

Slough Borough Council

# Recovery, Rehabilitation & Reablement Service

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Requires Improvement** 

Is the service caring?

**Requires Improvement** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Inadequate** 

# Summary of findings

## Overall summary

### About the service

Recovery, Rehabilitation & Reablement Service is a service providing care and support to people in their own home. At the time of the inspection the service was supporting 11 people. The service provided short term care, normally up to six weeks, and therefore the numbers of people receiving support varied on a weekly basis.

The service operated three separate care pathways. Some people received support as part of discharge to assess arrangements, meaning they were supported short term following hospital discharge. Some people received reablement support, meaning the service worked with them to regain more independence with daily activities. Some people also received end of life care.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

### People's experience of using this service and what we found

The service was not well managed or monitored. A registered manager was in place, however the manager and provider failed to undertake effective oversight and governance. The registered manager was not visible to all staff and people using the service. People told us, "I have no idea who the manager is" and "I have no idea who the management are...it would be helpful if we did know who is who."

We found some policies and procedures were not in line with best practice. We made recommendations the service develop their approach in relation to handling complaints, staff awareness of people's nutritional and swallowing needs, and recommended the service review the end of life care policy.

People were given telephone numbers to use if they needed to seek assistance or raise a concern. People told us their experiences of contacting the service had been generally positive. One person told us, "I have found they answer the phone very quickly and are helpful when you want to make changes to when the carer is wanted or not."

We found safe care and treatment was not always provided. People were not always safeguarded from risks to them, including infection control risks in relation to COVID-19. Safe medicine practices were not always followed. Accident and incidents relating to people using the service were not effectively monitored to identify wider learning for the service.

Some people told us they received safe care and spoke positively about the outcomes the service had helped them achieve. People were supported to use aids and equipment to help regain more independence with day to day tasks. One family member told us, "Alongside the equipment and adaptations, staff have trained my relative to use them. They have gone from not being able to get in or out of their bed but now

they are really trying and their mobility has improved and what they have taught us has lessened their risks of falling."

People's experiences of using the service were not always person-centred and caring. We found people were not always asked their likes, dislikes or preferences when their needs were assessed. Most people spoke positively about the staff who supported them but some people raised a concern about not receiving regular carers. Comments included, "They are all nice ladies who come and know exactly what they have to do" and "The carers were outstanding, anticipating and encouraging." A third person commented, "It is difficult to know just how much knowledge and training carers have had. There is a care plan and...we have had eight to ten different carers in just two weeks which is not really satisfactory."

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

Rating at last inspection

This service was registered with us on 21/08/2020 and this is the first inspection.

Why we inspected

The inspection was prompted in part due to concerns received about medicines, infection control, staffing, governance, person-centred care and management of risks. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. This included improvements in relation to the management of risks, staffing, person-centred care, consent and governance.

You can see what action we have asked the provider to take at the end of this full report.

Following our site visit the provider agreed to develop an action plan in response to our findings. The provider also took initial steps to mitigate some areas of risk, such as checking the competency of staff in relation to their use of personal protective equipment (PPE).

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, staffing, good governance, person centred care, consent, and in informing the Commission of incidents and information they are required to.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

**Requires Improvement** ●

### Is the service caring?

The service was not always caring.

**Requires Improvement** ●

### Is the service responsive?

The service was not always responsive.

**Requires Improvement** ●

### Is the service well-led?

The service was not well-led.

**Inadequate** ●

# Recovery, Rehabilitation & Reablement Service

## **Detailed findings**

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

#### Inspection team

The inspection was carried out by two inspectors and one 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.

#### Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

#### Notice of inspection

We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 24 February 2021 and ended on 2 March 2021. We visited the office location on 24 February 2021 and 25 February 2021 where we spoke with staff and viewed a range of records. We continued to review documents shared electronically. We contacted staff by telephone between 24 February

2021 and 1 March 2021. We gathered feedback from people and families by telephone on 1 March 2021 and 2 March 2021. We conducted a virtual meeting with the registered manager on 1 March 2021 where we provided feedback and requested additional information and supporting evidence.

#### What we did before the inspection

We reviewed information we had received about the service since it was registered with the Care Quality Commission on 21 August 2020. We also sought feedback from the local authority.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We also requested feedback from Healthwatch in Berkshire. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used all of this information to plan our inspection.

#### During the inspection

During the inspection we spoke with three people using the service and nine family members. We also spoke with 18 members of staff, including ten reablement assistants, three reablement supervisors, two occupational therapists, the senior reablement supervisor, registered manager and operations manager. We also received email feedback from an occupational therapy assistant.

We reviewed a range of records. This included 19 people's care and support plans and four medicine records. The service provided short term care, and therefore we reviewed a selection of care plans for people who either currently or recently used the service. We looked at five staff files in relation to recruitment, training and supervision. We reviewed a variety of records relating to management of the service including policies and procedures, staff risk assessments, training records and quality assurance surveys.

#### After the inspection

We continued to review records shared electronically and continued to seek clarification from the provider to validate evidence found. We sought feedback from professionals and received a response from two professionals during the inspection process.

