

The Royal Borough of Windsor and Maidenhead

Short Term Support and Rehabilitation Team

Inspection report

York House
41 Sheet Street
Windsor
Berkshire
SL4 1DD

Tel: 01628621981
Website: www.rbwm.gov.uk

Date of inspection visit:
25 February 2016
26 February 2016

Date of publication:
08 April 2016

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 Short Term Support and Rehabilitation Team provides short-term support to help people recover or cope after a decline in health, an injury or an illness. The service encourages adults to achieve maximum independence, health and wellbeing. Services include supporting people to manage their personal care (washing and dressing), other daily tasks such as meal preparation and advice and referrals to other services as needed. As the local authority is the provider, the service is situated in the offices of the local authority in central Windsor.

At the time of the inspection, there was 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 location was last inspected under the Health and Social Care Act (Regulated Activities) Regulations 2010 on 20 February 2014, where the five outcomes we inspected were compliant. Prior to this, the location was inspected on 19 July 2012 as part of a national thematic review of domiciliary care under section 48 of the Health and Social Care Act. All five outcomes that were inspected were compliant. You can find thematic review reports on our website.

This inspection took place on 25 February 2016 and 26 February 2016 and was announced.

The service was flexible as the number of people that received personal care varied at any given point. This was due to referrals from GPs and other community healthcare professionals, and also because of pressure from local hospitals when there were not always enough beds. This meant that the nature of the service was sometimes unpredictable. The service also operated 24 hours a day, seven days a week and people, relatives, staff and healthcare professionals could telephone the office anytime to receive support. The service worked in conjunction with an NHS Trust to ensure that rehabilitation was fully implemented into people's care packages. This joint working enabled people to regain their independence as quickly as possible.

We found the Short Term Support and Rehabilitation Team used a comprehensive assessment and care planning process which ensured that people's care was detailed and holistic. Staff we communicated with were professional and caring and enjoyed working with people who used the service. People's opinions of the care provided was consistently positive. There were sufficient staff to meet people's needs at all times, and the service incorporated a robust method of determining correct staff deployment. People's medicines were administered, stored and documented appropriately.

The service was effective in the care it provided to people. Staff received extensive induction, training, supervision and performance appraisal for their roles. The service had embraced Skills for Care's 'Care Certificate' for new support workers and there was evidence that staff had successfully completed the many

components. Staff received regular supervision with their managers and were able to set and achieve their own employment goals. Recruitment and selection of new staff members was robust and ensured safety for people who used the service. Consent was gained from people before care was commenced and people's right to refuse care was respected.

We found staff were kind and generous. People's comments mirrored our findings from the inspection. Staff told us they respected people's privacy and dignity, and ensured that life in their homes was as close as possible to being independent. People had regular opportunities to provide feedback to the service and also have their say in how things operated.

The service was responsive to people's needs. People had the ability to share their compliments, concerns and complaints in an open and transparent manner. Where feedback was provided by people or relatives, management would undertake necessary investigations, make changes to their care package and report back to the person who complained. The service was successful in its aims, even with the short term period of the care and the high referral rates. This was because there was a goal of people gaining their independence in six weeks. Evidence from the inspection showed in the majority of cases, people were prevented from having to move from their own home, for example, into care homes.

All of the people, relatives, staff and community teams we spoke with as part of the inspection commented that the service was well-led. They felt that the managers took time to listen and would take action to make improvements when needed. People felt that management were approachable and had a visible presence in the operation of the service. We found that the management conducted a range checks to assess the standard of care. This included satisfaction surveys where people consistently rated the service as outstanding.

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.

People were protected from abuse or neglect because staff were trained, knowledgeable and not hesitant to act or report matters.

Comprehensive risk assessment and care plans were an integral part of the service which ensured safe care for people.

Suitable numbers of staff were deployed to provide personal care.

Staff encouraged people to be independent with taking their medicines.

Is the service effective?

Good ●

The service was effective.

Staff received excellent training during induction and on a continual basis to ensure people received the best possible care.

The service had identified steps they could change in their process for gaining people's consent to care.

Staff recognised that sufficient nutrition and hydration was an important part of personal care and recovery from illness or injury.

Links to community health professionals were strong.

Is the service caring?

Good ●

The service was caring.

