East Sussex County Council

Joint Community Rehabilitation 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?	Good

Summary of findings

Overall summary

About the service
The Joint Community Rehabilitation Service (JCR) provides reablement and rehabilitation for people in their own homes. It is a partnership between the local authority and East Sussex Healthcare NHS Trust. The service provides support for people for up to six weeks, in most cases following discharge from hospital following an accident or illness. Some people were referred to the service from GP's or other health care professionals. The service aims to maximise people's chance of continuing to live independently in their own homes. The service was supporting 50 people at the time of the inspection.

People's experience of using this service and what we found
People told us that they were supported safely. People were protected from abuse and harm and all staff had completed safeguarding training and were able to tell us what steps they would take if they had concerns. Accidents and incidents were reported, recorded and dealt with appropriately with any learning being taken forward and shared with staff. Risk assessments were personalised to individual needs and were reviewed weekly. There were sufficient numbers of trained staff to cover all visits to people. Calls were never missed and were rarely late. If a staff member was delayed in reaching a visit, a contingency plan enabled other staff to cover. Staff were recruited safely. Some people were supported with taking medicines and this was done safely.

Staff induction was comprehensive and involved staff completing a probationary year before being fully signed off. Ongoing support was provided through supervision and appraisal meetings. Ongoing training was provided and in addition to mandatory courses, staff were able to choose training courses that they felt would help them develop. People were supported to access health and social care professionals and care calls were adapted to fit around people's appointments.
Staff had been trained in mental capacity and were aware of the importance of consent and choice. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People using the service were treated with respect and dignity. Comments from people included: "Went well beyond what I'd expected," "They are 100%. Perfect" and "Without their help I wouldn't be at home now." People's privacy was respected but their safety never compromised. Staff supported people to regain their confidence and independence with personal care and tasks around their homes.

Despite the relatively quick turnover of people using the service, staff knew people well. Care and support were person-centred, and this was reflected in people's care plans. A complaints process was in place and accessible to everyone using the service, a copy of the policy and process was left in people's homes. There was a process for dealing with minor issues and concerns and those received had been dealt with appropriately. Staff had received training in end of life care.

The registered manager fostered a positive culture across the service. They were aware of their responsibilities under the duty of candour. A new computer system was being introduced which made recording visits much more efficient for staff. People and staff were provided a variety of ways to feed back about the service and we saw that the service management listened to feedback and made changes when appropriate. Audits were carried out and often these were done across all three JCR services in East Sussex which provided managers an opportunity for sharing best practice across the service. JCR had established positive working relationships with local hospitals, GP's community nurses and other key local authority services.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
Good. (Report published 28 July 2017)

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our reinspection 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 safe. Details are in our safe findings below.	**Good**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was well-led. Details are in our well-Led findings below.	**Good**

Joint Community Rehabilitation 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 one inspector.

Service and service type
The Joint Community Rehabilitation (JCR) service provides reablement and rehabilitation for people in their own homes. It is an East Sussex County Council (ESCC) service run in partnership with the East Sussex Healthcare NHS Trust (ESHT). Short term support of up to six weeks is provided to people, usually following discharge from hospital after an illness or accident. Rehabilitation including personal care is provided to people to maximise their ability to live independently. An urgent referral process is also in place from GP's or healthcare professionals to prevent a person being re-admitted to hospital. There were 50 people being supported by the service at the time of the inspection.

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 24 hours' notice of the inspection so that the manager could arrange home visits from an inspector.

What we did before the inspection
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. Providers are legally obliged to inform us about significant incidents that happen at their service. We examined these reports. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
On the first day of the inspection we visited the provider's office. We spoke to the registered manager, the deputy manager, the practice manager, three senior support workers and two support workers. We reviewed six care plans and related documents, for example risk assessments and medication records. We examined records relating to the running of the service including, training records, four personnel files, complaints, quality assurance and auditing processes.
On the second day of the inspection we carried out two home visits speaking to two people who used the service, one relative and one support worker. We returned to the provider's office where we spoke with one senior support worker and one support worker.

After the inspection
We continued to seek clarification from the provider to validate evidence we found. We spoke to five people, two relatives and contacted five professionals who had regular contact with the service.

