Rehab Without Walls Limited

Rehab Without Walls

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	**Outstanding** ☆
Is the service effective?	**Good** ●
Is the service caring?	**Good** ●
Is the service responsive?	**Good** ●
Is the service well-led?	**Outstanding** ☆

Summary of findings

Overall summary

This inspection took place on 15 and 18 January 2016 and was announced.

Rehab Without Walls are regulated to provide personal care to people living in their own homes. They provide a bespoke case management service for people who have a brain or spinal cord injury or catastrophic injury. They support individuals and their families affected by brain injury by providing access to the services and support they need. At the time of our inspection there were 70 people using the service nationwide.

The service had a registered manager. 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 was a good emphasis by the provider and staff on protecting people from possible harm. Staff knew how to report any concerns about people's welfare to the appropriate authorities. People were empowered to take positive risks, to ensure they had greater choice and control of their lives. The positive risk taking approach demonstrated by the service showed that they respected people's right for independence, their right to self -determination and their right to take risks.

There were appropriate numbers of staff employed to meet people's needs. People were supported to safely recruit their own staff, either by the service or through a care agency.

There were suitable arrangements in place for the safe management of medicines.

Staff received good support and training and were knowledgeable about their roles and responsibilities. They were provided with ongoing training to update their skills and knowledge to support people with their care and support needs. People's consent to care and treatment was sought in line with current legislation. People were supported to eat and drink sufficient amounts to ensure their dietary needs were met. Staff supported people to attend healthcare appointments and liaised with their GP and other healthcare professionals as required

People were looked after by staff that were caring, compassionate and promoted their privacy and dignity. The service responded to complaints within the agreed timescale.

People's needs were comprehensively assessed and intervention and treatment plans gave clear guidance on how people were to be supported. Care was personalised so that each person's support reflected their preferences. We saw that people were at the centre of their care and found clear evidence that their care and support was planned with them and not for them. People were supported to attend a range of educational, occupational and leisure activities as well as being able to develop their own independent

living skills.

People, relatives and staff were very positive about the leadership of the service and about the support they were able to provide for people with an acquired brain injury. Staff demonstrated a passion and commitment to providing excellent care that supported people to be independent. People told us the service engaged consistently and meaningfully with families. Relatives that we spoke with reported feeling involved and being part of an extended family. They told us that the service was responsive, open and transparent and they felt actively involved in all aspects of their family members care. We found the service had a positive culture that was person centred, inclusive and empowering.

We found regular quality monitoring of the service had been undertaken. In addition to continuous self-monitoring, the service became the first UK case management company to be awarded a three year accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) and the only company to be accredited for the combined adult and paediatric case management and brain injury case management programmes. This is an internationally recognised award as proof of their commitment to providing a quality service to people who have an acquired brain injury.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Outstanding ☆

This service was safe.

People were protected from harm. They had confidence in the service and told us they felt safe. Staff were knowledgeable about the principles and reporting requirements of safeguarding people from abuse.

The provider and people using the service worked together to arrive at innovative and creative solutions to ensure people were able to take positive risks.

There were enough staff to ensure people received a reliable and consistent service.

People's medicines were managed safely by staff who had received appropriate training.

Is the service effective?

Good

This service was effective

Staff had the specialist knowledge and skills required to meet people's individual needs and promote their health and wellbeing.

Staff obtained people's consent to care and treatment.

People were supported to eat and drink sufficient amounts to meet their nutritional needs, preferences, likes and dislikes. Where able, some people were supported to shop, prepare and cook their own meals.

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Case managers liaised and worked in partnership with other health care professionals to ensure people could access services quickly.

Is the service caring?

Good

This service was caring

Without exception, people and relatives praised the staff for their

caring and professional approach.

Staff understood how to respect people's privacy, dignity and human rights. They knew the person they were caring for and supporting, including their preferences and personal likes and dislikes.

The service has a strong, visible person centred culture and people and staff had high expectations of what people could achieve.

People and relatives told us they were involved in making decisions about their care and were listened to by the service.

Is the service responsive?

Good

This service was responsive

People told us the service engaged consistently and meaningfully with them and their families.

People's care was based around their individual rehabilitation and personal needs and aspirations.

