London Borough of Waltham Forest

London Borough of Waltham Forest, Independent Living Team

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 9 and 10 October 2018 and was announced. The provider was given 24 hours notice of the inspection as they provide personal care to people in their own homes and we needed to be sure someone would be available in the office during the inspection.

The service was last inspected in June 2018 when we identified the service had not yet met breaches of regulations identified in January 2018. We required the provider to submit regular updates on their action plan to address our concerns.

At this inspection we found the provider had made progress since our June 2018 inspection. However, the service was not operating at full capacity and issues with the quality of care plans, risk assessments and deployment of staff remained.

London borough of Waltham Forest – Independent Living Team is registered to provide personal care to people in their own homes. They provide up to six weeks support to people to help them regain their independence and confidence. At the time of the inspection in October 2018 they were providing personal care support to approximately 20 people. The provider told us their target operating capacity was 45 people.

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.

Risks to people were identified as part of the assessment process. However, the measures in place to mitigate risks were not always clear and not all risks had been subject to a risk assessment. The service was not supporting people to take medicines at the time of this inspection so we were not able to evaluate if they had made progress in this area.

The provider told us they had made significant improvements in terms of staff deployment. Although there were now fewer missed visits, staff punctuality was poor and people experienced a lack of continuity in their reablement officers. Despite operating well below their usual capacity, the service was unable to offer people fixed times for their care and did not demonstrate a person centred approach to scheduling.

The provider had made improvements to their referral and assessment process. People and referring agencies now had much better information about the nature and scope of the service. Assessments were completed in a timely manner and people told us they were involved in the process. However, although there were improvements in terms of capturing information about people's personal history, care plans continued to lack detail about how staff needed to support people to achieve their goals. Information about people's health conditions and the impact these had on people's care was not consistent and was not

always clear. The service was not consistently exploring the impact of people's sexual or gender identity, religious beliefs or cultural background on their care preferences. We have made a recommendation about including these aspects as part of the assessment and care planning process.

The provider had strengthened their governance and quality assurance systems. However, they were not yet operating effectively and had not always identified issues with the quality and safety of the service.

The provider collected feedback from people at regular intervals but did not always capture negative feedback as complaints. Complaints were investigated and responded to in line with the provider's policy, but as the systems did not include negative feedback some issues had not been identified by thematic analysis. We have made a recommendation about complaints.

People told us staff treated them with kindness and compassion. Staff told us the provision of additional time when they visited someone for the first time helped them establish positive, caring relationships.

Staff were knowledgeable about safeguarding adults from avoidable harm and abuse. People told us they felt safe with their reablement officers. Staff reported concerns and records showed incidents were investigated and responded to appropriately. Staff told us the office now responded promptly to any issues they raised and we saw reviews were taking place in a timely manner. The service was embedded within the local authority and we saw staff made onward referrals for additional services where this was appropriate.

Staff received the training they needed to perform their roles. The provider had identified gaps in training and we saw training sessions had been booked to ensure staff were up to date with their training requirements. Staff told us they received regular, supportive supervisions. The provider had identified the issues we found with supervision records and was implementing changes to supervision practice to address them.

People receiving a service were offered choices by their reablement officers. The service worked within the principles of the Mental Capacity Act 2005. Where concerns were identified about people's capacity to consent to their care appropriate assessments of their capacity were carried out.

Staff spoke highly about the registered manager and told us she had achieved real change in the service. Staff told us they now felt valued as part of the team. There were regular staff meetings which were used as an opportunity for development and gave staff a forum to provide feedback about the service. The registered manager was a member of various networks and groups to ensure they stayed up to date with best practice. The provider had changed their senior leadership structure to ensure appropriate operational oversight of the service.

We found continued breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding person centred care, safe care and treatment, staffing and good governance. Full details of a regulatory response are added to reports after all appeals and representations have been completed.