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

### Assessing risk, safety monitoring and management

- Risks were identified in people's care plans, but there was limited information about how to keep people safe. This was particularly relevant for discharge to assess care, when people received support following hospital discharge. Some staff reported a lack of robust assessment meant they felt they were going in "blind". Sometimes staff found an extra staff member was needed to meet the person's needs or identified concerns regarding the environment or a lack of equipment. Staff escalated their concerns to supervisors and occupational therapists to review, however this relied on the knowledge and experience of staff to identify risks which had not yet been mitigated by the provider.
- Some people were at risk of falls. One person's medical history identified they experienced breathlessness on exertion, dizziness episodes and occasional double vision. The care plan informed staff to ensure the bathroom floor was dry at all times, but contained no detailed risk assessment in relation to the person's risk of falls.
- Some people were at risk of skin breakdown. One person's care plan identified a pressure sore, redness to their legs and they experienced incontinence. A two-page care plan instructed staff to provide bed care, check their incontinence pad and reposition at each visit. The care plan did not include any guidance or risk assessment for staff in relation to promoting skin integrity, pressure care or safe repositioning.
- Some people needed support from two staff for safe moving and handling. We reviewed the care plan for a person who received end of life care. The care plan identified a risk of injury to staff and risk of skin breakdown. Staff were instructed to "dress [person] and place in a comfortable position." Staff were given no specific instructions on how to safely reposition the individual, such as whether the person could assist during repositioning, or if equipment would be required to move the person safely. This meant the person could have been at risk of skin damage or injury if staff were unsure how to work safely.
- One person was at risk of seizures. Their care plan identified they experienced seizures resulting from radiotherapy. There was no risk assessment in place to identify when the person last experienced a seizure, how seizures were managed or to instruct staff how they should respond if the person experienced a seizure whilst they provided support.
- Some people who used the service had diabetes. We reviewed seven care plans for people living with diabetes. There were no risk assessments on how to manage diabetes in any of the care plans. Some staff we spoke with were not aware of potential signs someone with diabetes may show when becoming unwell.
- Some people presented with behaviours that challenged. One person was described as becoming agitated at times due to dementia. The care plan made a general reference to challenging behaviour and informed staff, "client may decline care, staff to stay and assist as allowed by client." There was no specific



guidance for staff such as triggers or strategies for de-escalation. This meant staff may have been placed at risk of harm, and the person may have been placed at risk of unintentional self-neglect, if staff were unable to encourage them to accept support.

Risks to people were not clearly identified and managed, particularly for people using the service's discharge to assess pathway. This meant people were at risk of receiving unsafe care and treatment. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to develop an action plan in response to our findings. The provider indicated they planned to review the contents of care plans and risk assessments, aiming to improve the documentation.

- People benefited from equipment aids and adaptations to their home environment. A detailed occupational therapy assessment was completed for people receiving short term reablement support to promote independence or end of life care. This considered whether equipment could improve the person's safety and levels of independence. People using the service provided positive feedback regarding equipment aids. One person told us, "A gentleman came to do my assessment and was very helpful. He had an insert put on my walker and this enabled me to put my drink, dinner plate or anything else I needed to carry."
- Some people using the service also benefited from physiotherapy as part of their support. One family member commented, "A physio also came and put a plan in place for exercises to be done half an hour each day. These exercises are helping to rebuild their strength and muscle building." Another person was supported with stair safety, advising, "I have a spiral staircase and he showed me how to go up and down them using a walking stick, which he told me I wouldn't need for long and on that he was right."

#### Using medicines safely

- Medicines were not safely managed; we identified concerns in relation to the service's policy, staff competency checks and the recording of medicines support given.
- The medicines policy had been reviewed by the registered manager in October 2020. The policy was not in line with best practice guidance. The policy did not include guidance in relation to covert medicines, PRN 'as and when required' medicines, and drug allergies. There was limited reference to controlled drugs and how these should be managed and administered. Controlled drugs are medicines subject to legal controls and legislation determines how they are prescribed, supplied, stored and destroyed.
- Staff had supported individuals with patches, creams, and tablet medicines in blister packs, sometimes referred to as dosette boxes or monitored dosage system (MDS). Robust systems were not in place to assess staff competency in relation to each type of medicine they supported with. Competency was assessed as part of yearly direct observations however this system had lapsed, and we found one member of staff, employed since April 2020 had not received a direct observation since the start of employment.
- The policy to support from blister packs, with the exception of antibiotics, was not in line with best practice guidance. We were advised requests for blister packs had caused delays in some people's support or placed additional responsibility on the person's family to help until the pharmacy could supply a blister pack.
- The service used different colour medicines forms for patches, creams and blister pack medicines. When medicines was given from a blister pack, a list of the tablets was included within the care plan. We reviewed five medicine record forms for one person. Two forms did not include the person's full name and one form identified them as the wrong gender. Written records did not include whether the contents of each new blister pack had been checked against the list included in the care plan. This meant we could not be confident safe and proper management of medicines had taken place.

- Feedback from people and families indicated inconsistencies in relation to medicines practice. One family member indicated staff fully supported the person, advising, "the staff were quite happy to give any medication or apply creams the doctor provided." However another person commented, "We were told they don't do medication... [person's name] does require a patch being put on morning and evening, in the beginning the staff would not do it but they have started doing it now." Another family member commented staff were not allowed to support with medicines until they had been provided in a blister pack.

We found evidence safe medicine practices were not promoted and record keeping was not in line with best practice guidance. This meant safe and proper management of medicines had not taken place. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to review their policy in relation to medicines. The provider also told us they would temporarily stop supporting people who needed medicines support until safe systems were in place. Whilst this mitigated risk, this was not a satisfactory outcome. The decision would prevent people who needed support with medicines from accessing the service. These people may have benefited from the short term support the service provided to receive independence building reablement support or end of life care.

- We reviewed the care plan and medicines record for a person supported with a medicated patch applied to the skin. The recording followed best practice guidance. The name and dosage of the medicine was documented. A body map was used daily to indicate where the patch was applied, and daily notes documented the time the patch was removed.
- Some staff we spoke with described giving safe medicines support. One member of staff highlighted the importance of changing gloves between administering different creams and commented they "can't administer anything without a label." Another member of staff felt online refresher training for medicines had been helpful, commenting this covered key principles including checking "dates, right route, right dose, right time and the person's right to refuse."

