SCC Adult Social Care

Elmbridge 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

The service was inspected on 29 July and was announced. The service met all legal requirements we checked at the last inspection in 2013 and the previous year.

Elmbridge Reablement Service is registered to provide personal care to people living in their own homes who have been in hospital or require support due to a decline in their health. The service is provided for a few days, or up to a maximum of 6 weeks depending on need. If it is identified that people may still require longer term support, the service worked with staff in local social care teams to help arrange long term support. At the time of the inspection 56 people were receiving support from the service.

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.

The service was described by people, their relatives, healthcare professionals, and professionals from the local authority in complimentary terms in respect of leadership, person centred care, partnership working and compassion.

People told us they felt safe with the support they received from staff. There were arrangements in place to help safeguard people from the risk of abuse. The provider had appropriate policies and procedures in place to inform people who used the service and staff knew how to report potential or suspected abuse. Staff understood what constituted abuse and were aware of the steps to take to protect people.

There were risk assessments and management plans for people to reduce the likelihood of harm. There were safe recruitment procedures in place to help protect people from the risks of being cared for by staff assessed to be unfit or unsuitable.

Staff had received training in relevant areas of their work. This enabled them to support people effectively.

Staff and the registered manager understood their responsibilities in relation to the Mental Capacity Act 2005. People were involved in making decisions about their care and support and their consent was sought and documented.

People were supported to eat and drink in a safe manner where this was required. Care plans included an assessment of their nutrition and hydration needs.

People told us they were treated with dignity and respect. Staff understood the need to protect people's privacy and dignity. People told us staff knocked on their doors before they could enter their homes.

The provider had systems in place to continually monitor the quality of the service and people were asked for their opinions and where required action plans were developed to address areas for improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff understood how to protect people from abuse and harm. Risks to people's health and welfare were assessed and managed.

There was a sufficient number of staff deployed to meet people's needs. People confirmed there were enough staff to meet their needs.

Staffing arrangements were flexible to meet people's needs. Recruitment practice protected people from staff who might not be suitable to work with them.

Is the service effective?

Good

The service was effective.

People received individualised support that met their needs.

People were involved in planning and choosing their care and were able to make decisions for themselves.

Staff were supported to fulfil their roles through regular supervision and appraisals. Records of these had been kept. Staff confirmed they were supported by the management.

People were able to make choices about what they ate and were supported to eat and drink in a safe manner.

Is the service caring?

Good

The service was caring.

Staff told us how they ensured people's rights to privacy and dignity were maintained while supporting them.

People told us they were involved and their views were respected and acted on.

Staff respected people's individuality and encouraged them to

maintain their independence.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they received care to ensure the service was able to meet their needs.

The support plans and risk assessments detailed people's care and support needs. These were reviewed on a regular basis.

The service had a complaints policy and procedure, so that people knew what to do if they had a complaint.

Is the service well-led?

Good

The service was well-led.

Staff felt supported by the registered manager who they described as approachable.

The service worked in partnership with other organisations to make sure they were well informed of best practice and able to provide a high quality service.

There were systems in place to ensure that the quality of the service people received was assessed and monitored.

Elmbridge 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 inspection took place on 29 July and 5 August 2016 and was announced. We gave the registered provider 48 hours' notice as it was a community based service and we wanted to make sure people would be in.

The inspection team consisted of an adult social care inspector. Before our inspection we reviewed the information we held on the service. This included notifications we had received from the registered provider, about incidents that affect the health, safety and welfare of people. We also checked to see if any information concerning the care and welfare of people had been received.

The registered provider completed a Provider Information Return (PIR). This 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.

During our inspection we spoke with a range of people about the service. They included the registered manager, the organisation's directors, team leaders, support workers (reablement assistance), and healthcare professionals . As some people had complex needs we also contacted and spoke with their relatives. We also looked at people's care records and staff personnel records.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe and trusted staff. One person receiving care told us, "The service is very safe." One relative told us, "My relative has never had a reason to feel unsafe with staff who visits him." Another relative described the service as "Overall brilliant."

There were appropriate procedures in place to help ensure people were protected from all forms of abuse. There was a safeguarding policy. Staff had received training on how to identify abuse and understood the procedures for safeguarding people. Staff were able to describe the different ways that people might experience abuse and the correct steps to take if they were concerned that abuse had taken place. Safeguarding information was displayed in the office environment to provide staff with immediate access to information and guidance on how to report any concerns about people's safety. Staff told us they were confident that any concerns reported to managers would be treated seriously and appropriately. They told us they could report allegations of abuse to the local authority safeguarding team and the Care Quality Commission if management staff had taken no action in response to relevant information.

