Portsmouth City Council

Portsmouth Rehabilitation and Reablement Team (ILS)

Inspection report

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Tel: 02392684961

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Portsmouth Rehabilitation and Reablement Team (ILS) (known to the people who work there and use it as 'PRRT') on 18, 19 and 20 January 2017. The first day of the inspection was unannounced which meant the service did not know we were coming.

PRRT is an integrated health and social care service. The registered provider is Portsmouth City Council, although the service comprises a partnership between Portsmouth City Council and Solent NHS Trust. PRRT provides short term support for people who may need care, equipment or rehabilitation. The team includes nurses, social workers, physiotherapists, occupational therapists and rehabilitation assistants. The majority of care is provided to people in their own homes and focuses on supporting people to remain at home for as long as possible and preventing their admission to hospital.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People who used the service said they felt safe. Staff had received safeguarding training and could describe the forms of abuse people might be vulnerable to and how to report it appropriately. Recruitment procedures at the service were robust.

Risks to people had been assessed and managed. People were supported to take positive risks when the benefits outweighed potential adverse outcomes.

Staff who supported people to take their medicines had received training. Records showed medicines had been administered as prescribed.

There had been issues at the service with high caseloads; staff told us they had felt under pressure as a result. People told us they received the support they needed and never felt rushed by staff. The registered manager and service manager were in the process of re-evaluating the capacity of the service and recruiting more staff.

Records showed staff had access to training to support them in their roles. They also received regular supervision and an annual appraisal. Staff we spoke with said they felt supported by management to do their jobs.

People experiencing problems with their mental capacity were assessed in line with the Mental Capacity Act 2005 by social workers in PRRT. Other staff described how they gave people living with dementia choices to help them make day-to-day decisions.

The service supported people to meet their nutritional needs; we saw this often focused on building people's independence to cook and prepare drinks for themselves.

The service worked in partnership with other acute and community health and social care providers to help people meet their wider health needs.

People and their relatives told us PRRT staff were kind and caring. They also described staff as friendly and said they looked forward to their visits.

Records showed, and people told us, they set their own rehabilitation goals. Care plans focused on supporting people to regain and maximise their independence.

The service protected people's personal information and respected their confidentiality.

People's care plans were person-centred. They were supported by a multidisciplinary team of healthcare professionals within PRRT; this included the provision of specialist equipment or exercise regimes depending on people's assessed needs.

People's progress with their rehabilitation goals was assessed on a daily basis by PRRT at handover meetings and weekly at multidisciplinary team meetings.

Efforts were made by PRRT to arrange ongoing care packages for those people who needed them and to ensure a smooth transition to new home care providers.

Complaints were investigated and responded to appropriately. Compliments were used by the registered manager to motivate staff in the team.

Feedback from PRRT staff about the registered manager and other managers at the service was positive. People and their relatives thought the service was well managed.

A system of safety and quality monitoring was in place at the service. Various aspects of the service were discussed at weekly and monthly meetings within the team, and with the service's commissioners and stakeholder organisations on a monthly or bimonthly basis.

People were asked to feed back about their care experience with PRRT on surveys they were asked to complete when they were discharged. We saw almost all respondents were very complimentary.

Staff were asked to share ideas and suggestions to improve the service. These were discussed at monthly staff meetings.

Staff told us they thought the different teams of health and social care professionals that made up PRRT worked together to support people. They could explain the vision and values of the service and all told us they enjoyed their jobs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe. Staff understood how to safeguard people from abuse.

Staff had received medicines administration training. Records showed people received their medicines as prescribed.

Risks to people were assessed and managed. Some people had been supported to take positive risks.

Staff reported problems with high workload. The registered manager was taking action to improve this aspect of the service.

Is the service effective?

Good

The service was effective.

Staff told us, and records showed, they had access to the training, supervision and support they needed to meet people's needs.

The service was compliant with the Mental Capacity Act 2005.

People were supported to meet their nutritional and wider health needs by the service on a person-centred basis.

Is the service caring?

Good

The service was caring.

People and their relatives described staff as kind and friendly.

People set their own rehabilitation goals and the support provided focused on rebuilding their independence.

Where the service had supported people approaching the end of their lives, feedback from relatives was very positive.

Is the service responsive?

Good

The service was responsive.

People's care plans were person-centred and updated as their rehabilitation progressed.

The different healthcare professionals in the team worked together to support people to achieve their goals.

Complaints were dealt with properly by the service. Compliments were used to reward individual staff members and the team as a whole.

Is the service well-led?

Good

The service was well-led.