People felt staff that staff were genuinely kind, compassionate and empathetic to their individual needs.

People were actively involved in the commencement and review of the personal care provided.

People's privacy and dignity was respected.

The service was able to rapidly commence end of life care for people, and ensured comfort.

Is the service responsive?

Good ●

The service was responsive.

People were encouraged to be independent and staff supported people to regain their independence.

The service was able to deliver a package of care after two hours' notice from the provider. This meant people discharged from hospital quickly and that the service could respond to urgent calls from community healthcare professionals.

A robust complaints procedure was in place and the service demonstrated they were responsive to people's concerns about their care.

Transfer of people's care to other services was seamless and coordinated.

Is the service well-led?

Good ●

The service was well-led.

People's feedback indicated they felt the service was managed appropriately.

Staff and community healthcare professionals held high opinions about the management of the service and felt managers were approachable.

The service checked the quality of the care provided and identified if improvements were required.

Outcomes for people who received care were positive in most cases.

Short Term Support and Rehabilitation 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.

The inspection was undertaken by one inspector, took place on 25 February 2016 and 26 February 2016 and was announced. The provider was given 48 hours' notice because the location provided personal care in the community and we needed to be sure that staff and managers would be present in the office.

Before the inspection, the 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. We also reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is legally required to send us.

During the inspection we spoke with the registered manager, the assistant manager and ten other members of staff. We spoke with four people who used the service, three relatives. We also received feedback from 14 community-based healthcare professionals that worked with the Short Term Support and Rehabilitation Team. We did not visit people's homes as part of this inspection.

We looked at seven records related to people's individual care needs. These included support plans, risk assessments and daily monitoring records. We also looked at five staff personnel files and records associated with the management of the service, including quality audits.

Prior to the inspection, we surveyed more than 70 people who used the service and received 28 responses.

Is the service safe?

Our findings

All of the people who provided responses to our survey prior to the inspection agreed or strongly agreed that the service was safe. We also conducted four telephone interviews with people as part of the inspection. All four people we spoke with agreed that they felt safe with the personal care provided, that staff had not missed any calls to their home and that they were not rushed with care provided by staff.

The service's statement of purpose states "Leaving the service user feeling safe and secure" as one of their goals. Prior to the inspection, we contacted health professionals who worked with the service to seek their feedback. Fourteen health care professionals or organisations we contacted provided positive feedback about the safety of the Short Term Support and Rehabilitation Team. All of the respondents to our request for information stated that people received safe care. One professional we contacted told us: "[They] provide care to residents being discharged from hospital. [They] have a robust triaging process to help with planning and facilitating safe discharges. [They] challenge colleagues in acute settings, where... matters of safety are being overlooked and also help speed up discharges where progress has stalled".

We conducted telephone interviews with three relatives as part of the inspection. All three relatives told us that their loved one felt safe, staff arrived on time and that staff stayed the necessary amount of time to provide the personal care. The relatives also confirmed that staff had not missed any calls to the person who used the service.

There was a strong knowledge by staff and management regarding the principles of potential abuse and how to ensure people were safeguarded should allegations occur. Staff displayed confidence in their knowledge of types of abuse, signs of abuse and the action they would take if they suspected or witnessed abuse. Staff we interviewed felt they were able to report another colleague who might abuse a person who used the service. All staff we spoke with were aware of whistleblowing and authorities that they could approach if they needed to report something. The registered manager was clear about their part in managing safeguarding concerns. Safeguarding was an intrinsic part of new staff's induction and continued training. At the date of the inspection, 100 per cent of support workers and duty coordinators had completed safeguarding training in the last 12 months. Staff also knew about human rights, discrimination and equality because they received training in the subjects.

People were safe because their risk assessments and care plans reflected their individual risks. We looked at computer based and paper based records for seven people that used the service. We could see that people's risks were thoroughly assessed and documented. Risk assessment and care planning often occurred before the person had commenced receipt of the first personal care from the service. For example, the service would ask hospital discharge coordinators and GPs who referred people to the service about risks pertinent to the start or ongoing provision of care for the person. In the risk assessments and care plans we examined, we saw a comprehensive range of documents. Examples included environmental hazards in the person's accommodation, moving and handling assessments, how personal hygiene was conducted, and how nutrition and hydration would be assisted. The frequency of personal care also reflected people's individual needs. Calls and support from the service ranged from every other day to four times a day if the person

required this. The service also exceeded conventional risk assessment management because support workers reported changes or new risks to the duty coordinators, by telephone and by mobile documentation devices. This enabled decision making and support to staff in people's homes, and also a current list of risks managed or overcome.