The service used incident forms and body maps to highlight any significant incidents and how this was handed over to ensure all staff were aware of how to safely care for people. We saw examples of these. A risk reporting log had been recently introduced. This enabled senior management to have an overview of significant information.

Risk assessments were in place to reduce risks to people's safety. We saw assessments, including for those at risk of developing pressure sores, those with reduced mobility and people at risk of falls. There was evidence people were referred to healthcare professionals for particular assessments. People were given support when and how they needed it, including the use of walking aids for those with reduced mobility and pressure relieving mattresses for those at risk of developing pressure sores. In one example, a person with reduced mobility was referred to an occupational therapist and eventually provided with appropriate mobility equipment. Risk assessments were reviewed regularly to ensure appropriate action was taken to mitigate the risk. Staff were able to talk about areas of risk knowledgeably and they correctly explained strategies which had been agreed to protect people from harm.

Risk assessments for the environment had been drawn up and were regularly reviewed with the changing needs of the people in mind. The assessments contained action for minimising potential risks such as risks associated with smoking, stairs, electrical items, uneven floor, obstacles and infection control. In all identified examples, the service had taken appropriate actions to ensure people were kept safe and protected from foreseeable risks. For instance, we saw a number of referrals and joint assessments between local fire safety officers and the service, which led to installations of smoke alarms and provision of fire retardant blankets for people who were at risk. We saw two instances where the provider had worked with people for them to understand fire safety. This had resulted in people agreeing to have smoke alarms and other equipment fitted in their homes.

We looked at how the service was being staffed to make sure there were enough staff on duty to support

people. Most people had high level needs and needed staff support. Staff personnel records highlighted a number of suitably trained and experienced staff to support people safely. People and their relatives were mostly pleased with the staffing levels they or their family member received. One person told us, "We are well supported. There are enough staff to deliver care in the mornings and evenings." A relative said, "If the service was not available my life would have been a misery as my [relative] is my main carer. Without enough staff it would have been too much for him."

Staff told us that there were always enough staff to meet people's needs. People told us there were sufficient staff to support them to regain their independence and skills at home. Staffing was organised around people's needs. Staff understood the need for rotas to be flexible so that people's activities were at a time that suited the individual. We looked at a sample of rotas to check that enough staff were available and deployed to calls throughout the day. Each rota contained a list of staff with times of calls, people's details and the type of support to be provided.

We reviewed the personnel records of staff and looked at the recruitment and selection of six staff. We noted the people were protected from unsuitable staff because the service followed its recruitment procedure. Before staff began to work, they underwent a rigorous recruitment process. Recruitment records contained the relevant checks. These checks included a Disclosure and Barring Service (DBS) check, evidence of identity, right to work in the country, and a minimum of two references to ensure that staff were suitable and not barred from working with people who used the service. This helped to ensure people employed were of good character and had been assessed as suitable to work with people.

We looked at how the service managed medicines. People's medicines were handled safely and according to the service's own policy and procedure. There were suitable arrangements for the recording and administration of medicines. There were no gaps in the medicines administration charts examined. All staff had been trained in the management of medicines and received an annual observational supervision. They had all received a competency assessment.

Good

Is the service effective?

Our findings

People and their relatives told us they were cared for and supported effectively, according to their needs. Relatives were positive about the ability of staff to meet people's care needs. One person told us, "Staff are wonderful. They have helped me with [house chores], which allows me to enjoy my life." A relative told us "[My relative] would not have been able to carry out their day to day activities if the service was not there. Professionals we spoke with were equally complementary, reiterating that staff were well qualified and competent at what they did.

The service was committed at developing staff skills through training. Staff had received relevant training to carry out their responsibilities in providing people with the care and support they needed. They were supported and encouraged to complete a variety of training including, health and safety, safeguarding, medication administration, respect and dignity and food hygiene. We found staff to be knowledgeable in relation to these areas. A member of staff told us, "The training is excellent. I have received training to check blood pressure, sugar levels, wound care, weighing and measuring people."

Staff confirmed they had a comprehensive induction period which included completing specific training and shadowing more experienced members of staff. The induction followed the Care Certificate induction standards, which are nationally recognised standards of care which care staff needed to meet before they can safely work unsupervised. Relatives told us they thought the staff were highly trained and knowledgeable.