Although the service had made improvements, the rating for the 'safe' domain remains 'inadequate' and therefore the service remains in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant

improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risks to people were not always appropriately mitigated.

Despite operating well below capacity staff were not deployed effectively to meet people's needs and were often late.

Incidents were reported and appropriate investigations carried out to ensure people were protected from avoidable harm and abuse. When incidents occurred the service shared learning to ensure they were not repeated.

The service was not yet supporting people to take medicines so we could not check if this was done safely.

People told us staff wore appropriate protective equipment to protect them from the risk of infection.

Is the service effective?

Requires Improvement

The service was not always effective. There had been some improvements in the assessment and care planning systems, but some care plans still lacked detail on how to support people to achieve their goals.

Care plans did not always consider the impact that people's health conditions had on their experience of care. People told us staff would contact healthcare professionals on their behalf when needed.

Staff received the training and support they needed to perform their roles.

People were supported to prepare meals of their choice.

The service worked well with other organisations to ensure people received additional support and ongoing services.

People were offered choices and the service worked within the principles of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring. Assessments did not consistently ask people if their sexual or gender identity affected their preferences for care. Care plans did not consider the impact that people's religious beliefs and cultural background may have on their care preferences.

The service had made some improvements in the continuity of care workers, but people still felt they saw a lot of different reablement officers.

Each reablement officer was scheduled additional time on their first visit to help build and establish positive relationships with people.

People and relatives told us staff were kind, and treated them with respect.

The service promoted people's independence.

Is the service responsive?

Requires Improvement

The service was not always responsive. The provider's system for complaints did not ensure all feedback was captured and analysed. We have made a recommendation about complaints handling.

People and staff told us the service responded promptly to changes in people's needs. We saw records of care captured people's progress and reviews were completed in a timely way.

Care plans included information about people's pasts and communication style.

Is the service well-led?

Requires Improvement

The service was not always well-led. The quality assurance systems in place had not identified issues we found with the quality of records and staff deployment.

The quality assurance systems in place focussed on ensuring feedback was used to improve the service.

Staff spoke highly of the registered manager and felt valued and cared for.

The registered manager worked with other organisations and was a member of various networks to ensure they stayed up to date with best practice in the field.

London Borough of Waltham Forest, Independent Living Team

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.

We carried out this inspection to check that improvements to meet legal requirements planned by the provider after a previous comprehensive and focussed inspections in January and June 2018 had been made.

The inspection was completed by an inspector, an inspection manager and an expert-by-experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Since our inspection in June 2018 the service had been required to send us fortnightly updates on their action plans for improving the quality and safety of the service. We reviewed this information and considered this, and other information we held about the service as part of our ongoing monitoring and planning for this inspection.

During the inspection we spoke with three people who used the service and one relative. We spoke with 14 staff during the inspection. This included the registered manager, the nominated individual, the assistant director for safeguarding and family support, two practice managers, a coordinator and six reablement officers. We reviewed the care files for eight people who received a service including assessments, care plans and records of care delivered. We reviewed seven staff files including supervision, appraisal and training

records; no staff had been recruited to the service since our last inspection. We also reviewed various audits, survey results, meeting minutes, complaints and other documents relevant to the management of the service.

Inadequate

Is the service safe?

Our findings

In June 2018 we found the provider had not yet made sufficient progress to be meeting the legal requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were inconsistencies in risk assessments and a reliance on individual staff knowledge to mitigate risks. At this inspection we found the systems in place around risk assessments had been strengthened but information about how to mitigate risk remained limited in some cases.

Staff completed risk assessments as part of the needs assessment process before people started to receive a service. For most people, this assessment took place at the hospital before they were discharged home. Risks about people's mobility, nutrition, self-neglect and use of equipment and aids were identified, however the information about how to mitigate these risks varied. Some risk assessments included detailed instructions for staff on how to mitigate risks. For example, for one person the risk of mal-nutrition was mitigated by the provision of support to prepare meals.