### Preventing and controlling infection

- The service did not have effective infection control practices in place, in response to the COVID-19 pandemic.
- Most staff we spoke with had not received formal training in relation to donning and doffing personal protective equipment (PPE) since the beginning of the COVID-19 pandemic. Staff received information leaflets in relation to correct use of PPE and conversations were held as part of supervisions. This process did not include a visual check of competency for staff.
- People and families confirmed staff wore gloves, masks and aprons, but some people raised concerns regarding infection control measures. Some people commented staff did not wash their hands or use hand sanitiser. Other people expressed concerns staff did not change single use gloves when supporting with different tasks, and we heard staff placed their coats on people's floor, chair or bed. One person commented, "They do wear masks and aprons. They don't wash their hands or use gel as they put on gloves. They only wear one pair of gloves; they don't change them or take them off until they are leaving."
- Staff risk assessments were not personalised. We were advised one individual who worked from home had a personal risk assessment, although we did not see this risk assessment on their staff file. This meant risk assessments did not identify if staff were at higher risk because of health conditions or cultural background. For example, we found one staff member with two medical conditions associated with increased risks in relation to COVID-19, but this was not mentioned in their risk assessment. This meant systems were not in place to identify staff at greater risk if asked to support people with symptoms or a positive diagnosis of COVID-19.

- People's care plans identified if they were on the COVID-19 NHS shielding group list, however no robust systems were in place to consider each person's level of risk in relation to COVID-19. Staff provided feedback they had raised concerns in January 2021 regarding the risks of travelling between people with symptoms or a positive diagnosis of COVID-19 and people without symptoms. Staff were informed it would not be possible to implement changes due to absences in the team. This meant robust systems were not in place to minimise risks to people at greater risk from COVID-19 infection.

The service had failed to ensure appropriate infection control measures in response to the COVID-19 pandemic. This meant people were not adequately protected from the risk of infections. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to review measures in place for infection control, including arrangements for staff risk assessments and competency checks for staff use of PPE.

- The provider had an infection control policy in place.
- Staff we spoke with confirmed they had received adequate supplies of PPE, including eye protection. A senior supervisor prepared packs of PPE for staff to collect from a central location, ensuring they had enough for the number of care visits they were due to undertake.
- Staff were tested weekly for COVID-19 infection. We observed a coordinated system which considered infection control risks when staff visited the building to undertake swab tests.

#### Staffing and recruitment

- Staff were not always safely recruited into the service. We found concerns with four staff recruitment files. Some staff were employed for several years and therefore their recruitment pre-dated current regulations concerning safe recruitment. We found no evidence people had been asked to supply a full employment history and gaps in employment history had not been explored. We were advised people's full employment history was not checked as part of the recruitment process. The provider agreed to review recruitment processes in response to our feedback.
- We found evidence other essential recruitment checks were undertaken. DBS checks were conducted, two references were taken, and applicants attended for interview. A DBS check is a record of a person's criminal convictions and cautions carried out by the Disclosure and Barring Service
- There was low staff turnover and some staff had worked for Slough Borough Council for more than 20 years.
- The provider had a recruitment policy and learning and development policy in place. New staff experienced a period of induction, which included shadowing, and a probation process.
- Staff we spoke with indicated the service had enough staff. One staff member told us, "[we are a] good team and we help each other. I am not asked to do too many hours." A supervisor advised us they informally monitored staff hours as part of payroll, and made sure staff weren't working too many hours. They commented there were "no concerns about staff tiredness."
- Staff explained capacity of the service was reviewed daily and this information was shared to ensure new referrals were accepted when capacity allowed. The supervisor on duty monitored the rota daily to ensure staff were deployed to cover all scheduled visits.

#### Learning lessons when things go wrong

- Whilst individual incidents were responded to, there was no evidence effective or embedded systems were in place to analyse themes and trends from accidents and incidents, concerns and complaints and safeguarding concerns.

- An accident and incident form was in place, however there was no evidence this was an embedded process. Staff explained when a person using the service experienced an accident such as a fall, this was recorded on the person's record. Information was shared between supervisors and occupational therapists to consider changes required to the person's care or equipment. This method of logging information meant there was no effective system in place for the registered manager or provider to review the frequency of accidents and incidents for people using the service, either for each individual, or across the service.
- Accidents and incidents relating to staff were better documented and records included actions taken to prevent reoccurrence. For example, when a staff member slipped in the snow, the record explained how dangers of slippery surfaces were highlighted to the staff team.

#### Systems and processes to safeguard people from the risk of abuse

- Staff confirmed they understood how to raise concerns however we identified some staff had not completed safeguarding adults refresher training in line with the provider's policy.
- A template had been developed to keep a central record of safeguarding concerns raised, and another template had been designed to identify outcomes and learning for the service, but these were not in use at the time of our inspection.
- A whistleblowing policy and safeguarding policy were in place. We identified the safeguarding policy told staff "You can contact CQC PCAW Safeguarding Team" however did not explain the acronym or provide contact information for CQC. The registered manager agreed to review the policy in response to our feedback.
- Systems were in place to safeguard people from concerns of abuse or neglect. The service had identified recent safeguarding concerns and appropriately submitted referrals to the local authority safeguarding team.
- People and their relatives told us they felt safe. One person told us, "I have no worries about my safety with the carers." Another family member commented, "My family member has been receiving help from this service for a month now and he has always felt perfectly safe with the staff caring for him."

