The London Borough of Tower Hamlets

Reablement Service

Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 6 September and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. At our previous inspection on 30 January 2014 we found the provider was meeting the regulations we inspected.

Reablement service- London Borough of Tower Hamlets provides assessment, equipment and short term support to people in their own homes, the majority of whom have been discharged from hospital after an admission. The service is usually provided for up to six weeks and aims to help people to learn to live as independently as they can and to assess people's needs for longer term care.

At the time of the inspection there were 87 people receiving support from the service, although they were not all receiving personal care. Staff that went into people's homes to support them were known as 'reablement officers' and we have referred to them as such throughout the report.

There was a registered manager at the service. 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.

People and their relatives told us they felt safe in the presence of reablement officers and that they were kind and caring towards them. They said that they were supported to regain their independence and that reablement officers had the skills and training to help them achieve their goals.

People told us they received the same reablement officer and did not raise any issues regarding their time keeping. They said when they were running late, they always received a phone call letting them know.

People were given information before they began to use the service, included who to speak to if they wanted to complain. Where complaints had been raised, these were documented and the provider responded to them in a timely manner.

Reablement officers were aware of what to do if they had concerns about people's safety and who they could contact to report their concerns. We saw that the provider took appropriate steps when concerns were raised. However, there had been some incidents that required a formal CQC notification of which we were not notified.

The provider carried out appropriate checks on staff to ensure they were suitable to work with people. These included criminal record checks. There was a thorough induction programme in place for new starters. The provider had a three year training programme in place for existing staff which included a range of topics which helped to ensure they received training that was appropriate to meet the needs of people using the

service. This included health and safety, safeguarding, first aid and reablement training. It also included practical training that was delivered by occupational therapists (OTs) on specialist equipment that was used to mobilise and transfer people.

Staff received regular supervision and yearly appraisals during which they were able to discuss any concerns, identify any training needs and set any personal development objectives for the year.

Referrals to the service were checked by a member of the operations team and then passed onto an independence planner or an OT to carry out an assessment. An independence plan was developed which identified the areas that people needed support with. A goal setting document was also used to identify SMART (specific, measurable, achievable, realistic and timed) goals that people could work towards to improve their independence with regards to their daily living skills. Support typically lasted six weeks or ended when people achieved their goals.

Feedback was sought from people at the end of their support as part of the provider's quality assurance monitoring. Other audits such as checks on reablement officers, case studies and case file audits were carried out. Feedback from these was shared with the relevant person which enabled learning and improvements to take place.

We found a breach of regulation in relation to notifications. You can see what action we have told the provider to take at the back of the full version of this report.

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 using the service said they felt safe. Reablement officers were aware of safeguarding procedures and had received safeguarding training.

Risks to people were assessed during their initial assessment. These included ways in which people could be kept safe, for example through the use of equipment or staff support.

There were enough staff employed to support people.

People received adequate medicines support.

Is the service effective?

Good

The service was effective.

Staff received ongoing training and supervision. They told us they felt supported.

People told us they were involved in setting their goals and consented to them.

People's health and dietary support needs were met.

Is the service caring?

Good

The service was caring.

People told us that staff were caring and respected their wishes.

The provider was sensitive to people's cultural needs.

Is the service responsive?

Good

The service was responsive.

Referrals were vetted and assessments carried out which were developed into people's independence plans.

Achievable goals were identified in consultation with people and they were supported to try and reach them.

People were given a service user guide telling them who to contact if they were unhappy about the service. Complaints were documented and responded to in a timely manner.

Is the service well-led?

Requires Improvement

The service was not well-led in all aspects.

There were some incidents for which we did not receive a formal CQC notification.

Staff told us they had good support structures in place and they worked well together as a team.

Quality assurance checks such as feedbacks surveys and, audits were in place and these were effective.

Reablement Service

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 6 September 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

This inspection was carried out by one inspector.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

During the inspection, we spoke with staff including the registered manager, two independence planners, an occupational therapist, and five reablement officers. We looked at records including 11 people's care records, training records, four staff records and audits.

After the inspection, we carried out telephone interviews and spoke with 11 people using the service and two relatives.

Good

Is the service safe?

Our findings

People using the service told us they felt safe in the presence of the reablement officers. They said, "I feel safe with them, they are friendly" and "I feel safe, absolutely." Every person using the service was given a file containing information about the provider, the service and who they could contact if they had concerns about their safety.