Staff made sure that people were supported to make choices and have control of their lives.

People were consulted and involved in the running of the service and their views were sought and acted on.

Is the service well-led?

Outstanding

This service was very well-led.

The management team had very robust and effective systems in place to assess and monitor the quality of the service. There was a professionally recognised quality assurance system in place to drive continual improvement which benefited people, their relatives and staff.

The vision and values of the service were imaginative and person-centred and these made sure people were at the heart of the service.

The service had strong leadership and promoted clear values and an open, person centred culture. Staff felt valued, included and listened to.

The service worked in partnership with other organisations to

make sure they were following current best practice and providing a high quality service. They strived for excellence through consultation and reflective practice.

Rehab Without Walls

Detailed findings

Background to this inspection

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

This inspection took place on 15 and 18 January 2016 and was announced. We provided 48 hours' notice of the inspection to ensure management were available at their Milton Keynes office to facilitate our inspection. The inspection was undertaken by one inspector.

Prior to this inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

We had asked the provider to complete a Provider Information Return (PIR), which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was returned to us on 10th December 2015, prior to the inspection.

We used a number of different methods to help us understand the experiences of people using the service. We spoke with ten people who use the service and three relatives by telephone in order to gain their views about the quality of the service provided. We also spoke with seven staff members that included one of the directors, the registered manager, three case managers, one associate case manager and one support worker to determine whether the service had robust quality systems in place.

We reviewed intervention and treatment plans relating to six people who used the service, three staff files that contained information about recruitment, induction, training, supervisions and appraisals. We also looked at further records relating to the management of the service including quality audits, compliments and complaints.

Outstanding ☆

Is the service safe?

Our findings

People told us they felt safe using the service because they trusted the staff that supported them. One person said, "Yes I know I am totally safe. I have known my carers for a long time and they haven't changed. They are more like my friends." Another person said, "I am safe with [name of staff]. They look after me." A relative told us, "I have total trust in the staff and this provides us [family] with peace of mind." People, relatives and staff had good working relationships which enabled them to communicate honestly and without fear of repercussions and this was evident in our discussions with people. One person said, "I would tell [name of staff]. She will look after me."

Staff had taken action to minimise the risks of avoidable harm to people from abuse. One staff member told us, "I'm not shy about whistleblowing. I would look out for changes in people's behaviour and if I was at all worried I would, without hesitation, report my concerns either to [case manager], the manager or one of the directors." A second member of staff said, "I listen and I observe. If I had any concerns I have a duty of care to report them. I know I would be very well supported by the management team." Staff told us they had undertaken training in recognising and reporting abuse and were able to demonstrate their awareness of how to keep people safe. Records confirmed that all staff had completed safeguarding training for vulnerable adults and children.

Safeguarding was a core topic in the staff induction and throughout staff supervisions and staff meetings. We established that staff had a good understanding of the local safeguarding procedures and the different types of potential abuse that existed. One staff member said, "The training we had about safeguarding was thorough and applicable to our work." Records showed that safeguarding procedures, including those in relation to whistle blowing, were available to members of staff for guidance, in the case manager's handbook. We saw that potential safeguarding concerns had been referred to the local safeguarding team. The registered manager was able to demonstrate a good understanding of their responsibility to report allegations or concerns to the local authority and to notify the Care Quality Commission (CQC).

The provider's risk management policies and procedures showed the ethos of the service was to support people to have as much freedom of choice in their lives as possible. One person told us, "They listen to what I have to say, this is very important so I can make my own decisions." We saw that in people's intervention and treatment plans there were instructions for staff to 'adopt an enabling approach to encourage independent problem solving'. A relative told us, "With the help of the occupational therapist [relative] has been learning to cook. We were a bit worried about letting [relative] cook on their own so the occupational therapist sat outside in the car while [relative] prepared and cooked their first meal. We didn't have to worry. It went well but just in case there was a problem it was reassuring that someone was close by. I thought the risk was managed really well. Now [relative] cooks regularly for the family." We were also told that because of careful, well planned risk taking the person was now being supported to move into their own home.