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Systems for staff training and support were inconsistent across the team. Each supervisor supported a small team of staff known as reablement assistants. There was wide variation in frequency of supervisions, direct observations and completion of the provider's mandatory training, including refresher training.
- There was a historic arrangement in place to supervise staff bi-monthly. This was not in line with the provider's own policies in relation to supervision. Staff files contained conflicting information regarding how often supervision should be held. One file referred to supervision frequencies of two monthly, every four-six weeks or every eight weeks. Staff we spoke with also indicated supervision occurred at differing intervals, with examples of two monthly, three monthly or three to four monthly.
- The service supported people with long term conditions and specialised needs, such as people with a history of stroke, diabetes, dementia and needing support with catheter and stoma care. Some of these subjects were identified by the provider as non-mandatory training courses, and training records showed limited uptake of training in these areas. We reviewed training records for 27 members of staff. Only three staff members had undertaken dementia training, one staff member received stroke awareness training and no one had completed diabetes awareness training. This meant staff relied on their previous knowledge and experience when supporting people, which may not be in line with current best practice guidance.
- The process of yearly direct observations had lapsed, meaning some staff had not been observed by a supervisor since early 2019. This was of concern as direct observations were used to assess and review competency in relation to manual handling and medicines practice.
- Mandatory refresher training had also lapsed in key areas. We found annual moving and handling training was either incomplete or had elapsed for 22 of the 27 reablement assistants who delivered care in people's homes.
- Arrangements were in place for the induction of new staff, which included a period of shadowing colleagues. One member of staff had been employed since April 2020 however a direct observation of their work by a supervisor was not planned until April 2021. This meant a supervisor had not witnessed the member of staff supporting people to ensure they had the skills and knowledge needed to provide effective support.

People did not receive care from staff who were fully trained to meet their individual needs or assessed as competent. This meant the provider had failed to ensure staff were suitably qualified, skilled and experienced to meet the needs of people using the service. This was a breach of Regulation 18 (Staffing) of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to develop an action plan in response to our findings, and agreed to review the training opportunities available for the staff team.

- Records showed staff had received an appraisal within the last 12 months, to review their progress and development in their role.
- Staff we spoke with were positive regarding the support they received from their direct supervisor and the senior reablement supervisor. Staff working in the community could make telephone contact with a supervisor as part of the service's on-call system if they needed immediate advice or support. One member of staff told us they had used the on-call system many times, advising the line is "always answered immediately...and [supervisors] give advice we need...I'm very happy with all the supervisors."
- People and families we spoke with felt staff appeared to have sufficient training to meet their needs. One family member told us, "The people dealing with him are well trained and knowledgeable about the equipment they and he is using in order to keep him safe." Another person told us, "I always felt the staff had been well trained to help and support me."

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

- We found people's assessments and care plans did not clearly document the assessor's view of the person's mental capacity, where people were living with memory impairment or confusion. This meant we did not have confidence staff were working in line with the MCA, or in line with the provider's own policy.
- We received a copy of the provider's policy in relation to MCA, which was dated April 2010. The policy had not been updated to reflect subsequent developments in the application of the Mental Capacity Act and Deprivation of Liberty Safeguards. This meant the policy did not highlight in certain situations people in their own homes may require an application to authorise a deprivation of liberty.
- One person's care plan described them as having a number of cognitive difficulties including difficulties with executive function, speed of information processing, language and immediate memory. We found no evidence this person's mental capacity had been considered in relation to receiving care and support.
- Another person was receiving end of life care and was living with dementia. Their care plan highlighted a history of behaviours that challenge and informed staff the person may decline care. Given the person's resistance or reluctance to accept support, a mental capacity assessment should have been considered, to review whether they were able to give informed consent for the care they received.
- Staff showed varying levels of knowledge and understanding about the principles of MCA. Some staff had previously undertaken training in relation to MCA, however training records showed three members of staff

had not completed this training, and 12 members of staff had not completed refresher training in line with the provider's policy.

- Care plans did not record whether people had a do not attempt cardiopulmonary resuscitation (DNACPR) decision in place. We found one of the 19 care plans we reviewed contained this information. Some people with a DNACPR had a paper copy of the decision at their home address, however we could not be confident staff had quick access to the information required should they need to summon emergency medical assistance. This meant there was a risk cardiopulmonary resuscitation could be attempted on an individual against their wishes and against medical advice.

We found evidence care assessments and care planning did not follow the principles of the Mental Capacity Act 2005. This meant staff were not working in line with the principles of MCA. This was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to develop an action plan in response to our findings.

- Staff we spoke with understood the importance of seeking consent before delivering day to day care. Written records also indicated staff asked consent to support people when they arrived at their home.

Supporting people to eat and drink enough to maintain a balanced diet

- Care plans documented whether the person required support with food and drinks. Some care plans highlighted support provided by families with meal preparation. Where people required support, care plans asked staff to offer a choice of meal and hot drink, but did not document the person's usual preferences, likes or dislikes.

- Some staff had received training in food hygiene, however training records showed one member of staff had not received training, and training for eight staff had not been refreshed in line with the provider's policy.

- Staff had not received training in relation to meeting people's nutritional needs. Staff had not received training in relation to food textures and drink thickness for people with swallowing problems. Some staff we spoke with had supported people at risk of choking, and described using fluid thickeners and mashing up food with a fork. Staff did not demonstrate awareness of different levels of food textures for people who experience difficulties with swallowing.

- Some people using the service expressed concern staff were not allowed to use the oven to cook a main meal. One family member told us, "[person's name] is a fussy eater and trying to find ready meals for the carers to put in the microwave is challenging as they are not always the best meals." Another person commented, "They would only do microwave meals and they also did my breakfast."

We recommend the service develop their approach, to ensure the service protects people, especially those with complex needs, from the risk of poor nutrition, dehydration, swallowing problems and other medical conditions that affect their health.

- Staff encouraged people to maintain good levels of hydration. We heard examples of drinks being left out and during periods of hot weather staff were asked to promote hydration at every visit. One family member advised, "They do ask what she wants to eat and they encourage her to drink as she has a tendency not to drink enough." Another family member added, "The carers helped the family particularly my mother to encourage him to try and drink or eat more."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed by an occupational therapist following a referral to the service.



- People receiving short term support following discharge from hospital, known as discharge to assess care, were given a brief care plan which did not fully identify their needs, preferences and risks. People receiving reablement care to build independence, or end of life care, were given a more detailed care plan. We found care plans did not present a holistic picture of the person's physical, mental health and social needs. People's protected characteristics, such as their religion and ethnicity, was often not reflected within their care plan.