The safety and quality of the service was evaluated and analysed on a regular basis.

People and their relatives told us the service was well managed. Staff felt supported by their managers and described them as approachable.

Staff understood the vision and values of the service and enjoyed their jobs. They told us the integration of health and social care professionals into one team worked well.

Portsmouth Rehabilitation and Reablement Team (ILS)

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 18, 19 and 20 January 2017. The first day was unannounced and the other days were announced. The inspection team consisted of one adult social care inspector.

Before the inspection, we asked the provider to complete 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. The service submitted their PIR as required.

As part of the inspection we reviewed the information we held about the service and requested feedback from other stakeholders, including the local authority safeguarding team and Healthwatch Portsmouth. They did not share any concerns with us. After the inspection we contacted various other healthcare professionals for feedback, including social workers, community matrons, hospital consultants, physiotherapists and managers from other local services who referred people to the service. Those that responded gave us positive feedback, although some noted issues with capacity the service had experienced in the two months prior to this inspection.

During the inspection we visited three people who used the service in their own homes and spoke with seven other people over the telephone. We spoke with four people's relatives. We also spoke with the registered manager, the service manager, two community matrons, the social work assistant team manager, a social worker, an assistant social worker, a senior staff nurse, a staff nurse, two occupational therapists, a physiotherapist, a case coordinator and two rehabilitation assistants, all of whom worked for the Portsmouth Rehabilitation and Reablement Team.

As part of the inspection we looked at five people's care files and three other people's care plans; this included their risk assessments and assessment documents. We also inspected five staff members' recruitment, supervision and appraisal documents, staff training records, four people's medicines administration records, accident and incident forms, and various policies and procedures related to the running of the service.

Good

Is the service safe?

Our findings

People using the service said they felt safe when staff from the Portsmouth Rehabilitation and Reablement Team (PRRT) visited them at their homes. Comments included, "They make you feel safe and comfortable", "I feel safe. I welcome them", and, "I feel safe with them." People's relatives agreed. One relative told us, "They're all very nice."

Staff from the PRRT could describe the forms of abuse the people they supported might be vulnerable to and all said they would report concerns appropriately. One team member told us, "I'd phone the nurse so they could speak to the clinical manager. The social worker or nurse would raise a safeguarding", and a second said, "I'd raise a safeguarding issue and submit it to the safeguarding team at the council. I'd tell my manager." The training matrix showed staff were up to date with their safeguarding training. This meant staff could identify the signs of abuse and knew how to report it correctly.

We checked the records for accidents and incidents that had occurred at the service in January 2017 and December 2016. We found each one had been investigated and documented appropriately. Referrals had also been made to other services, for example to GPs or the local authority safeguarding team, when required. Each incident was given a risk rating and assessed for its impact and severity; we saw measures had been put in place to prevent a reoccurrence of each incident. This meant accidents and incidents had been managed appropriately by the service.

Some people using the service needed support to take their medicines. We saw this formed part of their initial assessment and the assistance required with oral or topical medicines was written into their care plans. We checked the medicine administration records (MAR) of four people who had received support; they showed all medicines had been administered as prescribed. People's medicines were dispensed in boxes and bottles, or in blister packs, depending on their preference. Blister packs are made up by pharmacies and contain the tablets each individual is prescribed at set times of the day. One person told us staff from PRRT had arranged for their medicine to be dispensed in a blister pack to make it easier for them to take; they told us, "They checked my NOMAD (blister pack) to make sure I'd taken them properly."

Records showed, and rehabilitation assistants told us, they had received medicines training and competency checks from senior staff members. One staff member told us, "A trained nurse comes out to check us." We saw the medicines competency assessment was a detailed document which covered the application of creams, infection control and what to do if people refuse their medicines. It also included a mock MAR to test staff understanding of medicines recording. Training records showed all staff administering medicines had received training for this. This meant medicines were administered safely for people who needed this type of support.

People's care plans contained comprehensive assessments carried out shortly after their referral by a specialist assessment team which were part of PRRT. We saw where risk was identified, more in depth risk assessments had been carried out. This included assessments for people's mobility, health and safety risks within their homes, and people's nutritional risks. Where risks were identified, we saw care plans had been

put in place. People's daily notes showed care plans were followed; for example, one person at risk of pressure ulcers had received specialist pressure relieving equipment and had their body checked (with their consent) by staff from the team regularly. We noted one person we visited was seated on a pressure relieving cushion; they told us, "One of the nurses brought this pressure cushion around for me. It's comfortable." Another person told us, "They looked for bed sores."