Relatives told us that risk management plans were completed with the person using the service and only with their relative's involvement if it was appropriate. We were told, "It's easy for family members to be over protective. We strive to empower people to achieve their goals and wishes which usually does involve some

form of positive risk taking." One relative said, "When [person's name] wants to try anything new all eventualities are covered. Risk assessments are completed, there are contingency plans in place if things go wrong and everyone involved is aware. Everything is discussed with us."

Staff acknowledged that some risks to people's health and wellbeing needed to be accepted and taken to promote positive experiences for people. Staff gave us numerous examples of how people are supported to take positive risks. For example, one staff member told us about the person they supported who liked to go out to different places independently. To enable them to achieve this, the person is supported to learn and remember bus routes and new journeys. When they have accomplished this they are then able to go out independently. The staff member told us, "I carry a mobile phone with me at all times so if [person using the service] gets lost they can call me. It doesn't matter if it's my day off. I will always answer. I ask where they are and talk them back to a place they recognise. It's very important to [name of service user] that they can be independent."

We also discussed with the director about how people were supported with positive risk taking. He told us he was responsible for signing off all risk management plans at the service. In the first instance a risk appraisal would be completed. This is a very detailed and comprehensive assessment about any risks that may occur. Where a risk is identified a risk management plan is then completed. These have a rating scale for the probability of the risk and a rating for the severity of the risk and record the controls to be put in place to minimise the risk. He gave us some examples of positive risk taking by people using the service. One was in relation to supporting a person to go to a football match and another to undertake archery. Another person who currently undertakes voluntary work has requested to go to North Africa with a team of volunteers to assist teaching the women in the village sewing skills and running workshops so they can make items to sell. At the time of our visit they were being supported to do this. We were also told that some people were taking risks to meet their emotional and sexual needs. The organisation had ensured that people understood the risks they were taking and had provided personal counselling in relation to this. This demonstrated that people were empowered to make their own decisions and take positive risks towards their rehabilitation and to meet their needs.

Risk management plans we looked at were proportionate and centred around the needs of the person. The service regularly reviewed them with other health care professionals and took note of equality and human rights legislation. We saw there were strategies to make sure that risks were known, anticipated, identified and managed. People who used the service told us they were fully involved and understood the risk strategies.

There were sufficient numbers of staff to meet people's needs. One person said, "Yes there are enough staff. I don't have to worry." A relative told us, "[Relative] has his own team of staff. They have been with us a long time. We have never been let down."

Staff confirmed they had a manageable workload and did not feel under pressure. One told us, "There are enough staff to meet people's needs. We work as a team on the same care package so if someone needs to take time off it means there is always someone knowledgeable to take over." A second staff member said, "Staffing is very good. We all support each other and there is always time to take things as slow as we need. We don't have to rush."

People and the staff had support from a suitable number of knowledgeable staff. All the staff spoke extremely highly of the support they received from the management team and commented that they were always available when they needed them. One staff member told us, "I never have any problems getting hold of someone to talk with if I have a problem."

The registered manager told us that when written instruction is received from a solicitor, financial deputy or insurer a case manager will undertake an initial assessment and make a case management proposal. This will include the number of support hours a person requires to meet their needs. This is how staffing levels are determined for each person. We looked at rotas and saw that a staff team for each care package was in place and sufficient to meet people's needs. This meant that each person received care from a consistent staff team.

The registered manager told us that the organisation did not directly employ care staff, but people using the service were supported to recruit their own staff and this was also often undertaken by the person's solicitor.

We looked at the arrangements in place for the safe administration of medicines and found that people received their medicines safely and as prescribed. One person said, "Yes I do my own tablets, but if I need help [name of staff member] will help me." A relative told us, "There are no problems with [relative] medicines."

Staff we spoke with told us they completed records to confirm they had administered people's medication as prescribed and that it had been given to people appropriately.

People medicines were handled safely and each person was supported to receive their medicine in a way that was suitable for their needs and abilities. We saw that there were clear instructions and guidance in people's care records for staff. We looked at the organisations policies and procedures for staff to follow regarding medication. These were clearly written for staff to follow.

We saw from the staff training records that staff received medication training. This ensured that staff were competent to administer medication safely.

Good

Is the service effective?