Other risks had not been mitigated or the information about how to mitigate them was insufficient. For example, one person was diagnosed with epilepsy and had broken their hip as a result of a seizure 18 months ago but there was no epilepsy risk assessment within the file. The registered manager told us the assessor had decided the risk of seizures for the person with epilepsy was low as their condition was well controlled with medication. However, they had not recorded this risk assessment and staff had no guidance about how to respond if this person had a seizure. Another person was identified as being a risk of developing deep vein thrombosis and pressure wounds. Deep vein thrombosis is a condition where people are at risk of developing blood clots. The risk was partially mitigated by the provision of stockings and support to wash however, the risk assessment had not considered the impact the person's limited mobility would have on their ability to fit the stockings. In a third file the person was identified as not having any support needs or risks in terms of their mobility despite the occupational therapist prescribing a frame and stool to assist with their mobility.

After people had returned to their homes staff visited to completed environmental risk assessments. Staff completing the initial visits of care told us they were confident to assess environmental risks ahead of the formal risk assessment. Despite previously identifying that the provider had delegated the mitigation of environmental risks to family members we found instances where this had continued to happen. For example, one person's home had flooring which presented a trip hazard. The assessor had advised the person to ask a relative to make the area safe. Although we saw the assessor had called to follow up on this with the person a few days later they had not checked with the relative.

The inconsistencies and lack of detail in risk assessments are a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2018.

We were not able to check if the provider's systems for supporting people to take medicines had improved. Following our inspection in January 2018 the provider had identified they were not in a position to safely support people to take medicines and had stopped providing support to people with these needs. Staff had

received updated training in medicines administration and the provider had utilised the resources of a pharmacist from the Clinical Commissioning Group to assist in reviewing and updating their medicines policies and procedures. At the time of this inspection the service had assessment training scheduled for senior staff so they would be able to assess the competence of staff delivering care. The service would not be administering medicines until this training had been completed.

In January 2018 we issued a warning notice regarding a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff were not deployed effectively to meet people's needs; they were given impossible schedules with simultaneous visits which meant they felt rushed and were often late to people's homes. The provider had made some progress in this area, but was operating well below their usual capacity and issues with the timeliness of visits remained. The registered manager told us prior to our last inspection they had been providing support to approximately 45 people and were currently supporting 20 people.

As part of the assessment people were offered a two-hour long window for their visits of care, rather than asked for their specific preference for time slot. A member of staff told us, "The two hour window protects us in terms of managing expectation." They told us the coordinators prioritised visits that were time critical to be at consistent times of day. A staff member told us, "We have done a bit of work on the difference between wants and needs. People do not always need care to be at a set point in time." This did not demonstrate a person-centred approach to scheduling or recognise the impact of having to wait for up to two hours to receive support.

Reablement officers told us their rotas had improved. One reablement officer said, "It has got much better, there's enough time to get to jobs." Another reablement officer said, "The rota is now do-able." One person told us, "The timing is difficult and I understand the problem getting from one client to the next. They're late on a fairly regular basis. One or two have phoned me to tell me that they've been held up, but not all carers let me know. They come when they can and they do their best. Very often I start without them but that does depend what I need help with; I wouldn't get in the shower on my own. I got my own breakfast this morning."

We reviewed the electronic call monitoring information for 19 reablement officers for a two week period. These showed that staff were no longer given impossible schedules with simultaneous visits. However, staff punctuality at visits was poor. The management team completed audits of call monitoring data to confirm visits had taken place and were of the correct duration. However, they were not auditing the punctuality of visits as part of these audits. Our analysis of the call monitoring data showed reablement officers attended visits within fifteen minutes of the scheduled time only 55% of the time. Reablement officers were more than half an hour outside of the schedule 28% of the time. This was despite staff recognising that their schedules were currently not full as the service was not working at capacity.