Staff from PRRT told us they assessed risks to people each time they went to their homes. One staff member said they checked to make sure people's homes were warm, there were no trip hazards, they had enough food in the fridge, their home was secure and the smoke detectors worked. A person we visited had suffered a fall and had problems mobilising to their front door to let care workers in. We saw they had a temporary key safe attached to sturdy railings on their property. A key safe is a secure device with a combination lock which contains a person's door key. The registered manager explained the team had a supply of temporary key safes, which could be attached to suitable fixtures on people's properties so staff from PRRT could enter people's homes to provide support. Another person's care plan we saw included the requirement for staff to leave the person's landing light on at their last visit of the day so the person could mobilise safely during the night if they needed to. This meant the service assessed and managed risks to people to help keep them safe.

The service also supported people to take positive risks where the benefits of an action were deemed to outweigh the risks. For example, concerns had been raised that a person living with dementia may attempt to leave their home unsupported and put themselves at risk when care workers and family members were not with them. In order to try and keep the person safe in their own home and not go into residential care, PRRT devised a plan to withdraw support gradually. This included staff observing the person's house after they left to see if the person left their home. The plan was successful and the person was able to remain in their own home. A second person living with dementia really enjoyed cooking. We saw PRRT had designed a care plan which involved the person being supported to cook their main meal each day with staff, so they could retain their independence whilst staying safe. This meant the service supported people to take positive risks in order to promote their independence and maximise their quality of life.

As part of this inspection we reviewed recruitment documentation for five members of staff employed at the service. All had a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups. Files also contained a copy of the original application in which gaps in employment were explained. Each file also contained two written references and records of their interview. Employees had provided photographic identification which had been copied and stored on file. This meant a robust recruitment process was in place to ensure new staff were suitable to work with vulnerable people.

We asked people and their relatives about the timing of the support visits they received from the service and if they saw the same staff members regularly. Comments included, "The staff are different but they're all from the same office. They're all very nice", "They were all different people, there were loads. They'd say their name and where they were from", and, "We saw a range of staff, perhaps the same four or five people." All the people and relatives we spoke with told us they had been informed by the service that support visits would be within a window of time, rather than at a specific time. No one reported having a late or missed visit and all said they had never felt rushed by the staff who came to support them. One person said, "They stayed as long as they needed", and a second told us, "They don't rush me at all."

The registered manager told us people's visits were arranged within four set windows of time, which were 7.30am to 11am, 11.30am to 2pm, 3pm to 6.30pm, and 7pm to 10pm. The number and timing of people's allocated visits depended on their identified needs. We asked staff if they thought there were enough staff to

meet the needs of the people the service supported. Feedback was mixed. One staff member told us, "It depends on caseloads and the patient needs", then added, "We could probably do with a lot more staff." Other staff members told us, "We absolutely need more staff, but there are new staff starting. We've had an extremely stressful two months", "Over the Christmas period staff were ill and it was difficult. It's calmed down now", and, "Everybody is stretched. The caseload is getting higher but staff levels aren't. I'm aware new staff are starting soon; things will be better when they're up and running."

We spoke with the registered manager and new service manager about the issues with staffing levels. The registered manager explained the system used to assess the manageability of workload. This system was updated each day depending on the number of people being supported and the staff available and resulted in the allocation of a rating: red for service at full capacity, amber for some issues with capacity, and green for no issues with the current caseload. On the days we inspected the service had red ratings. One staff member commented, "We're red daily quite often at the moment." The registered manager told us the colour rating was communicated to the provider each day and shared with stakeholders across the city; he explained, "We're re-looking at our escalation tool and how we decide our rating. Then we'll redefine our red, amber and green. Red will mean red. At the moment red means ask us and we'll see what we can do."

The new service manager had been in post for nearly two weeks at the time of this inspection. They told us, "We'll stop the service being safe if we keep taking more on", then added, "My first point is to sort out our capacity so we can say 'no, we can't do that.'" We were informed the service had closed to new admissions for three days the week before our inspection. The registered manager said of this, "It was very uncomfortable but it was just too much demand. We've got to look after the clients we have. It was difficult but the right thing to do."

A senior staff member explained how staff rotas were agreed a month in advance; any issues with staff capacity were highlighted and made available for existing staff to do as overtime. Gaps in rotas were also discussed at weekly team manager meetings. The registered manager said, "We prefer to use our own staff but we do have some regular agency staff." He also explained how changes to the red/amber/green capacity assessment tool and the new staff being recruited should make the PRRT workload more manageable and staff happier. This meant issues with team capacity and staff workload had been acknowledged by managers at the service and action was being taken to make improvements.