Our findings

Everyone we spoke with said the staff were well trained and were competent in their work. One relative told us, "I know they are very well trained and they get training all the time through the year." Another relative said, "They are all so professional. They always know what to do even in the strangest circumstances. It's obvious they have had good training." They continued to tell us, "If we have a new staff join the team they are always introduced to us first and then they always shadow the experienced staff until they are happy and we are happy."

Staff told us that they were well supported and explained that when they first started working at the service they completed an induction. They also told us that they were able to shadow more experienced staff until they felt confident in their role. One staff member said, "My induction was very good. I found the shadowing was really valuable." A second staff member commented, "My induction was very worthwhile. It involved, meeting the person I was going to support and understanding their needs. That was really important."

Records demonstrated that staff completed an induction programme before they commenced work.

Staff told us that they received refresher training and this benefitted the way in which they delivered care to people. We spoke with three case managers who told us they were able to update their professional development as and when necessary to ensure they maintained their professional qualification. One case manager told us, "I am able to source any courses or training that are applicable to my needs and [management team] will support me to access them." Another case manager commented, "The training is actually pretty good. We can attend various courses that are relevant to our personal qualifications."

We looked at the training and professional development records for staff to ensure they were fully supported and qualified to undertake their roles. Records demonstrated that staff mandatory training was up to date. In addition, we found that where staff had been recruited to a specific care package, specialist training had been provided. For example we saw that staff had received training in Acquired Brain Injury, Communication, Mental Capacity and Deprivation of Liberty's.

Staff also told us that they received regular supervision from either the directors; who supervise the clinical staff; the registered manager or a case manager and said they could approach them for support whenever they needed to. We were told that at each supervision case managers are assessed against the British Association of Brain Injury Case Managers (BABICM) competencies. There are seven competencies that include; communication, strategy, co-ordination and management, monitoring, duty of care, professionalism, and personal attributes. One case manager told us, "The directors have a vast knowledge and the BABICM competencies are a good way to measure your performance."

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. We saw that recently one of the directors had attended a meeting about Mental Capacity that focused on practical aspects of assessing Mental Capacity for people who have had a brain injury. Staff had received training in the Mental Capacity Act (MCA) 2005 and understood about acting in a person's best interests. They respected people's rights to make choices for themselves and encouraged people to maintain their independence. Staff understood mental capacity assessments could be undertaken to identify if a person could make their own decisions. This meant staff understood people's rights to make choices and the action to take if someone's mental condition deteriorated.

The law requires the Care Quality Commission (CQC) to monitor the operation of deprivation of liberty. This provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The service had no DoLS applications in place at the time of our inspection.

We looked at how the service supported people with a healthy diet. We saw guidance that detailed the support each person required in respect of food, drink and nutrition, which included the level of supervision required when preparing and cooking their own meals. For example, in one file we saw that the person had difficulties maintaining a healthy weight. They had been referred to the dietician and a healthy eating plan was in place. In addition, behavioural strategies had been implemented that aimed at reducing the use of food as a soothing strategy.

People and relatives raised no concerns about the quality of food and nutrition during our visit. A relative told us how their family member had been set goals to learn to how to cook independently. This had proved to be very successful and they were now able to prepare and cook meals for their family. One staff member told us, "I help [name of person using the service] to shop, and prepare their meals. Then we will cook together with me by their side prompting where needed. All they need is that little bit of reassurance."

People were supported to access health services in the community. One case manager commented, "It's my job to access any health care professionals that are needed. I support people and their families to get quicker access to services."

The service had links with other healthcare professionals, which was recorded in people's intervention and treatment plans. There was also clear evidence of the service seeking advice and support from other agencies and we saw that guidance from healthcare professionals had been incorporated in people's care plans. For example, we saw that one person had specific nutritional needs. There were guidance and contact details for the community dietician and nutritional nurse.

Records confirmed that people's health needs were frequently monitored and discussed with them. They demonstrated that people had received input from health professionals such as their GP, occupational therapist, physiotherapist, dietician and speech and language therapist.

Good

Is the service caring?