We also reviewed the call monitoring information for ten people who received a service for a two week period. Despite the provider telling us people were given a two hour window three people had more than a two hour span in their scheduled visits of care and five people experienced more than a two hour span in the delivery of their care; two people had more than three hours between their earliest attended visit and their latest attended visit.

Despite operating well below the capacity of the service staff were not deployed effectively. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not recruited any staff since our last inspection; staff who had joined the team had been recruited on an interim basis via an agency who carried out checks to ensure they were suitable and qualified to work in the service. The provider's recruitment policy described best practice in ensuring staff were suitable to work in a care setting.

Staff told us they had received training in safeguarding adults from avoidable harm and abuse. Reablement officers told us they would report any concerns to the office and they were confident office based staff would take action to ensure people's safety. Records showed no safeguarding concerns had been raised since our last inspection in June 2018. We reviewed incident reports and found the provider took appropriate action in response to incidents that had occurred. For example, a missed visit of care was thoroughly investigated with measures put in place to prevent recurrence. Incidents were discussed in staff meetings and individual supervisions. For example, there had been two incidents where confidential information may have been compromised and we saw there had been extensive discussions and training for staff on data protection and confidentiality.

Personal protective equipment such as gloves and aprons was made available for staff. People confirmed staff wore appropriate personal protective equipment. One person said, "They wear gloves. I'd say they [reablement officers] were clean. They are always nicely presented and tidy." A relative confirmed, "They wear gloves, are clean and wash their hands." We also saw managers had completed hand hygiene audits to ensure staff were maintaining hygiene in a way that protected people from the risk of infection.

Requires Improvement

Is the service effective?

Our findings

In January 2018 we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service's referral criteria was not clear and people's needs assessments, goals and support plans were not person-centred. The provider had done a lot of work with referral agencies to ensure clear referral and acceptance criteria were in place. However, goals remained generic and the quality of the guidance in place to inform staff how to support people to achieve their goals varied.

Since our inspection in January 2018 the provider had restructured the referral and assessment system. The provider had clearly established the referral criteria with referring agencies and had worked with referrers to ensure they understood the eligibility criteria. In order to ensure assessments were carried out in a timely manner, assessors from the provider were now based in the hospital. This meant most people had their needs assessed by the service before they were discharged from hospital.

People and their relatives told us they were involved in the assessments. One person said, "My relative and I were involved throughout. I have a folder with all the details in it." Another person said, "I came out of hospital and it was all in place." People's views about their care needs had been clearly captured in the assessment and support plan. However, people's goals were not always in line with the views expressed. For example,one person had clearly expressed their main goal was to be able to walk to a local café. This goal relied on the provision of community physiotherapy and additional equipment which was beyond the scope of the service. However, this was not clearly recorded as part of the assessment or support plan; the goal was still included.

Records showed people established goals relating to regaining their independence with personal hygiene, dressing and meal preparation. Although staff told us they felt there was now a greater level of detail about how to support people to meet their needs, we found the level of detail varied and in some cases was not sufficient to ensure people's needs and preferences were respected. People's needs were well described, but the support they needed to have their needs met was not always clear.

For example, one person's support plan stated for each area of need, "[Person] needs reablement programme to support her to regain independence and confidence in this area." The registered manager acknowledged this care plan was not sufficient and told us this had "slipped through the net" of the quality assurance systems. To demonstrate they understood the level of detail required they showed us another support plan written by the same assessor. Although this plan described the tasks to be completed they did not contain detail of how the tasks should be supported. For example, the support plan for regaining independence with dressing stated, "I can choose my own clothes. I am able to wear my blouse, night dress sitting down. I am not able to wear knickers without assistance and will need to be shown techniques to regain independence and skills to do this." There was no information to inform staff which techniques should be shown to help develop their independence. Another person's needs were described as fluctuating due to their health condition. Their personal hygiene plan stated, "I would need some help to get my legs in the bath" but did not describe this support.