People and their relatives told us staff supporting them with personal care and the application of topical creams wore personal protective equipment (PPE) such as gloves and aprons. Staff from the service said there was a plentiful supply at the office for them to collect when they needed to. We noted staff returning to the office from visits to people were 'bare below the elbows.' In other words, they wore short-sleeved uniforms, no watches or rings with stones and were not wearing false fingernails. The training matrix showed staff had received training on infection control. This meant that staff were aware of infection control measures and used PPE when it was required to keep people safe from infection.

Good

Is the service effective?

Our findings

People and their relatives told us staff had the skills and experience they needed to meet their needs. One person said, "They know what they're doing", a second commented, "One of the senior ones came round. She was really good and knew what was what", and a third told us, "They know their job."

Staff we spoke with gave positive feedback about the induction they received at the service. This had involved completing training on core subjects and shadowing different healthcare professionals in the team to better understand their role. Records showed staff recruited who were new to health and social care were enrolled on the Care Certificate. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care.

Training matrices evidenced existing staff members had completed or were in the process of completing updates on core subjects such as health and safety, information governance, safeguarding and fire safety. One staff member told us, "Mandatory training is online and we get notifications from the learning and development team. We can see a matrix that's colour coded. It tells us what to do." Staff members who supported people to mobilise had completed practical training in moving and handling. All the staff we spoke with said they could request additional training if they felt they needed it. An officer involved with delivering training to the Portsmouth Rehabilitation and Reablement Team (PRRT) told us, "Staff members are keen to participate in training and arrive promptly and always participate in discussions."

A community matron on the PRRT gave an example of attending a training session with a tissue viability nurse the day before the inspection and then sharing the learning around different dressings with staff at the service's daily handover meeting later the same day. We spoke with a clinical educator from Solent NHS Trust who told us they and their colleagues had provided various 'bitesize' training updates in the daily handover meetings in the six months prior to this inspection. Records showed subjects had included recognising sepsis, clinical observations and safeguarding. This meant staff received the training they needed to meet the needs of the people they supported.

Several staff members told us how much they valued the healthcare students who were placed with the team. These included trainee physiotherapists, occupational therapists and nurses. One staff member told us, "We tend to have student nurses most of the time. They bring new ideas share all the up to date learning. We need that", a second staff member added, "I like going out with students because they question me." Staff members also said they appreciated the skills, learning and peer support they gained from staff members of other disciplines with PRRT and the feeling that they all worked together for the people they supported. One told us, "I really enjoy working here because you learn things every day from OTs (occupational therapists) and physios (physiotherapists)."

Staff members told us, and records showed, they received regular supervision and an annual appraisal of their progress. One staff member told us, "I get monthly supervision. I get to discuss what I've been doing and how to improve", and a second said, "Supervision I find really, really helpful. It's a good opportunity to

discuss practice and progress." Staff from the different disciplines within the PRRT had supervision allocated slightly differently, in that some had more group supervision and shared learning sessions, and others focused on one-to-one supervision with managers. All the staff we spoke with told us they felt supported in their roles. A manager in the team said, "I think if you support staff to be good at their jobs, they can support the patients better."

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 make 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. When people are deprived of their liberty in the community, it is the local authority's role to apply to the Court of Protection for authorisation to do so.

Staff we spoke with had received training on the MCA and could describe how they supported people to make decisions by providing them with choices. Nursing staff told us they used an assessment test to establish whether people might have issues with their memory and cognition. We sat in on a multidisciplinary team meeting where staff from PRRT met with a hospital consultant to discuss people's progress. In the meeting rehabilitation assistants raised concerns around a person's ability to make decisions; the consultant asked for a more in-depth test of the person's cognition to be arranged, plus a mental capacity assessment in line with the MCA.

The social workers in the PRRT led on MCA assessments for people when decisions needed to be made around people's ongoing care needs. Records evidenced people had been supported to be involved in decision-making which included the consideration of different options to identify that which was the least restrictive. The social work assistant team manager knew the process for referral where it was thought people may be deprived of their liberty whilst receiving care in their own homes. This meant the PRRT was compliant with the MCA.

Some people using the service were supported by PRRT with eating and drinking as part of their rehabilitation. We saw this was reflected in their risk assessments, care plans and daily records. One staff member told us, "We have charts to record people's food and fluids so we can see how they are doing." Support often involved encouraging people to regain their independence to prepare their own food and drinks. Another staff member said, "If they're able we encourage them to cook. If it's part of their rehab we get them to do it safely." One person told us, "She's (a staff member) shown me how to use the microwave and next week she'll show me how to use the washing machine. She's written it all down for me'" We saw coloured dots had been stuck to the person's microwave and written instructions had been provided by the staff member. The same person was also a carer for their spouse; they told us when staff came to support with making meals and drinks for them, they also made them for their spouse.