- The service promoted the use of aids and equipment to encourage independence. Occupational therapists supplied a wide variety of equipment to help people with day to day tasks, such as commodes, shower seats, handrails and hospital style beds. One family member described how the provision of a specialist chair enabled their relative to independently transfer into an upright standing position to use their frame.

Supporting people to live healthier lives, access healthcare services and support

- Some people received support when their health needs changed. One person told us, "when creaming my legs and feet I told them my toe was hurting. They took a picture of it and said they would talk to someone... I now have an appointment to see a podiatrist next week."
- The service supported people to access treatment in a timely manner. A family member told us their relative had complained of a problem with their foot, advising, "they took a picture of it, rang the district nurse, sent the picture and she got the GP involved."

Staff working with other agencies to provide consistent, effective, timely care

- Some people using the service received occupational therapy input for equipment aids, physiotherapy and short term care support. Some people indicated processes were unclear and inconsistent. One family member described the service as, "difficult to navigate around". Another family member stated, "They said they would arrange the delivery of two commodes but they didn't appear. The following week we had a second assessment and I told them about the commodes, the assessor dropped them off the following morning...they also said they would arrange a third assessment and it should have been last week but that hasn't happened either."
- Staff we spoke with described good working relationships between reablement assistants supporting people in their own homes, supervisors and occupational therapists. A duty supervisor provided a link between community based staff and occupational therapy. This meant concerns or changes in a person's needs could be quickly escalated to request an occupational therapy review.
- Staff told us they worked closely with hospital teams to facilitate timely discharges. The service was in daily contact with the local hospital to provide feedback about the service's capacity.
- The service provided short term support. Some people were unable to achieve full independence and their care was transferred to long term care providers. We heard processes were in place to ensure a smooth transition. This included sharing information and the new care provider shadowed staff for one visit so the person could be introduced to their new care provider.



# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Care plans did not always include information about people's religion, culture or personal history. This meant some staff relied on using their initiative to find out additional information so they could respect the person's preferences. A member of staff explained they asked people their religion and checked their wishes. They told us, "I need to be mindful of clothing, some people like to keep underwear on in the bath and we respect that." This meant people's care plans did not contain enough information to enable staff to fully respect the person's preferences from the start of their support. We discussed our concerns with the registered manager and provider who agreed to review documentation in place to ensure this reflected people's needs and preferences.
- Some people and families provided positive feedback regarding support from staff. One person told us, "Staff have been very helpful and supportive when helping me to reach my goals, we have built up a good rapport." Another family member told us, "[Person's name] is very complimentary about her carers and says she has a laugh and joke with them." A third person told us, "Staff have been kind and compassionate."
- People informed us they did not feel rushed and staff stayed the required amount of time to support them. One person told us, "No one has ever rushed me." Another family member added, "Carers always ask if there is anything more they can do before they go."
- Staff we spoke with consistently demonstrated a compassionate, caring and respectful approach. One staff member told us, "I treat people how I would want to be treated with the upmost respect."

Supporting people to express their views and be involved in making decisions about their care

- People and families were involved in the assessment process to make some decisions about their care and received a copy of their care plan. Some people expressed they had not been asked about their preferences, likes or dislikes as part of this process. One family member explained, "They did enquire about what her needs were and what she could or couldn't do and what support she felt she needed...her likes or doesn't likes were not asked." This meant people's care plans included descriptions of tasks required but did not involve the person in a holistic assessment of their needs.
- People were not always able to fully express their views, as staff were not made aware of people's preferred methods and needs in relation to communication. Where individuals were living with sensory loss or speech difficulties, care plans did not inform staff how to best communicate with the individual. This meant there was a risk people could not express their views or communicate their decisions about their care. We discussed our concerns with the service who agreed to review information shared with staff regarding people's communication needs and preferences.

- Some people needed support with medication. The service had a policy to only support with tablet medicines if this was placed into a monitored dosage system (MDS). We were concerned this approach did not enable people to express and make their own decisions about how they wanted to manage their medicines. Whilst some people find an MDS helpful, other people may have preferred to retain their individual medicines packets, particularly if they had no previous experience of using an MDS. We discussed our concerns with the provider who agreed to review their approach.
- Some people raised a concern about a lack of regular carers impacting their ability to build a rapport with the service. One person told us, "Throughout the six weeks I received care from this service I did not get regular carers so couldn't build a proper relationship. This is not caring." Another person's family member stated, "Different carers come in, several are new." Staff we spoke with acknowledged the importance of building a relationship with people to help them engage with the service and express their views. One staff member explained, "I always make time to chat, it's important to build a relationship...helps to build trust and how we can gain other information."
- Staff described how they involved people in day to day decisions about their care. A staff member told us they achieve this by "asking them how they feel and what they'd like to achieve." Another staff member added, "Reabling people takes time, but it's very positive they are involved in their own care."
- Staff listened when people wanted more or less support. Some people expressed a need for less care as they worked towards achieving more independence. Staff supported people by sharing feedback with supervisors who attended multi-disciplinary meetings to help advocate on people's behalf regarding their needs.

