SCC Adult Social Care

East Surrey Area Reablement Service

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

East Surrey Reablement Service provides short-term support and personal care to people with the aim of enabling them to live independently in their own homes. The service also supports a hospital discharge assessment programme. The service provides reablement and personal care to older and disabled people living in their own houses and flats in the community. At the time of the inspection there were 41 people receiving the service.

At our last inspection in March 2016 we rated the service as good. Since the last inspection the service has matched the area they cover to that of the community health service (Reigate, Redhill, Horley and Tandridge) to facilitate effective joint working with health professionals.

At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were sufficient staff to deliver all the care hours that were commissioned and needed by people. There were safe staff recruitment practices in place. The team was being guided through a time of change in the service, following the strategic decision to integrate reablement with the community healthcare service.

People were kept safe from abuse because there were robust safeguarding procedures in place and staff were aware of potential harm and knew how to report it. The risks to people (and for staff) in the person's home were identified and recorded at the outset of any care provision. There were plans in place to reduce the risks and staff knew what actions to take. Incidents and accidents in the person's home were recorded and reviewed, and learning was discussed with staff. Staff also followed safe practice to reduce the spread of infections and kept people's homes clean.

Where people were assisted to take their medicines, this was being done safely and was closely monitored by managers. Following a medicines error, there had been staff meetings and action to ensure learning on the correct recording and administration procedure had taken place.
Staff received training to administer medicines.

People received an assessment in line with good practice before any service was provided. This was discussed with the person and their family and their support plan included specific goals for recovery or independence that had been agreed with the person themselves. These were kept under review as people

improved or if further needs were observed.

Staff had received a good induction and had access to mandatory refresher training as well as a wide range of other more specific and relevant training to be able to carry out their reablement role. Staff were supervised on a regular basis. They felt able to ask for support and advice at any time to meet the needs of people.

The service worked closely with healthcare services which meant that people's health and rehabilitation needs could be addressed sooner and so that the outcomes for people's health and well-being were improved. Staff worked together and fed back to their team leader any new concerns about a person that needed to be addressed.

People's consent was sought, prior to staff providing any support and care. Staff were aware of the responsibilities and worked in line with the principles of the Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People were treated with kindness and respect. Staff worked in partnership with people to agree their goals and to encourage their independence. Positive relationships were formed quickly and, where people required long term care, a personal handover was given to the new agency.

People's personal goals were included in their care and support plans. The service responded to individual requirements wherever possible. People's concerns were responded to personally. People knew how to complain but there had been no formal complaints in the last year.

The service had a clear and well-defined purpose, which the managers and all staff supported and able to promote. The service worked with, and alongside, other council managed care services and provided a flexible approach to meeting priority needs, for example during winter pressures. There was a positive staff culture in the face of adapting to change and meeting any challenges due to planned integration with healthcare.

There was a system in place to ensure regular quality assurance checks. Medicines audits and observed visits of staff in the home were also undertaken. Information on service performance and risks was reported to the council's service delivery team at least once a quarter. Statutory notifications to the CQC were sent correctly and oversight was maintained by senior managers.

The service was working collaboratively with health and social care services and relied on strong links with other care agencies, having a short-term and focused offer. These partnerships and relationships meant that people received joined up care provision at a time when they needed it.

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

East Surrey Area Reablement Service

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 14 and 15 November 2018 and was carried out by one inspector. The provider was given 48 hours' notice of the inspection visit because it is a short term domiciliary care and reablement service. We needed to be make sure someone would in the office. We also needed to get people's consent for us to visit them at home or telephone them as part of the inspection.

Before the inspection, we reviewed the information we held about the service. This included the previous inspection report and notifications since the last inspection. Notifications are changes, events and incidents that the service must inform us about. We used information the provider sent us in their Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we visited three people and their relatives in their own homes, asked about the reablement support they received and looked at their care records. We asked for medicines records for two other people and spoke with four people by phone. We also spoke with two reablement assistants, one team leader, the registered manager, a senior manager and the registered nominated individual for these services in Surrey.