Training records showed that staff had received safeguarding training. Staff that we spoke with were able to recognise potential signs of abuse and knew who to contact if they had any concerns about a person's wellbeing. Comments included, "We have had safeguarding training and lone working" and "We check the clients always for any signs of abuse, I would always report it."

Records showed that the provider raised safeguarding concerns in the appropriate manner with the appropriate authorities; however we found that CQC were not always notified of these incidents.

Before people started to use the service the provider assessed risks both in relation to the environment and to their support needs.

Independence planners or an occupational therapist (OT), if the person needed support with mobility, completed an independence plan for people after carrying out an initial assessment. The independence plan was designed to help people regain their confidence and independence in their daily living skills.

The independence plan included a 'functional assessment rating' for a number of domains. These domains were personal care, mobility, transfers, meal preparation, domestic management, community inclusion, financial/social independence, access to education and employment, relationships and behaviours. Each domain had a description of the person's ability (the need), a goal or outcome and a delivery plan on how to achieve the goal.

The description of each domain contained detailed information which included any identified risks. For example, the section on mobility included how people could safely mobilise in different rooms in their home, such as the bathroom or using stairs and accessing the community. It also included the use of any equipment and observations by the OT with respect to transferring people in and out of bed and to and from a chair. They also indicated how risks could be minimised, for example with the use of equipment to help keep people safe.

The OTs received the more complex referrals, often those involving moving and handling or transfers. They were responsible for ordering aids and adaptations such as commodes, hoists and grab rails. They often carried out joint visits with the reablement officers to show them the correct transfer techniques. Reablement officers told us they received training from OTs in the use of any equipment that people needed. One staff member said, "At the moment I am supporting someone with mild dementia and I observe [them] and make sure [they] are doing things safely."

People using the service told us they were supported to take risks in a safe manner, often because they were supported to develop specific skills or regain their independence within a specified timescale. They said that staff supported them to do this and gave us examples of when they were being supported to take their medicines, prepare meals or to improve their mobility. They said, "I saw the OT this morning and she checked my rails" and "They are arranging a stair rail for me and also in the bathroom."

People using the service told us they had regular reablement officers that supported them. Comments included, "They are friendly and I get the same carers", "He's never late", "They are always on time" and "They are usually on time, if they are late they always call."

Reablement officers worked in a certain 'patch' and reported to an impendence planner who was responsible for that area and the support needs of people living within that area. Reablement officers we spoke with told us they were given enough time to travel in-between visits and they were well supported. They said, "They [the independence planners] are flexible, if you need more time they never say no" and "They always tell us, if you need more time then stay until you finish the job."

The registered manager told us that they had not recruited any reablement officers within the last four or five years because they had no vacancies. However he talked us through the recruitment process, some of the functions of which were carried out by the Human Resourcing (HR) department. Applications were completed online and all the applications were sent to the registered manager by HR for shortlisting who would carry out a competency based interview. Once a person was accepted, HR carried out reference checks, Disclosure and Barring Service (DBS) checks and an occupational health questionnaire. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions

DBS checks and monitoring were managed by the HR team. During the inspection, we requested a complete list of reablement officers and their DBS status. We saw that 51 out of 52 reablement officers had a current DBS in place. One person's DBS had expired in line with the provider's renewal policy but we saw that they had completed a DBS renewal application and were waiting for the results.

A staff system was used to plan rotas and monitor the visit times of reablement officers. All reablement officers had a smartphone with an app to check their rotas for the coming week and this was also used to scan their visit times. A reablement officer showed us the app and how it worked on their smartphone, we saw that their visits for the next week were displayed and the details of the support needed were also available. One reablement officer said, "If the phone does not work, we can use the client's phone and a PIN number."

The registered manager told us that at the time of the inspection, the clocking in system was not working correctly and the issue had been raised with the support company. We saw evidence confirming that this was being looked into. Due to this, we were unable to verify the timeliness of the reablement officers. However, people that we spoke with did not raise any concerns about this area of the service.

People who received support with their medicines told us they were happy with the support they received. They said they managed their own medicines, with minimal staff support. One person said, "They sort out my medicines for me." Another said, "They ask me if I've taken my medicines."

Independence plans included details about people's support needs with regards to medicines, this included their current medicines and the level of support required to maintain their independence. For example, people with who needed prompting to take their medicines were advised and supported to purchase equipment to remind them to do this, for example a MemraBel clock rather than receiving full staff support.