Good

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People and relatives told us that the service provided safe care and support. A person said, "I'm getting stronger and I feel safe when they help me." Another said, "They are very safe but still making me independent." Another person told us, "I feel safe because I have them coming in. It's a great comfort to me."
- Staff were confident in their knowledge of safeguarding. Staff had received training, with regular updates, were able to describe scenarios to us and tell us what steps they would take if they had concerns. A staff member told us, "Always ask the person's views and permission to report. I'd speak to my line manager, record it separately and go to CQC if needed."
- The service had a whistleblowing policy. Staff told they knew about the policy and would use it if they needed to. Whistleblowing allows staff to raise concerns whilst protecting their anonymity.

Assessing risk, safety monitoring and management

- Support plans had risk assessments that were personalised to people. Most had a comprehensive falls assessments and details of clear contingencies and preventative measures. Independence related to mobility was a key issue for people and this was reviewed every week throughout a person's involvement with the service.
- Any ongoing or developing needs relating to risk were documented and liaison was made with other professionals. For example, to secure additional mobility equipment such as wheeled trolley walkers, raised seats and handrails were available.
- The service had identified staff members to become champions, to develop an expertise in specific areas so that colleagues could be supported. Champions were working in areas of risk for example, moving and handling and health and safety. The moving and handling champion told us, "I've completed trainer training and do a lot of in-house training for colleagues. I complete all the risk assessments for moving and handling and I've set up files for reference, for every piece of equipment." We saw risk assessments and the training program, both confirmed what we were told.
- Initial pre-assessments conducted in people's homes included environmental hazards and fire risks. If a home did not have working smoke detectors, the service would refer people for a home safety visit.

Staffing and recruitment

- Staff were recruited safely. Checks had been completed on staff before they started working at the service. Checks included references, employment history and Disclosure and Baring Service (DBS). DBS checks ensured that people had no criminal record that prevented them from working with children or adults and provided the service information from which they could decide whether a person could be safely employed.

● The service supported between 40 and 65 people at any one time and had 40 support workers and seven senior support workers to manage this. The service had a planner and administration staff who ensured that all care calls were covered. A system was in place to cover staff sickness and leave which meant that the service had never missed a care call.
● Staff never compromised care calls and stayed to complete all required tasks. In the event of a call running over time, the office was contacted and arrangements made for any subsequent calls to be covered. Similarly, if a staff member was running late, a call was made to the person and if needed, another member of staff sent to support. A person told us, "They've always turned up on time." Another said, "They are sometimes late but it's not their fault and I always get a call."

Using medicines safely
● Some people were supported with medicines. People were seen to progress from full support, to reminders to people then taking their medicines independently. In all cases we saw this progression had been made. A person told us, "My wife helps me with my pills but they (staff) will always check." Another said, "I was pretty independent (with medicines) from week two."
● The majority of staff had been trained in giving medicines. A staff member told us, "I've never had any issues but if I was ever in doubt, I'd call the office." We observed a member of staff supporting a person with their medicine. This was achieved at the pace the person wanted and was followed by the staff member correctly completing the medication administration record (MAR) forms.
● The service used a number of medicine forms. These included specific risk assessments, protocols, separate forms for the application of creams and the MAR forms themselves. We saw MAR charts, all had been completed correctly showing the date, time and quantity of medicine given as well as the name and signature of the staff member administering.
● 'As required', (PRN) medicine and homely remedies had separate protocols. PRN are medicines given in response to people's needs for example, pain relief. Homely remedies were medicines that could be obtained over the counter. Staff were aware of these protocols and told us that for any non-prescribed medicine they would double check with a senior support worker.
● Medicine errors were recorded and trends analysed. A process was in place for addressing staff errors which began with one to one conversations and escalated to staff being prevented from giving medicines until they had been retrained.