A member of the PRRT team explained how equipment could help people to meet their own nutritional needs independently. They gave an example of providing a perching stool and a wheel kitchen trolley to a person with mobility issues, so they could make meals and drinks and take them back to their sitting room by themselves. This meant people received the level of support they needed to eat and drink.

The PRRT consists of a range of health and social care professionals, including nurses, physiotherapists, occupational therapists, social workers and rehabilitation assistants. They worked together as a team to

support people to rehabilitate and recover, and either regain their independence completely or stay at home with an ongoing package of care from another provider. Records showed the service worked with a wide range of other services to meet people's needs, including services that referred people to PRRT and services PRRT referred people to. We saw a board in the main operations room at the office contained the details of a wide range of organisations and teams the service referred people to for additional support, including the continence team, home oxygen service, the Salvation Army and Red Cross. As part of the multidisciplinary team meeting we observed, people's holistic needs were discussed and referrals made by the liaison nurse on duty that day; these were done via email during the meeting.

The service worked closely with local hospitals, GPs, community and ambulance services with the aim of either supporting people being discharged from hospital or preventing people being admitted to hospital. PRRT was also part of a 'virtual ward', whereby community services worked together to help manage the health of 50 of the most complex patients in the area within their own homes. The registered manager told us, "It's trying to build a network. We attend these meetings weekly. It's good management of complex people in the community." This meant health and social care professionals within PRRT worked with each other, and with other external organisations and services, to help people meet their wider health and social care needs.

Good

Is the service caring?

Our findings

People and their relatives told us the staff from the Portsmouth Rehabilitation and Reablement Team (PRRT) were kind and caring. Comments included, "They're very kind", "They treat me very, very well", "They're all very charming and lovely people", and, "My experience has been very, very good."

Staff from the service described how they respected people's privacy and dignity by ensuring people were as covered up as much as possible during personal care and had privacy when using the toilet. One staff member said, "I always explain what I'm doing and respect their premises and property." People and their relatives confirmed staff respected them. One person said, "They go out the room while I wash myself", and relative told us, "There were no issues with dignity."

People and their relatives told us the staff from PRRT were friendly and they looked forward to their visits. One person said, "They're always friendly and had a laugh", a second said, "They were friendly but professional", and third commented, "What a lovely bunch of ladies." We visited one person while the staff member from PRRT was providing support. It was clear the staff member knew the person well as an individual; the person appeared relaxed in the staff member's company and friendly banter and joking was exchanged between them.

Efforts were made by staff from PRRT to provide additional support to people who were not fully prepared for their discharge from hospital. Records showed staff had collected clothing, bedding, toiletries and food for a person who had very little at home when they were about to be discharged from hospital. So much was donated by staff that a store was created for other people in need supported by the service. The registered manager told us staff would at times buy basic provisions, such as milk and bread, for people so there was something in their homes ready for them when they were discharged. Records also showed staff had donated money or gifts for people receiving a support visit from staff on Christmas Day. The registered manager told us, "It was nice for staff and the client to have a Christmas present." This showed us the service went the extra mile to support people and make them feel valued.

People told us they were involved in designing their care plans and setting their own rehabilitation goals. Comments from people included, "We had a meeting first of all to plan my care", "They're trying to get me back to normal", "They encouraged me to do things for myself", and, "They've helped me get independent again. It's what I wanted too." Records showed these focused on supporting people to recover from illness, injury or surgery so they could regain their independence. For example, care plan goals we saw included, 'To increase independence with managing personal care', 'To improve mobility and resume downstairs living', and, 'To increase independence with food and fluids.' People gave us examples of how staff had supported them to meet their goals. One person said, "The other day the nurse came and said, 'why don't you do it today?'", and a second person told us, "The bits of me I could wash they encouraged me to do."

People could also access support from independent advocates if they needed help to make decisions. The registered manager explained the referral process for local advocacy services and gave examples of people's situations or circumstances which would trigger a referral to be made by PRRT.

Staff we spoke with could give us examples of how they supported people to regain their independence. Comments included, "We set patient goals – what they want to achieve, what they think is important to them", "I encourage people to join me in the kitchen, to cook their own meals", and, "We explain to the patient we only assist where they need it." This meant the service supported people to regain their independence, when this was possible, and meet goals they had set for themselves.