Our findings

People received care and support from staff that knew and understand their history, likes, preferences, needs, hopes and goals. We found that people were happy with the care and support they received. People and relatives told us that staff were courteous, caring and patient when supporting their family members. One person said, "They look after me and help me." A relative told us, "The team are brilliant. They provide us all with support we need and then some. They are like family" Another relative told us about their family member's main carer, they said, "He is amazing. Nothing is too much trouble. I can rely on him 100% and that makes life so much easier for us."

Staff were also positive about the service and the relationships they had developed with people. One staff member told us, "I really like being able to work within a small team with a specific person. You really get to know each other and become more like friends." Another member of staff said, "This is the best company I have worked for. I've worked for a few but none of the others compare."

We looked at the staff rotas for three care packages and found these demonstrated that where possible, the service ensured people saw the same members of staff to allow them to build relationships to gain an understanding of their strengths and needs.

People told us that they; and their family members if appropriate; were involved in making decisions, goal setting and planning their own care. People had intervention and treatment plans in place which recorded their individual needs, set goals, personal wishes and preferences. We saw that these had been produced with the involvement of each individual so that the information within them focussed on them and their wishes. This meant that staff respected people' choice, autonomy and allowed them to maintain control about their care, treatment and support.

We were informed that the service provided them and their family members with the information they needed regarding the care package. One person told us, "They gave me enough information." A relative explained, "When care started we were provided with a guide to the service which included useful information, such as contact details and the complaints procedure." We looked at people's records and saw that this information was in place.

People told us that staff were respectful to them and their family members. One person commented, "My carer respects me and I respect her." A relative said, "The staff are very respectful and so patient. They never talk down to [name of person using the service] but treat him like an equal." Staff understood the importance of treating people with dignity and respect. For example one staff member told us, "We all want to be treated with respect and dignity."

The latest satisfaction surveys showed that some of the top results were in relation to staff respecting people's privacy; people being respected as a person and staff were respectful of people's culture.

Staff we spoke with understood what privacy and dignity meant in relation to supporting people. They gave

us examples' of how they maintained people's dignity and respected their wishes. One staff member said, "When I am supporting someone I will always talk to them like an adult and support them to reach their goals. I would never refer to someone by their condition and would also ask for permission before speaking on behalf of the person." Records showed that this approach was reflected in people's care plans and that these areas had been covered in staff induction and on-going training. We found that any private and confidential information relating to the care and treatment of people was stored securely.

Good

Is the service responsive?

Our findings

People received personalised care that was specific to meet their needs and they were involved in the planning, goal setting and reviewing of their care. People and relatives told us that they were visited in their homes by staff and a thorough assessment was carried out. at home before a care package was offered. They said that staff listened to what they had to say and took into account their preferences, likes, dislikes and future wishes. One relative commented, "The staff came to our house and discussed all my [family member's] needs. They asked us how we would like things
to be done and when. It was such a relief."

Staff are recruited to work for specific care packages. They received training that was specific to the person's needs which meant they got to know and understood the people they provided care for. Staff we spoke with demonstrated that they had taken time to familiarise themselves with people's care and rehabilitation records. This meant that staff had an understanding of people's needs and wishes, but also of their strengths and abilities. A case manager told us, "We try to involve families if it's appropriate because they can provide valuable insights into the person's character, their choices and ambitions. This is so important during the initial assessment and in the monitoring of their rehabilitation needs." Another staff member told us, "Before we start working with a person we are very well prepared. We are able to introduce ourselves and get to know the person and their family."

The registered manager explained to us that when written instruction is received by the service for a new care package, a case manager will make the initial assessment. Following the completion of the assessment a case management proposal will be written up and sent to the instructing person for their or their client's approval. The case management proposal identifies the person's needs and recommends interventions to meet them. This is also used to identify the skills and experience needed by the staff who were employed to care for them. Each person has a set of goals with target timeframes in which to achieve these. All case management documents are reviewed six monthly as a minimum standard. Case managers complete monthly summary reports which review people's goals and outline people's on-going progress. Records we examined confirmed this.

People and their relatives told us that their views about the service were regularly sought and acted upon. One relative said, "We are involved in reviews and also complete surveys about how satisfied we are." We looked at the most recent results from this survey and saw that all comments were positive about the quality of care and support provided. Some included, "Thank you for doing a spectacular job," and, "Thanks for a job expertly done." In praise of one particular staff member a comment read, "Well done Rehab Without Walls for having such a superior professional."