Preventing and controlling infection
● We were shown a small kitbag that staff carried which contained gloves, aprons, shoe covers and de-sanitisers. Staff told us there was never a shortage of protective equipment and we observed staff using their equipment during care calls. People told us that staff always used protective equipment.
● Some people were helped with food and drink preparation. Staff had received training in food hygiene and knew how to prepare food and drinks safely.
● Staff looked for any signs of infections, soreness or people feeling unwell. A person was wearing a limb support that had not been seen before by the support worker. The person explained that a physiotherapist had given them the support as a temporary measure to help with exercises. We saw the support worker ask questions and record their findings.

Learning lessons when things go wrong
● Accidents and incidents had been recorded appropriately. Trends were analysed and any learning taken forward. A staff member had accidently hurt themselves in the kitchen which resulted in a new management instruction requiring staff to wear protective gloves.
● Trends were quickly identified. Every three months a thorough audit took place of accidents and incidents across all three of the service locations. From this analysis the service had introduced a new way of

addressing medicine errors. Where no harm was caused, a documented conversation with staff took place and where there had been potential for harm, the staff member was removed from administering medicines until re-trained. The service employed a pharmacist to deliver training to support the safe administration of medicines.

Good

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.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

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

- People were referred to the service from local hospitals, GP surgeries or from community nurses when it had been identified that people required support at home to help them re-gain their independence. Pre-assessments were carried out by senior support workers or managers and would involve the person, their relatives or loved ones and professionals. A professional told us, "An intermediate care coordinator liaises with local hospitals and meets the service each day to discuss potential clients."
- Pre-assessment documents covered the entire range of people's care and support needs and their reablement targets. All areas were covered for example, nutrition, communication, medication, faith and cultural needs. Everyone then had a key-worker assigned to them, a senior support worker, who was responsible for reviewing progress against aims and goals. After a person had been taken on by the service, weekly reviews took place. A person told us, "My care package started at three calls a day. They review it all the time."
- The service used Waterlow assessments, which measured people's skin integrity and the malnutritional universal screening tool (MUST). MUST measures people's risk of becoming malnourished.

Staff support: induction, training, skills and experience

- The service provided a robust and supportive induction process. A senior member of staff had responsibility for induction and told us that they were involved in all stages of the process, including the application and the interview which enabled them to ensure consistency across the service. New staff were assigned a mentor and for the first three months, new staff completed training and were given opportunities to shadow more experienced staff. They were encouraged to work towards the care certificate and spent the first year on probation with regular reviews of their progression. They were provided with a welcome card with key names and phone numbers which staff told us they found helpful.
- Staff told us that the induction was very good and provided them with the knowledge and skills to do their job. A staff member said, "Very comprehensive and very supportive. They give you extra time with things if you need it." Following the successful completion of their probationary year, staff had monthly supervision meetings and annual appraisals. Managers also conducted regular checks on staff safe practice. A staff member told us, "Supervisions are a two-way process. I am given chance to talk about everything."
- Training was delivered either face to face or online. There was some responsibility on staff to keep themselves up to date with training bur reminders were sent when refreshers were due. Staff had received training in safeguarding, mental capacity, moving and handling and equality and diversity for example. The training manager told us that face to face training was an opportunity for staff reflection and exchanging

best practice.
● Staff told us they thought the training provided was very good and that they had opportunities to request training that they felt would be helpful to them. A staff member said, "The training is very good." Another said, "We keep ourselves up to date and can make requests." Staff personnel files confirmed everything we had been told with regard to staff induction and training.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutrition and hydration needs were met. Most people had support from relatives or loved ones with food and drink preparation, however staff did help some people to prepare meals. A common rehabilitation goal for people related to regaining independence in the kitchen. This support was provided with progress monitored.
● People told us they felt supported. Comments included: "I have small meals. They help me but I'm doing much more myself," and, "I can do some of the preparation now." Staff told us they made sure that people had enough food and drink and that if they noticed people were not taking enough, they would record it and report to a GP or nurse. We observed a staff member supporting a person to prepare their lunch. The person sat on a perching stool and was able to prepare a sandwich.
● No one using the service at the time of the inspection had specific dietary needs. All staff had received food and hygiene training.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked closely with colleagues from the health service who provided physiotherapy or occupational therapy to suit people's rehabilitation needs. By working together, people's mobility and strength improved and this in turn improved their ability to manage their own personal care and other care and support needs.
● Staff were quick to identify changes to people's health. We saw in a person's care plan notes relating to a person suspected by their support worker to have developed an infection. A community nurse was called and tests were carried out confirming the support workers suspicions. The person's medicine regime was altered as a result.
● Most people completed successful rehabilitation during their six weeks with the service. Some however required ongoing support beyond that time. A member of the team was responsible for planning with other agencies and professionals to provide that ongoing support if needed. Ongoing packages of care, help with finance and help with supportive technology for example lifeline (emergency call device), were provided to people.
● Professionals spoke well of the partnership working employed at the service which led to best outcomes for people. A professional, referring to this working arrangement told us, "This role has aided the flow of clients from acute hospitals back into their home safely."