As part of the assessment process people's health conditions were listed. However, the impact these had on people's support needs and preferences was not always described. For example, in one case the impact of the person's health condition was well captured, describing the limitations on their mobility and how this affected their confidence. However, in another person's file there was a list of technical medical terms and no exploration of what this meant in terms of their needs and preferences. Their care plan stated, "[Person] has diagnosis of Parkinson's, type 2 diabetes, HBP and history of stroke." There was no explanation of what "HBP" meant and other than stating Parkinson's disease caused hand tremors no exploration of what impact these health conditions had on their needs. Another care plan similarly listed medical history as, "Laparotomy after a failed SPC insertion. Post operative ileus + hypokalaemia. Bilateral THR, Progressive MS, Femoral fracture." There was no explanation of these terms or what impact, if any, they had on the person's day to day experience of care.

The above issues with the lack of detail in care plans are a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were confident in liaising with healthcare professionals. Records showed staff contacted community health services on behalf of people when requested. For example, one person was not sure of the advice regarding use of a medical device and reablement officers contacted the district nurses on their behalf to confirm the advice. People told us they were confident reablement officers would contact healthcare services on their behalf if needed. One person said, "When [health concern occurred] they liaised with the doctor and got the doctor out for me."

Staff told us they received the support and supervision they need to perform their roles. One reablement officer said, "We've had lots of training recently. There's been lots of down time so we have been able to come up to the office and do the e-learning." The registered manager maintained a training matrix and gap analysis. This showed staff where staff training was out of date and we saw training sessions had been booked where required. Staff had been supported to complete recognised qualifications in health and social care. People told us they were confident in staff ability to perform their roles. One person said, "They are good at their jobs, they are nice, cheerful people." A relative said, "They are good at what they do; [relative] says they're wonderful."

The provider had a supervision framework where reablement officers received supervisions four times a year and had recently introduced field based observations of practice. The provider had recently identified that supervision practice had not been effective as the records of supervisions were identical between staff. Supervisory roles and responsibilities had changed as a result. Other supervision records showed staff were given clear information and guidance about the expectations of their role and supported to ensure they achieved the requirements of their position. Where it was necessary and appropriate the provider used performance management approaches to ensure staff performance.

Staff told us they supported people to prepare meals where this was part of their support plan. One member of staff explained, "People tend to have microwave meals. Quite simple meals that they can prepare for themselves. They have a choice; we don't tell them what to have. We might suggest the one with the nearest date, but other than that we'll help them prepare what it is they want." People confirmed this was how they were supported with their meals. One person said, "They help with meals. Normally ready meals and sometimes if I need a soup warming up. It's something quick. They encourage me to drink more as a general rule."

The service was embedded within the local authority which facilitated close working relationships with other organisations involved in providing support to people. Records showed case workers identified where

other services were suitable to support people to have their needs met and made appropriate referrals. For example, we saw people were referred to other services for short term domestic support, and befriending services where people were at risk of social isolation. Reablement officers told us they would ask case workers to make these referrals if they identified the need during their visits. One reablement officer said, "I was speaking to one person and it was clear they were really lonely. I raised it with the office and they referred them to the befrienders. The office will make the referrals if we ask them to."

People told us they were offered choices by staff. One person said, "They usually ask me if there's anything that needs to be done; they're very accommodating." Another person said, "They asks me things if I can't make up my mind; sometimes I don't want to eat, but they encourage me to eat. They encourage me a lot." Staff told us they offered people choices and we saw care plans emphasised the importance of ensuring people made decisions about aspects of their care such as meals and clothing.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. In the community this is authorised by the Court of Protection. We checked whether the service was working within the principles of the MCA. In all the files reviewed the assessors had considered people's capacity to consent to their care. All the people reviewed had capacity to consent to their care. In one case a medical professional had expressed concern about the person's capacity and appropriate assessments of their capacity had been completed.