#### Respecting and promoting people's privacy, dignity and independence

- Some people and families provided examples where dignity had not been respected. One family member described staff did not leave the bathroom clean after supporting someone with personal care and later refused to use the bathroom until a family member had cleaned the shower. We were told instead they gave the person a "wipe down". Another family member described an incident where their relative had been washed in cold water, stating, "one carer who after [person's name] had a bad night, so required a strip wash not a shower, washed my relative in cold water."
- Some people did feel the service promoted their privacy and dignity. One person commented, "They were very respectful...if I was using the toilet they would wait outside the door." Another family member told us, "they give him privacy and reassurance especially when he has an accident due to his incontinence."
- Staff described how they protected people's privacy and dignity when providing care. One staff member told us, "I would always talk them through what I'm doing and offer them to do things for themselves." Another staff member explained how they use additional towels to protect the person's dignity and ensure they are warm during personal care support. A third staff member described ensuring curtains and doors were shut to maintain privacy.
- Staff maintained confidentiality as part of measures to ensure the people's privacy. One staff member we spoke with advised, "I never leave paperwork in my car and never discuss anybody in public or in front of visitors." Another staff member described confidentiality when completing paper records in people's homes. In some situations, daily records may be viewed by the person themselves, their family or visiting professionals. The staff member told us they considered carefully what to include and where necessary would share sensitive information with their supervisor by telephone instead of leaving a written record at the address.
- People and families described how staff helped people improve their levels of confidence and independence. This was a key priority for the service and occupational therapists considered how teaching people to use equipment aids could promote independence. One person told us, "They do encourage me to do as much for myself as I can."

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- We found people's assessments and care plans were not person-centred and were task focused. Assessments were conducted by occupational therapists and were effective in identifying a person's reablement potential and equipment needs. This meant assessments lacked a holistic picture of the person, and often basic information such as the person's preferred name was absent.
- We identified 11 care plans where the person receiving support was described as 'client' or 'SU', meaning service user. This was not respectful, or person-centred.
- None of the care plans we reviewed referred to the person's sexuality and this was not a field within the care plan form. This meant there was no evidence this had been explored as a potentially important part of the person's identity to build a holistic picture of the individual.
- We identified 15 care plans where the person's religion had not been documented, and six care plans where the person's ethnicity was absent. This meant we did not see evidence people's religious, cultural or spiritual needs had been fully explored as part of the assessment process. We were advised assessments considered factors such as whether the person would prefer a carer who could communicate in their first language. Feedback from people using the service indicated this was not always asked. One person commented, "It would have been nice to have been asked as if it was possible it would have been nice if [person's name] could have had a Punjabi speaker."
- Care plans contained limited information about the person's hobbies, preferred social activities or what was important to the individual. Some care plans described if people's family were supportive and five care plans listed hobbies such as watching television.
- Care plans described what tasks people needed support with, sometimes describing a person's ability to wash or dress part of their body, but information about personal likes, dislikes or preferences was limited. One person indicated their likes and dislikes had been asked, but there were more examples of people advising they had not been asked. One family member commented, "As to likes and dislikes we were not asked in fact it was prescribed."
- We were advised the service asked whether people preferred a male or female staff member to support them. The service had one male staff member, so care was mostly delivered by female staff. Feedback from people indicated they had not always been asked their preferences. One family member said, "I did state I only wanted females to care for my mum we were not asked." Another person said, "No we were never asked this question. I most certainly would not want a male to help with personal care. Luckily I have only had females."
- Care plans did not reflect people's emotional needs. One person's care plan indicated they had received

support from the mental health service for several years in connection with two mental health conditions. Information provided to staff was limited to a description of risks and tasks required. There was no reference to how staff could engage with the individual to support their emotional needs, or how they might be required to adapt their approach to good days or bad days.

The service had failed to ensure people received a personalised care plan, reflecting their social and cultural needs, or protected characteristics. This meant people did not always receive person-centred care. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service agreed to develop an action plan in response to our findings and advised they would review how care plans were approved, to ensure they contained sufficient and personalised information.

#### Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Information regarding people's communication needs was not clearly documented for staff. One person's care plan described the person as profoundly deaf but did not include any guidance for staff on how to achieve effective communication. We heard staff found it helpful to write down information for the person to read, and visits took longer to ensure they had time to do this. The person's care plan had not been updated to reflect the person's communication needs.
- Another person using the service had a diagnosis of aphasia, a condition which causes difficulties with language and speech. The person's care plan did not outline how this condition affected the person, or any strategies staff could use to achieve good communication.
- Some staff we spoke with described using their own knowledge and experience to work with people who experienced communication difficulties. One staff member told us, "I will point to things and key words they might understand." Another staff member described their experience of supporting someone hard of hearing, advising, "I used a bit of sign language and used my eyes, nodding, hello and goodbye...this level of detail was not in the care plan – we use our experience."
- Some people using the service experienced slurred speech. One family member provided positive feedback regarding the approach of staff. They commented, "[person's] speech is very slurred, but the staff tend to build a good rapport with them quickly...they communicate with them very well and they are extremely approachable."

#### Improving care quality in response to complaints or concerns

- A complaints procedure was in place. There was an emphasis on written complaints and the procedure was not accessible for individuals who required information in a different format or language. The policy did not identify some people need support to raise a complaint, such as with the help of an interpreter or advocate.
- The Slough Borough Council yearly complaints log showed no complaints had been submitted between 2018 and 2021. This was a system to record formal complaints but there was no central record of concerns raised and informally resolved by the service. This meant the registered manager and provider did not have oversight of concerns which did not proceed to a formal complaint, and therefore could not undertake analysis to identify themes or wider learning to improve the service.
- People using the service were encouraged to call the number on a bright yellow sheet of paper left in their home, if they had any concerns. People did not receive an information leaflet, meaning no written

information was supplied relating to how to raise a concern or formal complaint.

- Some people using the service indicated they had not been made aware of the complaints process. One person commented, "We were not told how to make a complaint or to whom, but we were given a sheet of telephone numbers we can ring for information." Another family member advised, "At no time during the assessment period was there a conversation on how to make a complaint."

We recommended the provider review arrangements for concerns and complaints, to ensure people know how to give feedback about their experiences of care and support and can do so in a range of accessible ways.