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Most people engaging with the service had mental capacity. Some were living with an early diagnosis of dementia and displayed variable capacity. Everyone was able to make day to day decisions about their care and support needs.
● Staff had received mental capacity and dementia training and understood the issues especially regarding obtaining consent form people. A staff member told us, "I'll always approach people and say, 'what would you like me to help you with?'". Another said, "I'll always give people enough time to decide and answer. It takes as long as it takes."
● Because mental capacity assessments were rare, one member of staff had been given responsibility for completing assessments if required. The staff member told us, "I look at specific decisions. Assessments are always done with people and relatives and then we can hold a best interest meeting if we need to." They told us of a recent assessment concerning a person's understanding of being moved to a nursing home. The assessment concluded that the person had capacity to understand this decision.
● This same staff member told us that they had in the past had to help with securing a community DoLS although none were currently in place.

Good

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.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People told us that they were treated with kindness and understanding by staff. Comments included: "Friendly approach," "They are supportive and caring," "They are wonderful, careful and friendly" and "They are absolutely caring."
- We observed staff supporting people in their homes. Staff were supportive and empathetic. During mobility exercises, a staff member encouraged the person, counting out the number of repeated moves, asking if they were alright and checking that they were not getting too breathless. The person responded by thanking the staff member and responding to their guidance.
- The service had an equality and diversity lead. Exploring people's equality needs formed part of the pre-assessment process. A staff member said, "I talk to them about issues and respect how much people want to tell us." The lead staff member told us that they had attended a 'confident with difference' forum and would be rolling out training to all staff. Confident with difference is a resource that empowers care staff to understand diversity and promote difference.
- Care plans reflected people's cultural, spiritual and equality needs. People who used the service had a variety of religious beliefs and the registered manager told us that care calls had been arranged and in some cases moved, to accommodate people's religious activities.

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

- The pre-assessment formed the core of the support plan. People were involved in this process and were able to talk through all aspects of their care and support needs. This included the support they received from their family and their aims and goals which were personalised to each person. Relatives loved ones and professionals were involved in this process.
- People could make choices about the support they received. A person told us that the previous day they were too tired to do the exercises when the staff member visited, and they decided to do them later in the day. Staff accommodated this change. Another person said, "I've had to cancel my visit later today as I've got a GP appointment. They are very helpful with that." A staff member told us, "We will always give people choice. It takes as long as it takes."
- Staff recorded daily progress made by people in each of their goals. Staff told us they could suggest updates for people's care plans based on changing needs. Weekly reviews carried out with people asked: 'What has been achieved this week? Has anything prevented me for achieving goals? And, what do I want to achieve next week?'

● Confidentiality was respected with care plans and any personal information kept securely either online or in locked cupboards.

Respecting and promoting people's privacy, dignity and independence

● Staff respected people's privacy whilst maintaining safe care and support. A staff member said, "I always give them privacy if possible and safe. If they are doing things for themselves, I'll say, 'you wash what you can and I'm here if you need me.'"

● Staff understood the importance of maintaining people's dignity. We saw a member of staff supporting a person with their mobility. The person said, "This can be so humiliating." The staff member took the person's arm and reassured them. They then supported them through moving exercises and said, "Just take your time, everything is alright. This will make you better and get you back on your feet."

● A primary focus of the service was helping people re-gain their independence so that they could continue to live in their own homes. Progress was clearly recorded in people's care plans. A person told us, "I'm getting my independence back," another said, "I should be back on my feet really soon." Staff were aware of the significance of encouraging people to be independent. A staff member said, "We show people techniques to help them," and "We have their best interest at heart, we do everything in an empowering way."