Staff told us they received regular supervision and annual appraisal, which we evidenced from records. Staff and their line supervisors discussed performance and development and the support needed in the role. This was then used to assess performance and focus on future objectives and opportunities. Staff felt fully supported by the management. A staff member told us, "Leaders are approachable." Another said, "I find the job rewarding." A further staff member said, "The manager is very approachable. Whenever I needed assistance beyond my team leader, I have contacted my manager, and she has always supported me."

People's needs had been identified in care plans and staff were pro-active in making sure these were well met. We discussed examples that demonstrated effective care with the registered manager, and staff. For instance, the incidents of falls for some people had decreased and some people had become fully independent as a result of the reablement team involvement. The staff team had developed and established strong on going links with GPs, occupational therapists, speech and language therapists, physiotherapists, dieticians, and other health professionals to ensure holistic and effective care was delivered to people. The joint working with health professionals was also enhanced by the recently introduced CARRDS Project (The Coordinated Assessment, Rapid Response and Discharge Service). This was a multi-disciplinary team working together to enable reduced length of stay and re-admission rates for people aged over 65. The registered manager told us the CARRDS Project facilitated joint working with the health teams. Professionals commented on good rapport with the service. One health professional told us, "There is a lot of joint working. The service keeps us up to date in terms of on-going reviews and changes to [people's] needs.

People had regular health checks and staff quickly acted on any health issues and monitored these. For example, the service worked closely with health professionals to help people return home for health and social care assessments instead of waiting for assessments to be carried out whilst in hospital. These referrals meant people were receiving the care they needed from other professionals in a timely manner.

People told us their healthcare and dietary needs were effectively monitored and staff quickly responded to changing needs and informed them of any concerns. The staff were aware of the importance of eating and drinking well. People told us they enjoyed their meals and received the necessary support. A staff member told us, "Nutritional needs are looked at during the assessment and on an on-going basis", which we saw from records. During the two days of extreme heat in July 2016, the service arranged with reablement staff to give extra support to people to ensure they were hydrated. This showed the service protected people, especially those with complex needs, from the risk of poor dehydration.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). In other settings such as supported living schemes authorisation should be sought from the Court of Protection. 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 were being met.

The service had policies in place in relation to the MCA. Staff were knowledgeable regarding the requirements of MCA. The registered manager told us, "Referrals from hospital would have acknowledged the mental capacity of the person. However, staff would make specific assessments for specific decisions." We saw from records staff determined people's capacity to make particular decisions. They knew what they needed to do to make sure decisions were in people's best interests. A staff member told us, "When we are carrying out assessments, family members will be present to add value to the assessment." We saw evidence that staff had ensured best interest decisions were carried out. These involved all interested parties in the process to protect the rights of people.

Good

Is the service caring?

Our findings

People were pleased with the care and support they received. They told us staff were always passionate about the care they provided. Relatives told us their family members were treated with kindness, respect and dignity. Elmbridge Reablement Service regularly received thank you cards and letters from people, complimenting the service they received. The registered manager stored these in a file in the office for staff to view. Compliments received included, "My experience with staff has been nothing but a pleasure. They have been hard working and honest. Each and every one has been a pleasure and made my day every time"; "The carers that looked after me when I came out of hospital helped me to be independent again regarding [personal care]" and "Your staff were all kind and helpful to our relative and we are really grateful for those few days when clearly we were not coping."

People told us staff treated them with respect and maintained their dignity while supporting them with personal care. This was also confirmed by relatives. They told us they were pleased with the care and support their family member received. Staff were described as always welcoming and passionate about the care they provided. A relative told us, "My [relative] needs help with personal care. Staff attending to these duties ensure [my relative's] privacy by asking when to enter their house and by ensuring curtains are drawn."

People experienced a level of care and support that promoted their wellbeing and encouraged them to enjoy a stimulating and meaningful life. A compliment from one person read, "I just wanted to let you know how very much I appreciated all the assistance you gave me. Without the help and guidance, the sympathetic ears and the humour of your team it would have been almost impossible to carry on a reasonable existence and I am extremely grateful to you all for enabling me to get back on my feet again" and another said, "As a disabled person, the help I get with washing, cleaning and going to bed, allow me to enjoy my life as otherwise these tasks would be difficult with my condition."