A MemRabel clock is designed to help people with memory issues. MemRabel can help people who have Dementia by providing daily memory prompts using personally recorded voice memo's at specific times of the day.

Good

Is the service effective?

Our findings

People told us the reablement officers had the necessary skills needed to support them. They said, "They've been coming since I came out of hospital. They have helped me to regain my mobility" and "They help me to become independent."

Staff praised the quality and the frequency of the training they received, telling us, "We get regular training. If you need more, you can tell your independence planner and they arrange it", "We get mini training sessions during our 'patch' meetings, last time we had someone talk to us about domestic violence. Previously we had LGBT and personal safety" and "Some of the training is delivered by the occupational therapists, sometimes we get external speakers such as information governance who spoke to us about data protection."

Although no reablement officers had been recruited recently, we saw that an induction checklist was in place for new staff. This included reading the provider's policies and procedures in safeguarding, the Mental Capacity Act 2005 (MCA), complaints and case file audits. It also included records and documentation to be completed such as communication books, goal plan records and other templates. New staff were given training in health and safety and an overview of the expectations of the role.

The registered manager told us they ran a three year training cycle which was reviewed for any changes at the end of the three years. We were shown the training strategy for 2013-2016 and the registered manager told us they were drafting the training strategy for 2016-2019. The current training strategy showed that reablement officers and independence planners were offered training in a wide range of topics to help them in their role. Topics included health and safety, safeguarding, information and clinical governance, first aid, health promotion, condition management, reablement promotion, disability education and diversity awareness. Staff were also given training by Occupational Therapists (OTs) in correct moving and handling and transferring techniques. One reablement officer said, "The OTs demonstrate the correct way to use the equipment." We saw that additional training was provided if relevant to people's individual needs, for example around pressure area care, dementia awareness and stoma/catheter care.

Staff told us they received regular supervision and appraisals. They said, "We have supervisions with our independence planner" and "We meet every six months for our personal development." Supervisions were carried out every three months and there was a yearly appraisal with a review at six months. Items that were discussed at supervision typically included discussing people they supported, health and wellbeing, training, annual leave and time sheets. Feedback along with actions to be followed up were recorded. Yearly appraisals included recording objectives for the year ahead and reviewing the previous year's objectives. The appraisals also included team and individual targets.

The Mental Capacity Act 2015 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in domiciliary care agencies are to be made to the Court of Protection.

People had consented to their care; they had signed their independence plans and goal setting records. The registered manager told us that people's capacity to consent was assessed by the hospital social workers before they referred to the service and they only accepted people who could consent and agree to the goals set for them. People's ability to consent was recorded in the referral form. People who were not able to consent to care were not considered to be appropriate referrals.

Staff had received training in the MCA and told us they were aware of the need to ask for people's consent before supporting them. One staff member said, "Mental capacity is about whether a client can make a decision or not." This helped to ensure that people's rights were protected.

Some people received support to prepare meals and drinks. People we spoke with told us, "They get me something to eat and drink" and "They make sure I have tea and breakfast and make sure I go to bathroom." Staff told us, "I prepare lunch, or warm food that is already prepared" and "I make sure they have their dinner and are ready for bed."

Independence plans included the support that people needed with respect to meal preparation, their preferences and their level of independence. Where people had goals set for them in relation to meal preparation, these were recorded and followed up by the reablement officers during their visits. These goals were set in a way that they were achievable for people within a short space for time. For example, we saw records where a reablement officer was to support a person 'to make breakfast and a hot drink independently' and this was broken down into small steps such as lift and drink from a cup by week two and fill and pour from a kettle by week three.

There was evidence seen in the care records about referrals made to other health care professionals, such as community nurses which helped to ensure a consistent approach to meeting people's health needs.

Independence plans, contained information regarding health conditions and medical diagnoses. Because people were usually referred for support after a stay in hospital, details of their hospital admission were included in the referral form which helped reablement officers to support them appropriately. Contact details of GPs and other appropriate professionals were also documented. Reablement officers monitored people's health and wellbeing and recorded this in their visit communication sheets.

Staff told us what steps they would take if someone became unwell or their needs changed. They were also aware that referrals could be made when seeking specialist advice. One staff member said, "If we need a Speech and Language Therapist or dietitian advice, we do referrals. This is also for physiotherapists and psychologists."

Good

Is the service caring?