We looked at five support and care plans, risk assessments or medicines records. We also saw policies, notes of meetings held and evidence of quality monitoring that demonstrated how the service was managed.

We later received feedback from two health and social care professionals about the service.

Good

Is the service safe?

Our findings

People felt safe with the care they received in their home. One person told us, "I was terrified when I came out of hospital. They make sure I am safe… I trust all the carers." Another person said, "Yes, I feel safe with them. I come down the stairs and they support me as I only have one handrail."

People were involved in managing the risks. Risk assessments signed by the person, were in place. They addressed safety issues whilst supporting people to be as independent as possible. For example, a person who needed a walking frame to mobilise wanted to safely carry a hot drink as well. This was resolved through the provision of a 'caddy' that clipped onto the frame with a cup holder. An assessment was used to determine the level of support a person needed with their medicines. A staff member told us, "We try not to take this away from the person, if they've been managing before, but they may need to relearn if they've been in hospital." Any actions required by the reablement assistants to reduce moving and handling risks were recorded. One person's plan said, "Please make sure I use my frame and supervise all transfers onto stairlift."

People were also protected from the risk of fire and falls by the preventative actions of the service. Evidence of a home risk assessment where any fire and environmental risks were identified, was seen. If needed, a referral was made to the fire home safety service to install or check there was a working smoke alarm and carry out other safety checks in the home. People were advised about telecare options in their home, and encouraged to get a pendant alarm if they were at risk of falls. A staff member said, "I make sure I look at the risk assessments when I go in at the beginning and then every time. It's the first thing we do."

Where people were being helped to take their medicines, this was done safely. With the person's consent, their doctor was informed of the reablement care to be given and asked to authorise and provide the correct list of medicines. This was to reduce mistakes that may occur when people came out of hospital with new or temporary medicines. The exact help the person needed was documented and a medicines administration record (MAR) and red folder was set up. The MAR charts were reviewed each month by a team leader. One person's medicine had been changed recently. Their relative told us they had informed the service and, "They came to the house to check this first." The team leader sought confirmation from the doctor before updating the MAR. Another person had been refusing some 'as required' medicines for several weeks. This was taken back to the doctor for a review.

People were protected from the risk of abuse. All staff had received safeguarding vulnerable adults training as part of their induction and then completed refresher training every two years. The safeguarding policy for service delivery in Surrey had recently been updated, so staff had been briefed on this and reminded of their responsibilities. One staff member told us they would, "Be aware and check that person is being treated well. If not, I would be on the phone right away." The policy also defined when a medication error or a missed call should be raised as a safeguarding concern.

People were protected from the spread of infection due to safe staff practice. Staff confirmed they had access to gloves and aprons and hand gel to support cleanliness. One person told us, "I've noticed they

always put gloves on." Uniforms were provided for staff going into the homes. There was a record that staff had received induction training on infection control and food safety hygiene and received online updates about safe practices in the community setting.

There were enough reablement assistants to provide people with the agreed level of care and to support them safely. Staff rotas for each week demonstrated that all calls to people were being covered with travel time provided for. There was a contingency for short notice referrals and for a flexible response when there were unexpected pressures on care services. A professional said, "They manage well under pressure. Our clients do not wait long for a service." The reablement assistants received a daily update via secure email to their phone with any updates to their rota to reduce any chance of a missed or unnecessary call. There were two teams covering different areas, and staff could be asked to travel to the other area to cover sickness if needed.

There was safe recruitment of staff. Staff folders demonstrated that they were suitable to work with people in their homes. It was evident that two references had been obtained, and proof of identity, address and a Disclosure and Barring Service (DBS) certificate were in place. A DBS check allows employers to see if an applicant has a police record for any convictions that may prevent them from working with people who use this type of service.