- Systems were in place to resolve concerns at the point of contact. A Reablement Supervisor was contactable by telephone. Actions taken were logged on the person's record, and where necessary, a handover of information took place between supervisors and occupational therapists.
- Some people we spoke with told us concerns had been dealt with effectively. One person described contacting the supervisor to request staff wear shoe covers and commented, "I had to ring twice but when I did speak with them about my concerns over PPE and it was resolved to my satisfaction."

#### End of life care and support

- The service supported some people approaching end of life. An end of life policy was in place. This explained the service provided up to six weeks intermediate care, for people with a medical prognosis of less than six weeks. The policy provided a brief overview of the pathway's aims and objectives, eligibility criteria and referral and assessment process. The policy did not highlight the importance of holistic support for people and families at end of life.
- We reviewed the care plan for someone previously supported with end of life care. This clearly identified the person was receiving end of life support. Staff were provided with a description of tasks, to ensure the person received the required help with personal and continence care. The person's occupational therapy assessment noted the situation impacted their relative's mental health. The care plan did not refer to emotional support the person or their relative may benefit from as part of the package of support.

We recommended the service review their end of life policy and procedure to ensure staff are aware of national good practice guidance and professional guidelines for end of life care and provide care in line with this consistently.

- Training matrixes indicated some staff had received training in relation to end of life care.
- Some staff we spoke with described supporting people at end of life. One staff member described providing compassionate, dignified care to a person, commenting, "[the person] was so uncomfortable, so I tried to help quickly so I didn't cause any discomfort."

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The management of the service was not visible for people using the service. One person told us, "I have no idea who the manager is or what they are called... I have been pleased with all the carers." Another family member commented, "I have no idea who the management are and there are no names on the sheet of telephone numbers they gave us." A third person commented, "I don't know who the manager is or anything about management of this service." This meant whilst people were generally happy with the staff who supported them on a day to day basis, the management of the service was not inclusive or easily accessible.
- The registered manager was not visible to frontline staff who worked to provide care in people's homes. Some staff we spoke with had not heard of the registered manager. Another staff member told us no direct communication had been initiated from the registered manager and described the team as frustrated with the lack of contact from the manager and provider. We heard one meeting was held with some staff in January 2021 and the registered manager told us they intended to improve their engagement with staff. The registered manager mainly worked from home during the pandemic and met some staff for the first time during our inspection. This indicated the registered manager was detached from the day to day operations of the service, and therefore did not understand the key challenges and concerns experienced by staff.
- At the time of our inspection, staff were deployed based on availability due to staff absences. This meant people did not receive continuity of care from regular staff. One family member informed us, "[person's name] has had eight to ten different carers in just two weeks. This is not really very satisfactory for an older person. You can't build a good working relationship when carers are different each time."
- We received varied feedback as to whether staff arrived on time to support people. One family member advised, "They are sometimes early or late but never ring and let us know." Another person commented, "On the whole their timing was good. On one occasion they were very late getting to me and no one phoned to let me know what was happening."
- We found examples of disempowering language used. Care plans left in people's home described people as 'client' or 'SU'.
- Support was not always person-centred or inclusive. People's care plans did not identify their preferences, likes and dislikes. Information in people's care plans were generic and task focused. This meant we could not be assured care records contained enough detail relating to people's individual needs to ensure these were met. One person's care plan advised they needed a modified diet due to dysphagia, meaning they experienced swallowing difficulties. The care plan informed staff to assist and encourage independence with meal preparation, drinks and snacks, but provided no guidance in relation to how the person's dietary



needs should be met.

Management systems were not in place to promote high quality, person centred care. This meant people's care was not person-centred to help them achieve good outcomes. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to implement an action plan in response to our findings, and the registered manager advised they planned to attend staff meetings on a more regular basis.

- The service had a clear strategy to promote people's independence whilst providing short term care. Some people gave examples of how the service had helped them to do more for themselves and build their confidence in their own abilities. One person said, "I am a very independent and determined person...they did however help with the things I couldn't do such as putting on or taking off my shoes." Another person described, "They have shown me how to keep my balance, but they do my toast at the same time as I'm making coffee so, they can check I am not taking risks. Currently they are encouraging me to walk around the sitting room."
- An established, stable staff team was in place. Some people had worked for the provider for over 20 years. The team worked well together and reported good communication and support from their direct supervisors and on-call system. Staff understood the approach of the service, and one staff member summarised this by commenting, "We're all working as a team to keep people independent."
- Although the registered manager did not have close contact with the wider team, we were advised the manager was in daily contact with the service's senior supervisor and worked closely with occupational therapists within the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service had a registered manager in place. The registered manager did not have a good knowledge or awareness of their responsibilities under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager needed to familiarise themselves with where documents and folders were located ahead of our visit, indicating a lack of regular oversight.
- The provider had developed a new quality assurance framework which was used in January-February 2021. There was no section for actions and the audit did not identify some of the concerns we found. The framework was only partially completed at the time of our visit.
- We reviewed quality assurance surveys undertaken with people using the service during 2020-2021. The registered manager had not reviewed the documents and there had been no analysis of themes or learning for the service.
- Some policies developed by the provider or registered manager were not in line with best practice or regulation. We identified concerns in relation to policies for medicines, complaints, end of life care and duty of candour.
- Where required improvements were identified, the pace of change was too slow. A service review carried out in 2018 identified actions including the introduction of a service leaflet, the need for medication competency assessments and the need to ensure all verbal and written complaints were recorded. These were still areas to be fully implemented at the time of our visit.
- The service used an action plan which was discussed by the registered manager and provider as part of regular meetings to review progress. A number of actions were showing as 100% complete which we found was incorrect. Service user satisfaction survey results had not been analysed, and the safeguarding log of referrals, outcomes and analysis of learning had not been completed.
- A system of case file audits carried out by a senior occupational therapist was in place. Audits did not

identify some of the concerns we identified, and there was no evidence the audits had been used to improve the service. We received copies of four case audits for the period January 2020 to January 2021. The frequency of audits completed was not in line with the provider's policy.