Requires Improvement

Is the service caring?

Our findings

In January 2018 we made a recommendation about ensuring people's religious beliefs, cultural background and sexual and gender identity were included as part of a holistic care package. People told us they felt their religion and culture were considered by the service. One person said, "They've got a lot of sensitivity to people with disabilities, cultural and religious needs."

Reablement officers told us they assumed assessment staff explored people's sexual and gender identity as part of the assessment. One reablement officer said, "I would think the assessors do explore [sexual and gender identity]. It's difficult to comment because it doesn't come up very often." We noted the assessment and care plan documentation did not contain space to record information about people's sexual or gender identity. The registered manager and nominated individual told us they had advised assessors to explore these areas but recognised this was not captured within the assessment and care plan records. This was partly due to the nature of the system used which did not include specific questions or templates relating to sexual or gender identity.

People's religious beliefs and cultural background were captured as part of the assessment and care planning process. However, as with other aspects of people's needs, the impact on people's care preferences was not explored. Although one person's file noted they prayed at home, another person's recorded that they no longer attended their place of worship as they were not confident to mobilise outside. The assessment did not capture if the person had said they wished support to regain their confidence to be able to attend their place of worship.

We continue to recommend the service seeks and follows best practice guidance from a reputable source about ensuring people's sexual and gender identity, cultural background and religious beliefs are considered as part of the assessment and care planning approach.

In January 2018 reablement officers and people told us the quality and strength of relationships were affected by the lack of continuity in reablement officers providing care to people. The nominated individual told us they felt they had made significant improvements in terms of continuity. They said, "We have made some improvements on the continuity. The amount of workers has reduced from 16-17 to eight or nine." Reablement officers felt there was much better continuity and this helped them build relationships with people. One reablement officer explained, "We're paired with people throughout and it's really nice as we can notice when they're improving." Another reablement officer said, "Sometimes people aren't keen on having us at first, but by the time we've had a chat, and they've met us a few times they realise that it's quite nice to keep us."

However, people's experience was still very much that there was a lack of continuity in the staff who worked with them. Everyone we spoke with said the reablement officers changed frequently. One person said, "I have different carers each time, but I'm getting to know them." Another person said, "The carers change but I've got to know them all." A relative also said, "The carers are different each time. They seem to do whatever it takes to look after mum and sit down and have a chat. They are never ever in a rush." The provider told us,

and reablement officers confirmed that they got an extra 15 minutes when they visited someone for the first time. This gave them time to read through the care plan with the person and put them at ease before supporting them with care tasks.

People told us they felt staff treated them with respect and kindness. One person said, "They're very caring. They've got a lot of sensitivity." Another person told us, "The staff are caring, friendly and professional." A relative said, "They're friendly and helpful and will do anything for you. They make my relative feel comfortable." Reablement officers spoke about how they put people at ease, as they recognised people were often having their first experience of care at home. One reablement officer said, "The extra time really helps as they can be really nervous. We have time to have a chat before getting started." Another reablement officer said, "It's important we take a gentle approach. When it comes to private parts I'll offer to stay outside and say they can call me back in when they need. I always offer that, particularly if I can see they're a bit embarrassed."

The focus of the service was on supporting people to regain their independence. Part of the initial referral criteria and assessment process included whether or not people were likely to be able to regain their independence in a range of different tasks. People's wish for independence was clearly captured during the assessment process. For example, one person's plan focussed on the things they needed to learn to be able to complete tasks independently.

Requires Improvement

Is the service responsive?

Our findings

During our focussed inspection of the service completed in June 2018 we found the service had continued to be in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not fully involved in their assessments and care plans were not person-centred.

The provider had made significant progress in ensuring people and their relatives were aware of the role and remit of the service. Reablement officers told us they no longer had to explain the limits of their role to people when visiting them. People and relatives confirmed they felt they were made aware of the role and scope of the service and were provided with thorough information. One person said, "We had a meeting up at the hospital. I came out of hospital and it was all in place." We saw people were given detailed information about the service, and other services available in the local area as part of their introduction to the service.