Our findings

People using the service told us that staff were caring and friendly and treated them with respect. Some of their comments were, "Brilliant", "He's a lovely man", "they look after me", "They help [my family member] with everything", "They are really nice, I get on well with them", "I'm very happy, they are attentive" and "He makes sure I'm Ok, we have a chat."

People said that reablement officers respected their choices with regards to their support needs, such as what they wanted to wear or have to eat. Reablement officers were aware of the importance of respecting people's privacy and dignity and gave us examples which demonstrated how they did this. One staff member said, "I always explain what I am about to do and ask them if they are OK with it" and another said, "Going into people's homes, you have to be careful that you do things how they want and ask their permission." Other staff said, "It's important to build a rapport and gain their trust", "I explain to people what I am about to do so their privacy and dignity is maintained" and "When clients come out from Hospital, they are very anxious, they have no confidence. We have to encourage them slowly."

Staff also said they enjoyed what they did and got satisfaction from supporting people to meet their goals and become independent. One staff member said, "It's amazing to see people gain their independence and it's nice knowing that we help them in that."

The provider promoted people's independence. Staff were aware their role was to try and encourage people to regain some level of independence. One staff member said, "We put water out for them, give them a flannel and encourage them to wash themselves." Other comments included, "I support service users to regain their skills" and "We help people coming out of hospital to get their independence."

Although Independence plans and goal setting records were developed with short term aims they also included people's views on how they liked to be supported and also took into consideration their views when identifying goals. Goals were written from the perspective of the person and included statements such as, "I want to be able to complete my personal care by myself. I want the reablement officer to assist me with washing" and "I want to be able to remember to take my medicines." People that we spoke with told us they were involved in setting their own goals.

The provider was sensitive to people's diverse needs. Staff were given training in diversity awareness and told us they respected people's cultural or religious beliefs. One staff member said, "We use shoe covers if people ask us to take our shoes off when we enter their homes." Information leaflets about the service were available in different languages and people whose first language was not English or who had expressed a wish for reablement officers from the same cultural background had their wishes considered.

Good

Is the service responsive?

Our findings

People's individual needs were assessed and met. The majority of the referrals came from hospital social work teams to support people to regain their independence after a hospital admission. In many instances, referrals came in at short notice requesting support in an emergency. Referrals were screened by the Reablement service's operations team. The decision to accept referrals was their responsibility and they liaised with the duty independence planners to check for the reablement officers availability.

The registered manager told us that it was sometimes difficult to carry out an initial assessment due to the nature of the support they provided which meant that they had to rely on the information submitted by the social workers. In order to try and work around this, they had introduced standard referral forms so they received consistent information. If a referral came in and there was no capacity to support the person, they were passed onto the brokerage team so that an alternative provider could be found.

We spoke with an independence planner who told us it was their responsibility to carry out the initial assessment following a referral and also to manage the reablement officers. "The ops team screen the referrals, they accept or decline them. Once accepted, they pass it onto us." Reablement officers completed an 'independence plan' for people after carrying out the initial assessment. The independence plan was designed to help people regain their confidence and independence with their daily living skills which included personal care, mobility, transfers, meal preparation, domestic management and community inclusion. Each identified area had a description of the person's ability (the need), a goal or outcome and a delivery plan about how to achieve the goal. Delivery plans included clear ways in which reablement officers were to encourage people's independence, for example by using long handled toe washes, button hooks or a reminder clock to alert people to when they should take their medicines.

Goal setting plans were also in place for people; these were identified from the information contained in the independence plans. These included an overall goal such as personal care and SMART (specific, measured, achievable, realistic and timed) goals which were 3 smaller goals identified in order to reach the overall goal. In one example that we saw the overall goal was 'I want to be able to complete my personal care by myself' and the related SMART goals were 'To be independent with washing within one week' and 'To be independent with bath within four weeks.' Smart goals included an agreed date and the action needed to reach those goals. A reablement officer said, "Everyone has individual goals, some need support with medicines, others need meal preparation or transfers." Another said, "There are targets and goals set and some exercises set by the occupational therapists (OTs) and we try and reach them."

The views of people who used the service were considered when setting goals and they told us that staff supported them to reach their goals. The registered manager told us that the goal setting document was the working document that the reablement officers used when they visited people. He also said that they were looking to incorporate the goal setting document within the independence plan in future.

An overall sense of involvement and wellbeing was assessed at the beginning and end of the support provided. The outcomes were based on Australian Therapy Outcome Measures (AusTOMs), these are tools

designed for Physiotherapists, Occupational Therapists and Speech Pathologists to use to measure the outcomes of the support provided to people.