People were supported to continue as part of the local community, attending church services and a variety of social clubs and social events in the area. The registered manager told us she looked at how the likes and hobbies of staff would match and complement an individual's likes and types of activity. This helped them develop meaningful relationships and enhanced the knowledge of the person's likes and preferences and share social and leisure time together.

People were fully involved in planning their care plans. Reviews were centred on them and were held in the way they chose for themselves. Where people were unable to express their views family members or advocates were involved in decision making processes to ensure people's views were expressed wherever possible. People were able to invite who they wished to the meeting, where it was held and what the topics would be discussed. One person told us, "I am involved in my care all the way."
People's spiritual or cultural wishes were respected. Staff told us how people's wishes were respected and accommodated. This included whether people wanted personal care to be delivered by same gender staff or how they preferred their food cooked. There was information about the different faiths and religions including relevant aspects of care. Staff referred to this when they needed guidance as and when people of

different faiths moved into the service.

The service went out of its way to ensure when people were nearing the end of life they received compassionate and supportive care. The registered manager told us people, their relatives and appropriate professionals contributed to people's plan of care so that staff knew their wishes and make sure the person had dignity, comfort and respect at the end of their life.

Good

Is the service responsive?

Our findings

People told us they were placed at the heart of care and that they were fully involved in their care. They said the service was responsive to their needs. A relative told us, "[My relative] has been involved in drawing up her care plan. Her husband has also contributed in this process. They have advised staff on the care that needs to be delivered and it is going well."

People had their needs assessed prior to receiving care and support. The assessment was used to gather personal information about people to help staff better understand their needs. It covered personal 'activities of daily living' such as personal care, eating and drinking, daily living routines, and shopping. The assessment also covered other areas such as health and medicines management. A corresponding 'functional measurement tool' scored dependency levels under each section to give an overall score. Scores ranged from 'one' (able to do without help) to 'four' (unable to do without help). At the end of the planned period of support each person was reassessed. This allowed the service to measure any improvements and successes in service delivery and improving people's independence.

We looked at people's care records and noted people received personalised care and support. Their care needs had been fully assessed and documented before they started receiving care. The assessments identified people's support needs and care plans were developed outlining how these needs were to be met. For example, one person was not able to take medicines on their own, and their care plan outlined how staff would support this person. Each care plan considered the person as an individual, with their own unique qualities, abilities, interests, preferences and challenges. This meant if the person accepted to receive support from the service, staff were ready to meet their needs.

People's individual needs were routinely reviewed to ensure care plans provided the most current information for staff to follow. For instance, a review sheet for one person indicated staff support had been reduced to one per visit because of noted improvements. In another example, staff supported one person with shopping, medicines administration and personal care until the person regained their independence. Any agreed changes arising from discussions between staff and people were written down with updates on how progress was being made.

The service was flexible and responsive to people's individual needs and preferences. We saw evidence the service sought ways to enable people to be as independent as possible. We asked people if the service was responsive to their needs, which they confirmed. The management had introduced specific systems to improve the responsiveness of the service to people's needs. For example, the service was facing increased demand for occupational therapy input, which meant the locality occupational therapy team was not always able to respond to people in a timely manner. On realising this, the service decided to get specialist support to train staff so they could carry out some duties, which previously were only undertaken by occupational therapists. For example, we saw the service had enlisted a professional company to deliver manual handling training to some care workers, who became manual handling link workers. This meant demand for occupational therapy assessments on the occupational therapy team was reduced and freed up time for them to undertake other specialist roles. It also ensured the service was able to respond to complex

manual handling cases in a timely manner.

The service also participated in the 'Hybrid Workers Project'. This aimed to create skilled and confident hybrid workers who could meet people's social care needs, perform healthcare tasks, carry out basic clinical observations and provide reablement services. For example, the hybrid workers employed by the service supported occupational therapists with strategies to assist people in daily living activities. The registered manager told us having the hybrid workers allowed the team to be more responsive to hospital discharges or if someone required equipment for them to remain safe at home. An OT told us, "Hybrid workers allow people to be provided with equipment to support them in their rehabilitation more quickly than if they were to wait for an OT to carry out an assessment." This all meant the service being responsive to people's needs.

The service sought to engage people in meaningful activities to keep them occupied in a range of social situations. The service employed a 'social care development coordinator', whose role was to source information regarding events within the community and to facilitate social inclusion. The registered manager explained, "If we identify that someone would benefit from shopping services, dog walking, going to a tea dance we can access this through our social care development coordinator." At this inspection we observed the service making plans to support people receiving care during the Ride London event. Ride London is a cycling event in central London, which also affected areas covered by the service. The registered manager told us, "As a team we have to ensure that all the people who use our service are fully informed of the event and road closures. The team continue to provide a service with careful planning."

