10:30 and 11:40 during a two week period. The actual visits completed varied between being five minutes and two hours and 58 minutes different from the schedule, including one occasion where instead of having four and a half hours between visits, there were 45 minutes. This meant people were not receiving support at times that suited them. People were told they were not able to have their preferences acted upon.

The above issues are a continued breach of Regulation 9(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's progress was reviewed by senior reablement officers who monitored people's progress towards their goals. If people had achieved their goals more quickly their cases were closed and the service stopped. People were asked to complete feedback questionnaires about their experience of the service. Although some of these had been completed, the provider had not completed any analysis of the feedback since April 2017. The team manager told us this was because they did not have capacity to complete this work. This meant the feedback from people about the scheduling and timing of their services had not been acted upon. The team manager told us they were making the case for additional business support for the team.

The service worked within the local authority's overarching complaints process. Records showed complaints were investigated and responded to in line with this process. However, the service did not hold or maintain a local record of less formal complaints and there was no record to show lessons had been learnt from complaints made. For example, two of the complaints reviewed related to people and their relatives feeling that services had been terminated too quickly. Neither complaint was upheld, but there was no record to show that the provider had considered the need to ensure people and relatives fully understood the scope and remit of the service. People told us they would phone the office to make complaints which was in line with the local processes in operation.

The reablement service did not provide support to people who were at the end of their lives. This was because the goal of the service was to support people to develop and achieve independence and this was an inappropriate and unrealistic goal for people approaching the end of their life.

Inadequate

Is the service well-led?

Our findings

At the last inspection in July 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems and processes were not operating effectively to monitor and improve the quality and safety of the service and staff recruitment records had not been appropriately retained. Although the provider had addressed the concerns about the retention of staff records, issues with the quality assurance systems remained widespread.

The senior practitioners told us they had a target of auditing four completed care files a week, however, they were unable to complete these due to other demands of their work. They told us that on average they were completing four audits per month. Completed audits were submitted to us. These showed issues with the quality, detail and personalisation of care files had been identified by the audits. However, as these issues remained widespread at the point of inspection the actions taken to address these concerns had not been effective.

The team manager submitted a quality report. This was completed in April 2017 and considered the feedback collected through questionnaires from people who had received a service. This showed that issues with continuity and punctuality had been raised. At the time, the proposed solution was a development of the scheduling and monitoring system. However, there had been no further analysis of feedback and no evaluation of the effectiveness of the new system in the nine months since this report had been completed. The team manager told us this was due to a lack of administrative support to the team. This meant there had been no analysis of feedback and no effective systems in place to identify and address issues with the quality and safety of the service.

The management team told us that incidents, complaints and feedback were captured on individual people's records of care. We asked how incidents, complaints and other feedback were reviewed or if there was any systematic analysis of themes arising from feedback. The management team was not able to explain how the service was evaluated or improvements planned. The governance arrangements for the service were not effective. For example, the medicines policy had been signed off in August 2016 and the provider had not identified that it referred to out of date regulations. The senior practitioners were not aware that guidance for medicines in home care had been issued in March 2017. This meant the systems for ensuring the service remained up to date with developments in practice had not operated effectively. The service had failed to identify or address concerns that medicines were not managed in a safe way.

The newly appointed team manager submitted a management action plan during the inspection. This focussed on establishing information pathways and did not include actions to address issues with the quality and safety of the service as identified during the inspection.

The above issues are a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The team manager had recently been appointed to the service and had only been working for the service for a week at the point of inspection. The previous registered manager had left in December 2017. Providers are obliged by law to tell CQC about changes to the registered manager of a service. They had not done so until prompted to during the inspection.

This is a breach of Regulation 15 of the CQC Registration Regulations 2009.

The service was about to start consultation with staff about a wide ranging restructure of the reablement service and it's place within the adult social care offering of the local authority. There were detailed plans to transform the service to focus on preventative care with a focus on therapy input to increase people's independence and skills, including detailed pathways of care to support people coming home from hospital and avoiding admission to hospital. The restructure would lead to an increased number of therapists and therapy assistants but a reduction in the number of reablement officers.

The pending restructure was causing significant anxiety amongst staff. For example, one staff member said, "We know there's going to be changes, but I'm not really sure what they are. I've not been told what the options are. The literature was loads of pages, not just the basics. There was far too much paperwork. I found it hard to go through all of it. It seemed to go all around the pages. To be honest I found it confusing." Another member of staff said, "To be honest, there have been loads of gaps in management. This feels like just another change. You can't change things so may as well embrace them."

Staff told us and records confirmed there were regular staff meetings. This included in-house training sessions on goal setting and support planning. Although the records showed this information had been shared with staff, the failure of the service to improve the quality and personalisation of care plans meant this had not been effective. Records of team meetings showed these were used to discuss overall service targets, including ensuring that people completed their reablement service within six weeks or were appropriately referred for additional support. They also discussed staffing issues and caseloads for staff. Meeting records showed information about other services and organisations within the area were discussed to ensure staff had information about other agencies that could provide support to people.

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 15 Registration Regulations 2009 Notifications – notices of change The provider had failed to notify us the registered manager had ceased managing the service.

The enforcement action we took:

We issued a fixed penalty notice of £1250.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs assessments were not completed in a personalised way and care was not delivered in line with people's preferences. Regulation 9(1)(c)(3)(b)

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not been appropriately identified or mitigated against. There was insufficient information about peoples medicines to ensure they were managed safely. Regulation 12(1)(2)(a)(b)(g)

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not operated effectively to ensure the safety and quality of the service was monitored and improved. Regulation 17(1)(2)(a)(b)

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Insufficient staff were deployed to meet people's needs. Regulation 18(1)

The enforcement action we took:

We issued a warning notice.