The building where the service was based was secure. Records showed staff had received training on information governance. During the inspection when we asked for certain records a member of staff checked with their line manager to make sure we were authorised to view the information. Another staff member explained how they had refused to divulge information to a person's neighbour when they had telephoned the service, without obtaining the person's permission first. This showed staff were following information governance procedures. Staff making home visits were provided with written details of people's addresses and home security arrangements. They told us they were very careful with this information and made sure it was disposed of correctly at the office. The registered manager told us staff were provided with lockable bags for storing patient's personal information. One staff member said, "I make sure I never keep paperwork in my car and shred documents when I'm finished with them." This meant PRRT staff protected people's confidentiality.

The registered manager explained the service did not routinely provide end of life care to people, and only did so when other community services in the area were struggling with their own capacity to meet people's needs. He told us, "The community nurses manage the case, we deliver the care." Feedback we saw from the relatives of people who had received end of life care from PRRT staff was very complimentary. Comments included, '[My relative] was wonderfully looked after by your fantastic team who showed great compassion, professionalism and attentiveness', and, 'We are so grateful to all the team for the care and dignity they gave to [my relative].' This meant the end of life care the service provided when the need arose was appreciated by people and their relatives.

Good

Is the service responsive?

Our findings

People and their relatives told us the Portsmouth Rehabilitation and Reablement Team (PRRT) was responsive to their needs. One person said, "Two (PRRT staff members) came round for a chat to see what I needed", and a second person told us, "I'm on the mend now. I've had the physio and nurses seeing to me. I can't fault the service at all." The registered manager explained the purpose of the service was to provide short-term support to people discharged home from hospital or community units, and to prevent the admission of people at home into hospital.

Care files we inspected contained a detailed initial assessment of people's needs, risk assessments and the care plans needed to manage any risks and help people achieve their goals. Care plans were concise. They consisted of a summary of the person's needs and goals, and included bullet pointed interventions or actions for staff to follow at each care visit. Care visits could be provided within four windows of time between 7am and 10pm. People told us the type of support they received had changed during their rehabilitation as their level of independence had increased. We saw this was reflected in people's care plans. One person said, "They dropped off the visits when I told them I could do it and they'd seen me do it." The registered manager explained, "We back off when people start to get better, or we may choose to go a bit later to see if people can manage on their own." The daily records completed by staff we saw evidenced people were supported according to their care plans.

Staff members told us they were kept up to date with people's progress at daily handover meetings. We attended one of these meetings during the inspection. We noted each person's needs and progress were discussed in turn; rehabilitation assistants who had visited people that day fed back any notable changes or made requests for additional referrals to the liaison nurse on duty.

PRRT received referrals from a wide range of services and healthcare professionals, including the ambulance service, GPs, local hospitals and community nurses. At the time of this inspection the service was supporting 82 people, and new people were admitted and discharged daily. Response times for new referrals depended on the urgency for the person to be seen. Referrals from the ambulance service and GPs with the aim of preventing a person's admission to hospital were triaged as requiring a visit within one or two hours for an assessment of needs. At this visit, staff from the PRRT would evaluate the type of support required and number of visits per day, and then draw up an initial care plan. The person would then be visited by a nurse within 24 hours to review the care plan and add any further details and to discuss the person's goals. This might include occupational therapy to regain independence at home, physiotherapy after falls or surgery, or support with washing and dressing during a period of illness. Nurse reviews then occurred on a weekly basis after that, or sooner if required. Assistance to plan a longer term package of care after rehabilitation by PRRT, if required, was arranged by the social workers in the team. Care plans we saw were person-centred and reflected each individual's needs.

The registered manager said the service was usually given a few days' notice by local hospitals and community rehabilitation units as they prepared to discharge people home; he told us, "We can then coordinate our service." The area covered by PRRT was divided into three in order to improve staff

continuity and cut travel times between visits. We saw details of people supported by the team were recorded on three large whiteboards in the main office; they showed which healthcare professionals were involved with each person, when their predicted date of discharge was and which other referrals were required. Care visits were arranged and monitored by case coordinators within the team and a liaison nurse was allocated each day. The liaison nurse carried a mobile phone which staff members visiting people at home could contact with any questions or queries around people's health. The registered manager told us, "We only finish in the office when we know all the visits are done for the day, just in case they need support."

People recovering from falls or surgery were provided with personalised exercise programmes by the team's physiotherapists and supported to do their exercises by rehabilitation assistants during their visits. One person told us, "I had a walk outside with [name] the physiotherapist last week. We also practised getting into and out of a car", and second person said, "[They] got me up and timed how long I could stand. We also practised with the zimmer to the foot of the stairs."