A reablement officer was assigned to each person and they reported back to the OT or the independence planners on a weekly basis as well as completing records of their visits. This also included a communication book and recording progress against outcomes.

People told us they knew how to raise concerns. They said, "They are very nice, I have no complaints", "I've got their numbers, I know who to call" and "There is a book here with all their contact numbers."

People were given details of how to raise a complaint or concern in a service user guide which was available in alternate languages. This gave details of who to contact if they were not satisfied with the support they received.

Complaints were either resolved formally through the formal complaints procedure or as 'locally resolved complaints/concerns.' The registered manager told us that because they were part of the local authority, they sometimes received complaints via the central complaints team and these were passed onto them and logged as well. The provider had a robust system in place for capturing complaints and this included the outcome and any actions taken. We reviewed these during the inspection and saw that the provider responded in a timely manner to every complaint that was recorded. Every month, the complaints received and the provider's response to them were sent to the corporate team for review to ensure that these had been managed and responded to effectively.

Requires Improvement

Is the service well-led?

Our findings

CQC had not received a number of notifications relating to safeguarding concerns and deaths. There had been eight deaths since January 2016 and although the notification forms had been completed, they had not been sent to CQC. The last safeguarding notifications we received were in November 2015. The registered manager said there had been some since then and although the provider had taken the correct steps in responding to these concerns, no notifications had been received by the CQC in relation to these. After the inspection, these were emailed to us.

The registered manager said there had been some changes in the team after April 2015 which meant that these notifications were not being sent.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 Care Quality Commission (Registration) Regulations 2009.

Both people using the service and staff thought the service was managed well. Comments from people included "The service is brilliant" and "They were very good, I completed a form for them, thanking them."

Staff told us they had good working relationships with their peers and managers and they felt well supported. They said, "We have good lines of communication, we feedback to our independence planner", "The staff in the office are very helpful", "There is a lot of support available, either from the OTs, the independence planners or other managers."

There was a clear staff structure in place to support people. The service was managed by the registered manager who was supported by an operational team which included a senior occupational therapist (OT) and a nurse advisor. There were seven assessors who were OTs and five 'independence planners'. The OT assessors and the independence planners were responsible for carrying out assessments and the independence planners managed a team of 39 reablement officers who supported people in their homes.

A number of meetings took place between various teams within the service. The operations team meetings were held every month. Topics of discussion included workforce issues, training, a waiting list for people wanting to use the service, audit and governance, strategy and performance and a reablement review. Professional staff meetings which were attended by occupational therapists and independence planners were also held. Independence planner meetings were held in which topics such as reablement officer issues, yearly appraisals, policies and procedures and workforce allocation were discussed. Reablement officers had monthly meetings within their own teams. Items discussed included changes to policies, hospital discharges, training, reporting concerns and incident/accident monitoring. An OT told us, "We meet on a monthly basis and have clinical effectiveness meetings between us and the independence planners."

The provider carried out a number of audits to monitor the quality of service provided to people.

Independence planners carried out two audits for each reablement officer per year, one was announced

and the second unannounced. These covered five themes which were respect, assessing/monitoring, health and safety, safeguarding and infection control. Any issues identified were included in an action plan and reviewed at individual supervisions.

Every person using the service received a questionnaire when they stopped receiving support. People were asked if they were happy with the service, if they were treated with respect, if the support was appropriate, if the information given to them was clear, and whether their views were listened to and acted upon. Responses were sent to the strategy team who provided feedback every quarter with analysis. 25 responses were received in the last quarter. There were no major concerns identified during the last quarter.

Case file audits were also completed; in August six files were audited. In these, a whole case was looked at by a senior staff member to identify if the information captured in the care plans was accurate. The main areas that were audited included general principles (consent in place, effective joint working, has the case progressed in a timely manner), engagement, person centred and documentation. These areas were rated either 0 (not achieved), 1 (partly achieved) or 2 (fully achieved). Any issues identified following these audits were fed back to the relevant staff.

Independence planners were also encouraged to write case studies highlighting good practice to enable learning. They were encouraged to do case studies in which there had been both good and poor outcomes for people as both added value in assessing and improving the quality of service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Commission without delay of some incidents related to abuse or allegations of abuse in relation to a service user; whilst services were being provided in the carrying on of a regulated activity. Regulation 18 (1)(2)(e).