There was a record of accident and incidents that occurred with people receiving a service. The log was checked by the team leaders for any patterns and learning from these. For example, following a medicines error, a best practice staff meeting had been held which focused on medicines administration and the correct recording on the charts. The registered manager told us. "We will keep this high on the agenda. The team leaders will follow up when they notice any gaps on the MAR." Where a person was unable to use their bath safely, and an accident was logged, the occupational therapist was involved to look at safe practice and the need for rails.

Good

Is the service effective?

Our findings

People's needs were assessed prior to receiving a reablement service to ensure the service was suitable and the right level of support could be provided. Most people were coming home from hospital. The service was developing a 'trusted assessor' route with health and social care professionals so that people did not have to repeat too much information and their needs could be met sooner. People were visited in their home by two staff to discuss the assessment and decide the outcomes they wanted. One person told us, "They came to see me, and we thought I should have someone coming in each day to begin with."

People were supported by staff who had good access to training and were developing their knowledge and skills. There was a three week induction for all new staff, including essentials such as moving and handling of people, first aid, reporting and recording, safeguarding and inclusion. This was followed by the completion of the Care Certificate which is a nationally recognised standard for care workers. Staff had access to online refresher training as well as further teaching on health issues to prepare for the changing needs of people and the new service demands. There was a training log for each staff member and there was a plan to ensure they remained up to date. One staff member said, "We have loads of great training. We do e-learning now. There are a lot of courses and we are given time to do them in the office. I recently did something on lone working."

Staff were supervised regularly by a manager and appraisals were in place. One staff member told us, "Supervision meetings are every three months and the appraisal every six months. We also have observed practice in the home by the team leader."

People benefitted from the multi-disciplinary setting that the reablement service was part of. There was good communication with doctors, community nurses, and other professionals which meant that people's rehabilitation, equipment and health needs were met sooner. One person had become suddenly unwell and bed bound. The team leader had liaised with the family about getting medical help. The reablement assistant had taken samples to the person's doctor to facilitate the diagnosis. The team leader was making sure other services were aware. They said, "Everyone is kept in the loop." Another person had been referred to the reablement service by their doctor to prevent further health decline. They told us, "I stopped wanting to go out or do anything. But they have got me motivated."

The service was working towards closer integration with health services. A professional told us there was, "An enhanced service offering health therapies when needed as well as the on- going reablement service." Reablement assistants had been trained to assess and provide smaller items of equipment to enable people at home. Another benefit was joint care provision for some people. One person was being seen by the physiotherapist three times as week as well as receiving personal care support. They said, "I had some rehab in a hospital. They told me when I left I could have this help and continue to improve at home."

Technology was used to support effective service delivery. For example, staff had access to mobile phone applications to assist them with timeliness of care calls and to retain secure information about the people they were supporting. People were supported to get access to personal lifelines and special communication

aids to support their independence.

People's nutrition and overall wellbeing was monitored. People were given help to prepare their meals and eat in a healthy way. They were encouraged to be involved in the meal planning and preparation wherever possible. Where a person was not interested in food, or showing signs of decline, a referral to the dietitian was made. One staff member said, "If a person is not eating enough we can get the doctor involved. We are vigilant. We leave people drinks and snacks, make a hot drink or leave a flask if they cannot use the kettle."

We checked whether the service was working within the principles of the Mental Capacity Act 2015 (MCA) and whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. People's consent was sought in line with the principles of the Mental Capacity Act 2005. In people's homes there was evidence that consent had been discussed with people and documents were signed showing their agreement to care being provided and to their information being shared when required. Staff understood the need to enable people to make decisions and to act in the least restrictive way. Where a person's mental capacity to agree to the support was in question, the service asked for social work intervention. Depending on the issues with the person's decision making, this may mean the person was not able to benefit from a reablement service.

Good

Is the service caring?