Good

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences. Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Care plans were person-centred and staff knew people well. The service was moving to a new computer-based system which reduced the amount of time staff had to spend on paperwork and sped up the process for logging attendance at a call and recording medication.
- The service used a keyworker system for reviews of people's care and support needs. Senior support workers held keyworker responsibilities and got to know people well over the six-week period. We saw staff interact with people. People and relatives were pleased to see the staff, greeting them, smiling and joking with them. During one interaction the person was talking about their grandchildren and the staff member knew their names.
- Care plans had a key information page which provided details of people's family and friends, who to contact in an emergency and their preferred names. It also contained important information relating to the person and their health and support needs. A professional said, "It's clear that they get to know people well and quickly. They are able to put a package of care in place really quickly."
- People were encouraged to maintain and pursue their own interests and hobbies and care calls would be arranged to fit in with people's social activities and commitments.
- For some people accessing the community was an important goal. We tracked one person's progress, where they were initially unable to go out. In following weeks, the person had achieved visits to a local cinema and to a local pub. During the warmer weather, people were encouraged to make use of outdoor spaces they had such as patios and gardens.

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.

- People using the service were able to communicate their wishes to staff. Some people were living with early diagnoses of dementia and some had sensory needs for example, their hearing or sight required aids.
- Staff knew people's communication needs and responded appropriately, taking time with people and speaking clearly and directly to people. A person told us, "They take their time with things, explain slowly everything that is going to happen."
- The service had invested in a variety of items that were designed to help people remember important

tasks or events throughout the week. For example, a talking lid on a medicine dispenser to remind people when to take their medication. Also, bin collection days clearly labelled on calendars, food charts showing when food went out of date and large print medication charts that served as reminders to people. Flashcards were also available if needed.

● The local authority sensory team attended team meetings and had helped to introduce braille stickers. These were information for people who were unable to see clearly that could be stuck to kitchen equipment for example a microwave. This helped people to find their way around their kitchen.

Improving care quality in response to complaints or concerns

● People told us they knew how to raise complaints and concerns if they needed to. Comments included: "I have no issues with complaints. I had a pack of information that explained the process," I've never had to complain but I'd know how to" and "I'd speak to my support worker first."

● The service had a complaints policy that was accessible to everyone. A copy of the policy was included in the 'service user pack' of information, placed in everyone's care plans in their homes. The policy and guidance about making a complaint was explained to people as part of the pre-assessment process.

● There had been no complaints made about the service during the 14 months before our inspection. Nevertheless, complaints from across all three JCR locations were reviewed by managers regularly to see if any trends were developing and what, if any, action needed to be taken.

● A separate file contained a protocol for addressing minor concerns. These issues had been documented and dealt with appropriately.

● The service had received numerous compliments some of which had been written on memo paper and hung on a 'compliments tree' in the middle of the office. The theme of the majority of the compliments related to successful rehabilitation and the caring and patient manner of staff.

End of life care and support

● The nature of the service meant that dealing with people who were end of life was not routine. However, most staff we spoke to had experienced dealing with people who were at the end of their lives and all had received training.

● Staff knew the important aspects of care for people who were end of life. A member of staff told us, "It's important to empower them, give them a voice somehow. Make them comfortable and listen to their wishes." Another said, "Show empathy. Give them time to do whatever they want. Be tactful in what you say and support the relatives." Staff told us they were supported by managers if they had dealt with an end of life situation.

● Most care plans contained 'Respect' forms. These were forms completed with people, with input from professionals, giving details of their future care wishes should they become incapable of making decisions in the future.