When the service came to an end, staff recorded successes and outcomes for each person. Although the service was usually provided for a maximum of six weeks, the service demonstrated flexibility and provided additional support. This meant there was a smooth transition for people when transferring from one service to another.

A process was in place to record and respond to complaints. People told us they knew how to make a complaint and that staff responded positively to any complaints or concerns raised. All complaints were reviewed by a member of the management team to ensure the complaint was investigated appropriately and action was taken to address the concerns. The registered manager told us about the improvements they had made following complaints they had received. This showed us that people's concerns were listened to and acted upon.

Good

Is the service well-led?

Our findings

People told us the service was well led. People and their relatives made positive comments about the management and the staff. They complimented management and staff for their dedication and kindness. Compliments form people included, "We will miss your dedication to help us" and "Very appreciative of such an excellent service."

There were clear management structures in place. The registered manager was supported by team leaders and a service director. Surrey County Council also had a dedicated senior manager responsible for the reablement service. Staff were aware of their roles and responsibilities and the reporting structures in place within hours and out of hours.

The registered manager worked closely with people receiving care and the staff team. We found the registered manager to be dedicated to providing an effective service to people. She had extensive experience in managing reablement services. She had been involved in developing the reablement model for the past 5 years. She is currently on the NICE (National Institute of Health and Clinical Excellence) working group for reablement guidelines. Committee members are appointed by virtue of their relevant experience or specific technical skills.

People, relatives and staff told us that they were involved in making decisions about the service and that suggestions were listened to and acted upon where possible. People's opinions were sought through their participation in assessments, care planning, care reviews, and surveys. This was evident in their care records. We also saw evidence the new staff training matrix was created using staff feedback.

We looked at the survey results which related to the period between January 2016 and June 2016. A questionnaire had been sent to people who had recently received a reablement service and covered seven separate categories on the deliverance of reablement services, including information and advice, flexible and integrated support, accommodation and personal belongings, active and supportive communities and health. People commented positively to statements regarding easy access to information; flexibility of the service; involvement, and independence. People's views were analysed by the operational manager to identify any areas of development. For example, the rota system was changed to improve the service's responsiveness to people's needs.

We viewed some of the latest quality questionnaires received and found feedback mostly positive and high scoring in all areas. Some quotes included: "I was pleasantly surprised that this service is available in these times of cut-backs. Well done", "It was an excellent service at all times. Put it in prospectus. 110% overall", "I was very happy with the excellent service. Thank you" and "Very satisfied with the service."

There were procedures in place to monitor the quality of the service. The quality monitoring tool was designed around CQC's key lines of enquiry and fundamental standards. Monitoring was carried out by the quality assurance manager and other designated senior staff. Any shortfalls were quickly acted upon and lessons learnt helped improve the service. We saw that recent audits had prompted action in areas of care

including, medicines administration, infection control, consent and mental capacity assessments. As result at this inspection we found improvements had been made in these areas. For example, as a result of an audit a recommendation was made that all staff were observed administering medicines before they were deemed competent. In addition, competency was to be checked at least annually. At this inspection we saw that all staff competencies had been checked and were subject to annual checks.

A Quality Assurance and Risk reporting log has been introduced. This enabled the senior management team to have an overview of significant information, identify trends and monitor progress. The log captured all incidents reported under health and safety requirements including, safeguarding alerts, CQC notifications, deprivation of liberty safeguards applications, restrictive interventions, mental capacity assessments, medication errors. Monthly report summarising the data was presented in monthly senior management team meetings.

Health and social care professionals told us that the management team regularly consulted with them and asked their views on offering the best care possible. This demonstrated the registered manager promoted collaborative ways to source best practice. The service worked proactively with other key organisations to support care provision and service development. They strived for excellence through consultation and reflective practice. The service actively looked for opportunities to improve the service. Recently the service shared guidance on how to support people with HIV and AIDS. There was evidence the service working closely with health partners to deliver the NHS Five Year Forward View. The NHS Five Year Forward View was published on 23 October 2014 and sets out a new shared vision for the future of the NHS based around the new models of care.

The staff office contained up to date information about CQC and other aspects of health and social care such as information about the changes resulting from the Care Act 2014. There were information boards, resources and best practice information that staff were encouraged to read.