Our findings

People were treated in a caring way by staff, with kindness and respect. One person said, "I like them all. They are kind and caring. I can't fault them." We read some recent feedback which said, "I cannot express how helpful and kind the reablement team were." We observed that the reablement assistants interacted with respect, compassion and with humour to bring the best out of the people. One person said, "They don't take over, I look on them as friends who are there to help get me going again."

People had emotional support when needed. Staff showed an awareness that people had been through a traumatic time and a period of ill health. One staff member said, "We start with where they are, we are there to support but not disable them. Our support evolves with them." A person said, "They've helped me survive!" This person wanted to see their reablement assistant more often, but recognised it was due to feelings of loneliness and social isolation. Alternative services and activities were discussed with them to help relieve this.

People were asked at the first meeting to score their own wellbeing, on a scale of one to five. This helped the service to gauge the person's mood and needs. Where a person rated themselves with low wellbeing we were told, "We keep a closer check on them and may involve the GP with their permission."

People were involved in deciding their own reablement goals and in any decisions about them and their care. One person said, "We plan the programme together." Another person told us, "It was all explained to me and I had my say. They are giving me confidence to do more now." The family or partner of a person often took part in the assessment and support planning. A relative said, "They involved us in the planning and they review every two weeks." The notes in the home were available for the person and their family to see, and to write in if they wished. Information was given about the service aims and this could be provided in braille, on a CD, or in another language.

People's independence was promoted. This was a core objective of the service. One staff member explained, "We are all about helping people regain skills. At first it is difficult to stand back and not do everything for people. But we know it works. We encourage and help them do as much as possible. Most people are re-abled. If not, and they need more care, we always stay involved until this is in place." Staff prepared people for when their support would come to an end, and provided a personal handover to other care workers where this was needed.

People's privacy and dignity was respected. People who we spoke with confirmed this. One said, "Yes, they always treat me with respect." A relative told us, "If they use anything they put it away and they always tidy the bathroom." A staff member told us that they, "Carry a pair of indoor shoes, for when it is wet or muddy," being mindful of people's homes and carpets. If anyone requested not to have a male carer in their home this was respected by the service.

People had been asked about their experience of reablement. A healthcare professional told us that the results showed the service was, "Above a national benchmark, including service users' feeling they were

treated with dignity and respect throughout."

Good

Is the service responsive?

Our findings

People received care in a personalised way that responded to their assessed reablement needs. This was evidenced in people's support plans, and goals that had been agreed with the person were written in a straightforward way. For example, people were asked, "What I feel is causing a problem," and, "What I would like to achieve." Individualised outcomes were agreed. One person's plan said, "To regain my stamina and strength and manage my personal care." We talked to the person and their family and they thought that progress was being made. Another person told us that they wanted to be able to walk more confidently around the
home and, longer term, to walk outside again. We saw that this had been documented as a personal goal and the daily notes recorded any improvements.

People's preferences and choices were listened to and understood. One relative told us, "He is very slow when he wakes up. They let him do things at his own pace." One person said that the staff "Always call me [first name] which I like and prefer." Another person explained how the staff had adapted their style since coming, saying, "I need to be told sometimes, I like to argue." The reablement assistant said, "I realised [name] needed humour and banter, so this is how I communicate now." Staff rotas included instructions to suit people's requirements, for example for an early call or a male carer was needed. However, the service did not guarantee the exact time of calls. The team leader said, "We are a short-term service and we have to be flexible to meet demand. But we do try accommodate people's wishes."

People's communication needs were considered when people first started using the service and this formed part of the initial assessment. Some staff had attended a training session that day, to learn about how technology and new equipment can assist people with sensory impairments to have greater independence. One member of staff told us how they had worked with a person with word finding problems. They said, "The speech and language therapist helped them with a book that has pictures and they used this to communicate better with us." There was also access to an interpreting service where a person's first language was not English, and a family member was not available to help.

People's cultural and religious requirements were considered. One staff member said that, "Some people have special needs, and it takes them longer to wash and dress due to rituals or their religious practice. We have to meet these wherever possible." Where meals were prepared, people's personal and cultural wishes were respected.