Good

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.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

- The registered manager promoted a positive culture at the service and empowered staff to achieve positive care and support for people. The registered manager had introduced champion roles for key areas of work for example, equality and diversity, safeguarding, moving and handling and staff induction.
- Champions were given time to learn more about an area and to feedback learning and best practise to all staff. For example, the moving and handling champion had helped to introduce a new piece of equipment that supported people following a fall, making people as comfortable as possible.
- Working with staff, the registered manager had developed a 'mission statement' and 'values'. These reflected the person-centred approach to people highlighting the importance of respect, empowerment, support and working together.
- Care plans reflected the positive approach from staff. We observed a review with a person where the person emphasized their need to improve mobility and this was recorded in the care plan with clear indications being given to other staff about the immediate rehabilitation needs.
- Staff told us that they felt supported by the registered manager and that the service worked well as a large team. A staff member said, "The registered manager is excellent. There is always two-way feedback and positives and negatives are discussed." Another said about the registered manager, "Very supportive. Can talk to them whenever you like." Another told us, "They (registered manager) are very supportive. They would come out with me anytime if I needed support."

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. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager understood their responsibilities under the duty of candour. The service had a duty of candour policy which described the process following an incident. This included informing those involved, providing support, being honest and offering an apology if appropriate. This process had been followed and documented in the accidents and incidents, minor incidents and concerns and complaints processes.
- There is a legal obligation on registered managers to inform CQC of significant events that happen at their service. This obligation had been fulfilled. Details of the last CQC report were clearly displayed in a communal area of the service and was displayed on the service website.

● The registered manager kept themselves up to date with current best practice by attending forums and meetings for all managers. They visited CQC and local authority websites. Managers from the service had visited other services across the country where high ratings had been given by CQC. This was done to gain knowledge and examples of best practice. For example, the appointment of a technology champion, responsible for all information technology at the service.
● Clear roles and responsibilities among staff were observed, with senior support workers responsible for weekly reviews and each having champion and key worker responsibilities. Care workers supported people with specific needs only when fully trained and having completed their probationary period.
● The registered manager maintained oversight on auditing processes. A monthly quality assurance report was produced covering for example, training, recruitment, accidents, complaints and medicines. Trends were analysed and opportunities explored for improving the service. For example, they had adopted a new process of checking online for driving licence endorsements for staff. This had greatly reduced the waiting time for new staff beginning work at the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager sought feedback from people, relatives, staff and professionals. People were given daily opportunities to feed back about the service and at the end of their six-week rehabilitation, a more formal meeting took place where feedback was captured. Feedback was reviewed and changes made where appropriate. For example, a concern was raised about sufficient food being provided for a person who was learning how to prepare food for themselves. Fluid and food charts were immediately put in place and a referral made to the GP.
● An annual forum for people took place. Feedback from this forum led directly to the inclusion of a form in the home care plan which provided details of how to return equipment.
● Staff could feedback about the service face to face at supervision meetings, during team meetings or through an anonymous suggestion box. As a result of staff feedback, a working group was set up to look at paperwork. This led to a review and an updated, clearer, initial front page to care plans. Staff told us this was a huge improvement on the previous system.
● There were a range of meetings run by the registered manager which kept staff informed of daily and weekly developments and changing care and support needs for people. Staff told us they were kept well informed. A staff member told us, "There are regular team meetings and chances every day to speak to supervisors."
● A senior support worker had built a folder containing community contacts that staff had come across over time and this served as a helpful point of reference when searching for additional support. For example, a church in a rural area provided volunteers as a 'sitting service', spending time talking to people who were otherwise alone. Another person was put in touch with a local fishing club and another with a voluntary service that offered advice to people about paying household bills.
● Relationships had also been established with places of worship in the area that were used by people.

Continuous learning and improving care
● We were shown a service innovation file. This contained good news stories and learning that had been taken forward by the managers from incidents that had happened. An example was a person who had multiple falls and whose confidence to mobilise was severely affected. The service arranged for perching stools and mobility aids. Following regular visits form the service, both mobility and confidence had improved. Another person was experiencing periods of loneliness and depression. The service taught them how to access games and puzzles on an iPad.

Working in partnership with others

● The service had established strong relationships with statutory partners. All referrals were received from partner agencies, hospital, GP's and community nurses and pre-assessments were conducted usually with professionals' present. A professional told us, "I work with the hospitals and JCR assist us enormously with discharges, maintaining a regular flow of clients." Another said, "We work closely with seniors and support workers. We support their competency training and have joint management meetings."