Staff told us they were also asked to complete an annual survey and we saw that the results for latest one were also positive and staff were happy working at the service.

People were encouraged to raise any concerns or complaints they might have about the service. They were confident that any concerns would be dealt with appropriately and in a timely manner. One person told us,

"Yes I would complain." A relative said, "I haven't had to make any complaints. I would do if I needed to though. I would feel perfectly comfortable." Another relative said, "There is never a need to complain. We have such a small team and we all work together closely. So any problems are dealt with there and then."

Outstanding ☆

Is the service well-led?

Our findings

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. In addition to the registered manager, there are two directors, one of whom is a consultant neuropsychologist and the other has clinical, managerial, and community experience in brain injury, spinal injury, mental health, and terminal illness. They support case managers and the registered manager via supervisions and meetings. During supervisions case managers are assessed against the British Association of Brain Injury Case Managers (BABICM) competencies. This is a professional assessment to promote the development of case management in the field of acquired brain injury. One case manager told us, "I find it really useful to have something to work towards. There are three different levels and each time you achieve a level you also receive a pay rise." Another case manager told us, "I feel very supported in my role. It's very professional and I find there is always someone available to talk with. It doesn't matter what problems I have they [management team] will always be able to help me sort it out and they are a great source of advice."

Staff we spoke with said the registered manager and the directors were excellent role models who actively sought and acted on the views of people. Promoting independence, health promotion and safe risk taking were fundamental aspects of the ethos of care and support at all levels. The feedback, culture and attitude of all the staff we spoke with was that nothing was too much trouble and everyone involved was willing to go above and beyond expectations to ensure people were able to have enriched and fulfilled lives. Staff told us they have regular case manager meetings held at least 5-6 times a year. These include speakers and training in relation to changes in legislation, clinical negligence, the rehabilitation code and the BABICM competencies. Staff we spoke with also said they were encouraged to use each other as a source of support. Case managers come from healthcare backgrounds such as social work, occupational therapy, nursing and physiotherapy so they have an array of knowledge and expertise. One case manager told us, "We do have a large network of contacts and advisers, so if we don't know something ourselves we can always find someone who does."

People using the service, relatives and staff all spoke highly of the management and the staff team. Relatives we spoke with told us about the positive impact the service had on their welfare. They said, "Other agencies sent lots of different staff and that was not what we wanted. [Relative] needs consistency. Two of our staff have been with us for over three years. [Relative] has his own team. I can go to them and things get sorted. The case manager is brilliant. She has been sorting things out for me which takes a weight off my mind and gives me time to spend with [relative]. She even sorted some paperwork out for me on her day off. They go over and beyond what they have to do." A second relative told us, "What [case manager] does for us is invaluable. They take the stress out of everything and it has taken a huge amount of pressure off me and my family."

When we spoke with the registered manager they had a clear understanding of the key principles and focus of the service, based on the organisational values and priorities. They told us they worked to continuously

improve services by providing an increased quality of life for people who had an acquired brain injury, with a strong focus on inclusion, positive risk taking and equality and diversity issues. This showed us that people who received care and support benefited from a management team that had a positive sense of direction, strong leadership and a sustained track record of delivering good performance and managing improvement. Where areas for improvement emerged, the service recognised and managed them well.

To ensure people knew what to expect from the service they were given information about the standards they had a right to expect and the service's aims and objectives. All the people using the service, relatives and staff we spoke with were open, honest and were enthusiastic about sharing their experiences with us. Without exception all the people we spoke with told us they would recommend Rehab Without Walls to anyone who wanted care and support in their own home. One person said, "They are the best out there. They do more than they need to and are more like friends than agency staff." Another person commented, "I would recommend them to anybody. They are brilliant. I can't say any more than that."