There was a complaints process in place, the details of which were made available to people and a leaflet was placed in their home. There had not been any formal complaints in the last year. A person told us, "I am very good at complaining… and would do it if needed. But I am positive about their help." The service was accessible to people and families in responding to concerns. For example, a relative had rung the office that day to request a later morning call for her mother who was not sleeping well and was too tired when the staff arrived. They told us, "They are easy to call."

The service had not supported anyone with end of life care recently. There were occasions when they were

asked to provide personal care in such situations. The registered manager told us, "We have received end of life care training from our health colleagues. We also have a good working relationship with the local hospice and community nurses."

Good

Is the service well-led?

Our findings

The reablement service demonstrated a clear purpose and strategy to provide a well-defined care and support service that enabled people to increase their levels of independence at home. Staff were clear about their role. One said, "We are well led, and we all believe in what we are doing." A care professional told us there was "Visibility of management which offers clear direction and leadership."

There was a positive culture and we saw there was good communication between the managers and all staff. The service worked flexibly and, at times of crisis or increased demand, had responded. There was an openness to embrace the changes which would come with the decision to integrate with health services. New integrated service job roles were being developed which would impact on staff in the near future. One staff member told us,"There's lots of change at the moment, but it's for the better. The benefits are for the people we help." The registered manager acknowledged there may be some cultural challenges ahead to overcome but there was a positive approach. They said, "We have strong leadership, and we are not a service that would ever give a blanket 'no'."

The reablement service worked in line with a nationally agreed approach and outcome measures for similar services that, "Help people recover, regain independence and remain at home." The service had been included in a national health benchmarking audit. A healthcare professional said, that the results evidenced that people, "Receive an efficient service with improvement in rehabilitation at discharge."

There was a county wide governance and accountability process in place with quarterly internal monitoring on key indicators such as staffing levels, training compliance and supervisions, and medicines errors, accidents and incidents and complaints. Information from this service fed into the council's service delivery team reports and ensured there was oversight of any incidents and statutory notifications to the CQC. The registered manager attended the quarterly oversight meetings and had been able to bring back learning from other services. For example, staff files had needed reviewing and action was taken to bring staff supervisions up to date.

Earlier in the year an audit was undertaken with the service using the CQC measures for a safe service. This had identified improvements for the reporting of accidents and incidents, and that some staff needed refresher training in safeguarding. Medicines charts were also amended to support improved recording of the reasons when a medicine was not taken.

Staff had the opportunity to be involved in the development of the service. For example, they were involved in a workshop to co-design the paperwork and to explore other changes that were needed because of joining with health services. All staff received a weekly update from their team leader to ensure they were fully involved and aware of any decisions or changes in service. There were regular best practice meetings being held which meant staff were involved in discussing how they could implement improvements. One staff member said, "Almost every month we attend meetings where important things are discussed, for example, we looked at improving medicines recording and the recent changes to safeguarding."

People's views were sought. The service sent out a survey to a sample of 20 people each month to give people and families a chance to feedback their views on the service. Every six months the feedback was collated across the county to analyse. The East Surrey area had the highest number of respondents last time with 36%. Following the most recent analysis, one action was to, "Consider if more can be done to support people to access community support?" Feedback was shared with staff and any negative comments used as learning points. However, it had also been noted that some people did not answer all the questions and may not always understand their purpose. The registered manager said they would like to adapt the surveys to be more "person friendly." The service manager told us, "We are exploring other methods of getting people's views."

The service had developed strong partnerships with the local acute and community health services, at both an operational and strategic level. As a result, people being sent home from hospital were supported in a timely way and staff engaged in joint training packages with the community health provider. Through the planned integration and co-location of services, over the next six months, the aim was to ensure that more people got the reablement and preventative help from the right professional service to reduce any duplication. The service also worked collaboratively and flexibly to handover care to other agencies when this was needed for those people who needed longer term care.