In addition to support with medicines and personal care, some people said they had been provided with equipment by occupational therapists and other staff to help them regain their independence. This had often been at their assessment visit on their day of discharge from hospital. Comments from people included, "They lent us a zimmer and a commode", "I've got a raised commode and a handle on my bed", and, "When they sent the commode it was like a miracle. They brought it on their first visit." We saw in one person's house panels had been placed on either side of a raised door threshold to reduce the risk of the person tripping over. The registered manager listed a range of smaller equipment PRRT kept in its own stores for staff members to take to people's homes as required; staff doing assessments told us they used discharge information to anticipate what equipment people would need and took it with them at the first visit, if possible. The service could also order larger equipment, such as special beds, for next day delivery to people's homes if required. This meant the service supplied equipment to people and supported them to exercise in order to promote their rehabilitation and independence.

People's ongoing health and social care needs were discussed during weekly multidisciplinary team meetings; three were held each week, one for each of the geographical areas the team covered. We attended one of these meetings; it was attended by representatives of each of the healthcare professionals in PRRT and chaired by a consultant in older people's medicine from the local hospital. A holistic progress assessment was made for each person against their set goals and their date of discharge amended accordingly. This meant the different healthcare professionals worked as a team to support people using the service.

The registered manager told us people's predicted date of discharge from the service was discussed with them at the first assessment visit. He said, "It gives them a goal and lets them know they need to be motivated." Most people receiving rehabilitation wished to return to complete independence, however, some needed to have regular ongoing care visits after their discharge from PRRT. This care package was brokered by social workers at the service. The social work assistant team manager in the team told us, "We're allocating social workers much earlier in the process now to build up relationships with people and their families." The registered manager explained how the service communicated with people, their relatives and the service provider taking over the person's care to ensure a smooth transition at discharge and said the new providers could ring for additional information if they needed to once the transition had taken place. This meant the service worked to ensure people needing ongoing support after discharge from PRRT got the care they needed.

None of the people or relatives we spoke with said they had made a complaint about the service. One written complaint had been received by the service in 2016. Records showed it had been investigated and

responded to appropriately and an apology issued by the chief executive officer of Solent NHS Trust. A community matron described the measures put in place to ensure the situation which had occurred did not happen again. The service received numerous compliments in 2016. The registered manager told us compliments were discussed at the monthly staff meeting as a way of highlighting the good work the team were doing and motivating staff. He said if a compliment named a specific member of staff, "I always email them and give them a copy of the feedback." One staff member told us, "We get feedback from the questionnaires. It gets emailed to us." This meant the service responded to complaints appropriately and used compliments as a means to celebrate the achievements of staff.

Good

Is the service well-led?

Our findings

People and their relatives told us they thought the Portsmouth Rehabilitation and Reablement service (PRRT) was well managed. One person said, "It's well managed for me", a second told us, "I don't think there's anything else they could have offered me", and a relative said, "I think the overall service was superb. We've got no complaints at all."

Feedback from staff about the registered manager and other senior managers at PRRT was also positive. Comments included, "[The registered manager] is a lovely manager. He's very supportive. The community matrons are very passionate", "I think the managers are as supportive as they can be, they're so busy. They do as much as possible to help, their door's always open", and, "If I have any problems I'd speak to a clinical manager, they're approachable."

The registered manager and other team managers compiled daily statistics on the caseload of the service, the staff available to support people, the number of new admissions and number of predicted discharges. As discussed earlier in this report, this generated a red, amber or green rating, and was used to communicate to the service provider and other local stakeholders whether the service was in a position to take new referrals. The registered manager also reported against targets set by the service commissioner on a monthly or quarterly basis at meetings with the commissioner. These included targets for the percentage of people aged over 65 years still at home three months after receiving rehabilitation from PRRT, the friends and family test and the number of people achieving or partly achieving their goals. PRRT had targets to visit certain people referred to them within either one or two hours, depending on the urgency of the referral. The registered manager told us, "It's daily management. It's an operational service. You've got to know what you can do each day." One stakeholder told us, "They (PRRT) are clear where their service fits within the wider pathways and keen to protect the quality of the service delivery when the wider system in Portsmouth is under significant pressure." This meant the capacity of the service to meet people's needs and its success in terms of helping people to achieve their goals was evaluated on a daily and monthly basis.