Assessors had greatly improved the level of detail about people's background and history. Care plans were written in a style that reflected the individual personality of the person they related to. Important relationships and interactions were well described as well as people's own views about their care needs. For example, one person's care plan stated, "I just want some support with my morning breakfast. I do not think I need a lot of help and should be fine in a few days time." The style of the background sections to the care plans provided reablement officers with an indication about how to communicate with people in a way that matched their communication style.

Reablement officers were recording details of the care delivered and the amount of support people required to achieve their goals. The records captured the progress people made while receiving a service. In January 2018 we had found changes in people's needs were not always responded to in a timely manner. Reablement officers told us this was no longer the case. They were now able to access work emails through the mobile phones and this meant they were not reliant on phone messages to raise issues with the office based staff. One reablement officer said, "I never thought I'd be the one to say 'Thank goodness for emails' but I really am. Now if I notice something, or I think someone has got to independence I can email the case worker straight away and I know they've got the message. They turn things around much more quickly now."

Records showed where reablement officers raised issues with the office these were acted upon. For example, during the inspection a person had refused support and told the reablement officer they did not want or need a service. The reablement officer reported this via email and the assessor visited the person on the same day to explore what had happened between the assessment the day before and refusing support. The assessor established there had been a miscommunication about how the person completed their personal hygiene and confirmed they did wish to receive support the next day. We also saw reablement officers liaised with the office when they thought people were ready to end the service and reviews were completed in a timely manner.

People told us they knew how to make complaints if they needed. One person said, "I would call the office and there's a number in the pamphlet. I think they would respond if we had concerns." We saw people were given a copy of the complaints process as part of the information bundle provided when the service started. There was an easy-to-read version of this policy available if people needed this format. The service was part of the local authority and used their complaints policy and procedure. This procedure did not require written records of complaints which were resolved locally before reaching the formal complaint stage. We noted that people had raised issues about the quality and nature of their support through feedback questionnaires. Although these had been responded to on a case by case basis, as they were not captured as complaints they were not subject to the same auditing and thematic analysis as formal complaints. This meant there was a risk that concerns raised outside the formal complaints process were not used as a method for driving improvement in the service.

Six complaints were recorded since our last inspection in January 2018. Each of these had been investigated thoroughly with complainants receiving a response within the agreed timescales. The registered manager audited complaints and identified lessons to be learnt. However, there was no detail about how these lessons would be implemented. For example, the audit had identified an issue with communication, the lesson was noted as, "Need to get better at communicating with partners." There was no plan about what the service, and staff working within the service, needed to do to make these improvements.

We recommend the service seeks and follows best practice guidance from a reputable source about handling and learning from complaints.

Requires Improvement

Is the service well-led?

Our findings

In January 2018 we identified a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the systems and processes in place had not operated effectively to ensure the quality and safety of the service was monitored and improved. Following our inspection in June 2018 we required the provider to send us fortnightly updates regarding how they monitored and improved the quality and safety of the service.

The provider had submitted the reports as required, and had introduced a range of audits and quality assurance checks since our last inspection. The provider had changed the senior management structure since our last inspection in June 2018. The nominated individual had changed and the post-holder now had operational oversight of the service. The interim manager who was in post in June 2018 had successfully registered with us.

There was an oversight and assurance improvement board with representatives of the service, local authority safeguarding, contracts and quality assurance teams as well as the local Healthwatch attending. They held regular meetings to review the plans in place to improve the service.

The provider had introduced a new system of audits of all areas of operation including care files, recruitment and staff records, including training and development, and other records including incidents, accidents and complaints. These audits led to quality assurance reports which included recommendations for improvements which were incorporated into the registered manager's workbook and reported to the nominated individual. The nominated individual monitored progress of the workbooks and audits. This meant there was a quality assurance loop with a focus on learning and development.