- People's care plans often contained blank spaces where information such as people's preferred name, ethnicity, language or religion would be recorded. We found no evidence systems were in place to monitor the completeness of records or address the widespread gaps we observed.
- Data was collected via an administrator contacting people 91 days after leaving the service, to check their location and outcomes. We were advised this information was accessible to the administrator and had not yet been analysed for the year February 2020 onwards.
- Systems were either not in place, or not embedded to analyse and identify themes and trends in relation to safeguarding concerns, concerns which did not proceed to a formal complaint and accidents and incidents involving people using the service. The registered manager and provider demonstrated a lack of awareness regarding the nature of incidents which took place or concerns people brought to the service's attention.
- The inspection could not take place at the service's registered location. We were asked to undertake our site visit at a day centre which had been closed during the pandemic. We found the service's paper files, such as staff files and accident and incident records, were stored at this alternate location.

People did not receive care from a service which was effectively monitored and managed. This meant systems were not in place to identify learning or required improvements in the quality of care people received. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to develop an action plan in response to our findings and planned to fully implement the quality assurance framework which had recently commenced.

- Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. The service had identified potential safeguarding concerns and submitted safeguarding referrals to the local authority. The service had failed to make the required notifications to CQC.
- The registered manager demonstrated a lack of awareness regarding other incidents or events which may require them to notify CQC.

Systems were not in place to report incidents to CQC in accordance with requirements. This meant CQC did not receive the required information in a timely manner. This was a breach of Regulation 18 (Care Quality Commission Registration Regulations 2009).

The provider confirmed they would develop an action plan in response to our findings and submitted the required notifications retrospectively following our inspection visit.

- The registered manager confirmed the organisation's statement of purpose had been updated in October 2020. This had not been shared with CQC and the registered manager was not aware of the requirement to do so.

Systems were not in place to make the required notification to CQC in accordance with requirements. This meant CQC did not receive the required information in a timely manner. This was a breach of Regulation 12 (Care Quality Commission Registration Regulations 2009).



The registered manager agreed to submit the required notification retrospectively and completed this following our site visit.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The registered manager and provider had not formally engaged with all staff on a regular basis for the purpose of gathering feedback or to identify ideas to improve the service. The registered manager told us they planned to attend more team meetings to engage with staff.
- The registered manager informed us there were no formal systems in place to seek feedback about the service from external organisations, stakeholders or professionals they worked with.
- The service undertook quality assurance questionnaires to gather people's experiences of using the service. We reviewed the quality assurance surveys undertaken during 2020-2021. There were 18 surveys conducted in 2020 and five in 2021. The service had a high turnover of people they supported up to six weeks, and therefore the number of surveys completed was relatively low when considered against the numbers of people the service supported each year.
- We were advised quality assurance questionnaires had previously been undertaken in person and were now carried out by telephone due to the COVID-19 pandemic. The process did not take into consideration people's protected characteristics. Some people using the service spoke limited English or experienced hearing loss. Some people may have preferred to receive a written feedback questionnaire written in their own language.
- Some people told us communication with people and their relatives could be improved. One family member told us, "I think they need to improve the way they provide information relating to the service...when one is new to having to obtain care and reablement for a relative they need to be better at discussions and explaining what they can and can't provide." Another person informed us, "I have no idea who the manager or anyone else apart from the carers was. A man called on my first day, but I have no idea who he was. I have concerns about the way the service is managed as there was a lack of consistency."

The service had failed to effectively seek and act on feedback from relevant persons, including staff and people using the service. This meant the service had failed to use feedback to identify and implement improvements. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The service had a duty of candour policy in place. The document referred to a different service run by the same provider Slough Borough Council and therefore we were not confident the policy was implemented at the service we inspected.
- The policy made a general reference to supporting the individual, stating "give support and assistance to the service user and staff and any relevant information/assistance available". The policy did not identify what forms of support this might need to take. Some individuals may need to access advocacy, an interpreter or communication aids.
- The registered manager advised no incidents had met the duty of candour since the service's registration with CQC in August 2020.
- The service had an 'easy read' style duty of candour document for people who would find it easier to understand information with less words and helpful use of images. It was not clear how this document was shared with people who may find it beneficial as people using the service did not receive an information pack about the service.

### Working in partnership with others

- The service worked with other agencies to provide end of life care. One professional informed us their team had stopped trying to refer people into the service, stating, "they never have capacity." The professional also explained when they previously referred people, they had to take into consideration the service would not support people with boxed medicines, and would only provide medicines support if the person had a monitored dosage system (MDS).
- Staff informed us they had good links and worked closely with other professionals, such as district nurses and GPs. People's day to day needs were met by care staff known as reablement assistants. The wider team included occupational therapy and physiotherapy who worked to provide equipment and promote people's independence with day to day tasks. The team also had links with the local authority social work teams and referred people for long term support when required.
- The registered manager explained the service was in daily contact with the local hospital to provide updates regarding the capacity of the service. The registered manager also advised they held regular meetings with the hospital to discuss any concerns, such as failed discharges.

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 12 Registration Regulations 2009 (Schedule 3) Statement of purpose  Systems were not in place to make the required notification to CQC in accordance with requirements.
Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents  Systems were not in place to report incidents to CQC in accordance with requirements.
Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care  Care assessments and care planning was task focused, and not person-centred.
Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent  People's assessments and care plans did not demonstrate staff were working in line with the Mental Capacity Act 2005.
Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  People did not receive care from staff who were fully trained to meet their individual needs or

assessed as competent.

This section is primarily information for the provider

## Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  Risks to people were not clearly identified and managed, and systems were not established to promote learning from incidents to mitigate risks to people.

**The enforcement action we took:**

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  The service was not effectively managed and good governance was not established.

**The enforcement action we took:**

We served a warning notice.