We found the management team promoted an open culture, which was person centred, inclusive, open and transparent. Staff were able to demonstrate that they understood the principles of individualised, person centred care through talking with us about how they met people's care and support needs. They spoke about their commitment to providing the best quality care they could. One case manager told us, "I will do whatever is in my power to ensure [name of person using the service] gets everything they need to make their rehabilitation the best it can be." Another case manager said, "What I like the most is that we are allowed to think outside of the box to tackle any problems or difficulties that arise, so we can meet the rehabilitation needs of people." The provider's web site states that Rehab Without Walls takes a "whatever it takes" approach to rehabilitation and long term support for people who have had catastrophic injuries, particularly brain and spinal injury. Staff we spoke with agreed with this statement and a support worker told us, "We are able to focus all our time and energy supporting people. They [provider] are right when they say, 'whatever it takes' because that's just how it works. Nothing is too much trouble and all problems can be overcome."

We looked at the service training and development strategy. The service provided a comprehensive induction programme and staff development was a high priority for the service. Staff told us they were proud to be part of the organisation, they said they were well supported and felt valued. All the staff said that if they felt they needed specific training or specialist training in an identified area they could find an appropriate training course and they would be supported to attend. One member of staff told us, "It doesn't get any better than this. I have worked for lots of different organisations in the past and this is by far the best." Staff were clear about their roles in supporting people to be independent with access to the local community and were always looking at how they could improve peoples' lives. Other comments from staff included, "This is not like a job. It ranks as number one for me. I am treated fairly and I feel that my opinions matter." Another member of staff commented, "You forget [management team] are directors. They make you feel comfortable, valued and nothing is too small or too much trouble."

The registered manager explained how accidents and incidents were monitored and analysed and learning from these was used to improve the service. We saw records to confirm this.

We found there was a strong emphasis to continually strive to improve, recognise, promote and implement innovative systems in order to provide a high quality service. The service had in place a recognised quality assurance accreditation system. For example, they became the first UK case management company to be awarded a three year accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF). In addition they are the only company to be accredited for the combined adult and paediatric case management and brain injury case management programmes. They have since received further three year

accreditations with CARF. CARF is an independent, non-profit organisation, based in America, which carries out rigorous surveys of rehabilitation service providers and grants accreditation internationally. This meant that the provider was committed to self-monitoring and using a verifiable professionally recognised quality assurance system reflecting aims and outcomes for people that they supported in their own homes.

The service had effective quality assurance and quality monitoring systems in place. These were in place to measure the success in meeting the aims and objectives of the organisation. The quality assurance systems were based on seeking the views of people who used the service, their relatives, friends and health and social care staff who were involved in peoples care. We saw that a consumer experience survey was used annually to gather feedback from people about the quality of the service they received. We looked at the results for the latest survey and found that people had experienced good quality care and support, expressed satisfaction and had been complimentary about the service. This meant people's views were valued and any concerns responded to without delay.

We also saw there was a system for self-monitoring that included regular internal audits such as intervention and treatment plans, risk management plans, staff training, staff supervision, reviews of people's goals and recruitment records. An employee climate survey is sent to all employees annually. We looked at the results of the most recent survey. Some of these included, '100% of staff were aware of the organisations mission and overall direction' and '100% of staff were aware of the organisations focus on service satisfaction'. Comments from the staff survey also included, "Being part of a company that prides itself on providing a high quality service," and "Being listened to and treated fairly." This meant the provider had successfully embedded a robust quality assurance and auditing system, whilst maintaining a strong, committed team who were steadfast in providing high standards of care.

We saw that policies, procedures and practice were regularly reviewed in light of changing legislation and of good practice and advice. For example, we saw that one of the directors had organised; with the support of the Division of Neuropsychology of the British Psychological Society; a meeting on 'Assessing Mental Capacity: An update for psychologists'. The meeting focused on the practical aspects of assessing Mental Capacity for people who have had a brain injury. The service also works in partnership with key organisations and agencies to support people's care provision and service development. Legal obligations, including conditions of registration from the Care Quality Commission (CQC) and those placed on them by other external organisations were understood and met such as solicitors and other social and health care professionals. This demonstrated that the service worked proactively with other key organisations to support care provision and service development. They strived for excellence through consultation and reflective practice.

We found record keeping was to a consistently high standard. All records held in the office were kept securely, up to date and in good order, and maintained and used in accordance with the Data Protection Act.