Practice managers and the registered manager completed audits of a sample of files each month, with the nominated individual completing a further audit of a sample of these files to ensure consistency in approach. Although these audits had identified the issues we found with staff files, they had not identified the issues we found with care files. For example, a care file where a risk assessment had not been put in place regarding a health condition had been audited but this issue had not been identified. Likewise, the audits had not identified that the details of how people wished to be supported to achieve their goals were not sufficient.

The registered manager and practice managers had completed internal reviews of the service in relation to the key questions of CQC inspections. However, these audits did not match the findings of inspection and were over-optimistic in their assessment of the quality of care plans and risk assessments. For example, the evaluation of the 'responsive' domain stated, "Service user's care, treatment and support are set out in a written plan that describes what staff need to do to make sure that personalised care is provided." This statement was scored as 'exceeds expectation'. However while we found improvements in some areas, care plans did not consistently contain clear information or guidance for staff. Likewise, the evaluation of the safe domain had not identified any of the issues found during the inspection regarding call monitoring and risk assessments. This meant that despite some improvements, the systems were not yet operating effectively to

monitor and improve the quality of the service.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider collected feedback from people and staff through regular surveys. Most questions had over 75% positive responses. Where people and staff gave negative responses, there was an action plan in place to address the issues. The staff survey showed staff were much more confident that issues raised by them would be responded to appropriately by the office. This was confirmed by the staff we spoke with. One reablement officer said, "Before it was like an 'us and them' mentality. We were the troops on the battlefield and we didn't get any help. It's all changed now and I think they care about us as staff now." Another reablement officer told us they felt well looked after by management. They said, "I think they care about us now. If the system isn't showing a call they'll ring and check I'm alright. Particularly on the weekends our personal safety is considered. The person on call will check on me if I'm running late, or if I'm working in a particular area." A third reablement officer said, "They [management staff] are definitely listening to us now."

There were regular staff meetings taking place. Records showed these were used to discuss changes to ways of working as well as to deliver focussed training sessions on specific areas of work. We also saw learning from incidents was shared. For example, keeping information safe and confidentiality had been discussed at several meetings following an incident.

Staff spoke highly of the registered manager. One reablement officer said, "[Registered Manager] really does listen." Another reablement officer said, "One of the problems was that we'd had lots of different managers. [Registered manager] does listen and checks what's best with us. It's a big improvement." Emails showed the registered manager provided positive feedback and compliments to staff to demonstrate she valued their contribution to the service and recognised the shared involvement of colleagues in improving the service.

The registered manager attended the local Skills for Care registered manager's network, as well as being part of several registered manager social media forums and having two mentors from high performing services. She told us this helped her stay up to date with best practice and benchmark the service with other similar organisations. We saw the registered manager posted inspirational quotations in the service. She also ensured the service and staff team recognised national events and awareness days. For example, during the inspection it was national mental health awareness week and the registered manager had a focussed team meeting about this, and ensured wellbeing was discussed.

The provider was working closely with the local hospital. Staff from the reablement team were now based in the hospital and secondment arrangements had been established. The nominated individual's role included the hospital discharge teams and they were working at a strategic level to ensure discharge pathways from hospital to home worked effectively so people received safe and effective care. A member of staff from the reablement service had represented the local authority at a conference out of area to talk about the families first approach of the local authority.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not contain sufficient information about how to meet people's needs. Regulation 9(3)(b)

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not always been appropriately mitigated. Regulation 12(1)(2)(a)(b)

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems had not operated effectively to identify and address issues with the quality and safety of the service. Regulation 17(1)(2)(a)(b)

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not been effectively deployed as they were often late and people not able to choose set times for their visits. Regulation 18(1)

The enforcement action we took:

We imposed a condition on the provider's registration.