The safety and quality of the service was monitored at weekly managers' meetings, in bimonthly PRRT governance meetings, in bimonthly clinical governance committee meetings with senior managers from Solent NHS Trust, and at monthly contract review meetings with the service commissioners. Meeting minutes evidenced the discussion and analysis of accidents and incidents (including safeguarding), complaints, risks to the service, and better ways of working with other services. We saw this resulted in actions and lessons learned. Other monitoring undertaken at the service in 2016 included an audit of outcome measures and care documentation to see if people's goals were fully or partially achieved, an audit of supervision and appraisal of staff, and a staff hand hygiene audit. Each person's care plans, medicines records and daily records were monitored by nurses at their weekly care review. One of the community matrons described how the system of medicines administration recording had changed shortly before the inspection; they were planning a series of medicines administration record audits to ensure staff training on the new system had been effective. This meant systems were in place to evaluate the safety and quality of the service.

All people who used the service were asked to complete a questionnaire when they were discharged from PRRT in order to obtain feedback. We reviewed the questionnaires received in the three months prior to this inspection. All of the feedback received was positive. Comments included, 'All staff gave me wonderful service', 'The reliability and thoughtfulness of all the carers was outstanding', 'A well organised and professional team', and, 'They were very kind and treated me with respect.' The questionnaire also included the 'Friends and Family Test', whereby people were asked if they would recommend the service to their own friends and family if they needed it. We saw nearly all of the people had responded to say they would recommend the service to their friends and family. Results of questionnaires were discussed and analysed at monthly PRRT staff meetings. This meant people were asked about their experience of using the service in order to help the service improve.

Staff members of PRRT were also asked to share their views and ideas about the service at the monthly staff meeting. One of the senior managers told us, "I like the office door open so the staff feel they can come and ask questions." There was a suggestion box in the office for staff to post any ideas or comments. Staff meeting minutes for August 2016 showed there had been a discussion on how to improve communication with the office when staff visiting people in their homes needed to escalate concerns around the worsening of a person's condition. We saw it was in response to an incident when concerns had not been raised appropriately. This led to the introduction of a mobile telephone carried by the liaison nurse on duty. Previously staff raising concerns had telephoned the case coordinators, who were not registered nurses. One of the community matrons told us, "I thought it was unfair for case coordinators to make decisions like that and triage." Staff we spoke with felt the introduction of the nurse telephone was positive and had taken pressure off the case coordinators. This meant staff were asked for their feedback and involved in problem-solving at the service.

We asked staff at the service whether they thought the PRRT which consisted of health and social care professionals worked together as a team. They all said it did. Comments included, "It does work. It used to be 'them and us' but it's us now", "I think it's a really good team. I like MDT (multidisciplinary team) working", "I like the integration. I've seen the benefits for the patient when we all work together. It's the way forward", and, "For the first 18 months it felt 'us and them', but it does seem to be working well now." We spent two days in the main office during this inspection. We observed the atmosphere was busy but friendly and supportive, and overheard several discussions outside the handover and multidisciplinary team meetings between different health and social care professionals about people's needs. This meant the different professionals within PRRT liked the integrated way of working and worked well together as a team.

We asked managers at PRRT about the vision and values of the service and how these were communicated to the staff in the team. A community matron told us, "I try to demonstrate them. I show that I'll do all the things they do. I talk about the patient being uppermost." We saw the vision and values of Solent NHS Trust were prominently displayed in the service's main office; these included honesty, respect and teamwork. The vision and values were also discussed in staff supervision and appraisal meetings and during staff induction to the service. We asked staff why they worked for PRRT. One staff member told us, "I get satisfaction out of helping people", a second said, "They can start with us bed bound and leave walking with a frame. That's job satisfaction", and a third replied, "I love seeing patients progress and how all the different things we do works together to build people's independence." Our observations plus feedback from people, their relatives and other stakeholders in the service showed PRRT staff supported people according to the vision and values of the service.

In 2016 the service had started a project to implement the new NHS England Accessible Information Standard, which came into force in August 2016. The standard places a requirement on all providers of health and social care in England to provide people who use their services with information in a format they

understand. At the time of this inspection the service had already undertaken a focus group with staff to find out what they knew about the standard, and held a focus group with people using the service to generate feedback on the communication they had received from the service. We were told the next step was to generate a welcome pack for people referred to the service and their families in a range of formats, and to design a PRRT leaflet to explain the service to people and other stakeholders.

A community matron explained how some members of PRRT had lead roles on various aspects of care, including chronic obstructive pulmonary disease, palliative care, infection control and tissue viability. They attended meetings with peers from other services with the goal of improving working relationships and keeping up to date with evidence-based practice. This meant the service sought to ensure it complied with national standards and followed best practice.