The number of people who used the service varied from day to day. At the time of the inspection there were 110 people in receipt of personal care in their homes. We found there was an appropriate number of deployed staff that provided personal care and a team of staff who worked in the office location to support staff that provided care in people's homes. When we spoke to the registered manager, they told us the service had set a maximum number of people that they could support at any one time and that this would never be exceeded. Staff whereabouts and timing of calls was tracked in the community using portable technology that the staff member carried with them, and this was checked by duty coordinators back in the office. Staff were expected to call and message the office if they either exceeded the time they needed for a single call or had developed available time during their shift pattern. This meant the staffing was tailored to people's individual needs and calls were not cut short or routinely missed. Looking at records in the office we found there were no missed calls, although the service was honest that not all calls were problem-free.

The service had strong recruitment and selection procedures that ensured suitable, experienced applicants were offered and accepted employment. We looked at five personnel files. In conjunction with the provider's human resources support, applications and interviews had the necessary scrutiny and challenge to ensure candidates were suitable for the type of care provided. Staff we spoke with told us they had to pass a number of stages to be successful in gaining their employment. These included a computer based written application, a face to face interview and examples of question based scenarios. Personnel files contained all of the necessary information required by the applicable regulation and no documents or checks were missing. The registered manager explained that applicants would not be accepted for employment if they did not demonstrate their ability to thoroughly learn and accept responsibility for people's safe care in their own homes.

A business continuity plan and emergency procedures were in place if there were events which may impede or prevent calls. When we spoke with staff, they told us they knew what to do in the event of extreme weather like floods or heavy snow. One staff member even explained they had purchased a shovel they kept in their vehicle in the event they had to use it in the snow to succeed at making their visits to people.

Staff and management were confident that people who received personal care received their medicines safely. We were told that in people's homes, their medicines were often pre-packed into blister packs by the dispensing pharmacy. Where possible, the person themselves was encouraged by staff to administer the medicines to themselves, with staff supervision. Staff only supported the person if their ability to administer the medicines themselves was affected by their medical or physical conditions. Where medicines came in bottles and packets, staff still encouraged people to be independent in taking it themselves. In a small amount of cases staff were required to intervene to assist the person. Staff explained their response when people refused to take their medicines. They told us they would stay with the person, explain the importance of taking their medicines and see if the person would then take them. If the person continued to refuse to take their medicines, they would report this to the office location for further action.

Is the service effective?

Our findings

All of the people who used the service, relatives, health professionals and staff we spoke with told us that they felt staff were well trained and that they knew how to meet peoples' personal care needs. In one example, a support worker had stayed with a person in their house after personal care was delivered because the boiler had broken down and the environment was cold. The staff member waited with the person to ensure that emergency repairs were completed by a contractor before they departed the premises to continue with their shift. Various field and office based staff we spoke with told us they had received training in a number of subjects, including dementia awareness training and had a good understanding of supporting people with challenging behaviours. Health professionals who responded to our request for feedback stated that staff worked to ensure that people exhibiting challenging behaviour were supported sensitively and professionally.

New staff received effective induction and support to establish their knowledge and skills in their role. The registered manager and assistant manager showed us records of staff inductions. We saw a carefully planned calendar for new staff that was spaced out over more than two weeks. The programme allowed the new staff to attend formal mandatory training, shadow experienced staff in the community and work with partner agencies to understand what people's needs would be when they commenced receipt of care. The provider also used industry-wide training methods for adult social care staff, such as Skills for Care's 'Care Certificate'. New staff, where appropriate, were required to undertake the required 'Care Certificate' to ensure they were able to carry out their roles and responsibilities. Tracking of staff progress through the 'Care Certificate' was closely monitored. At the time of the inspection, one new staff member had not progressed their knowledge and skills at the expected rate for new staff members. The management explained that there was an understanding by them and that they extended the period for the staff member to complete induction. The staff member was supported closely to build their confidence and ability to perform effective personal care for people.

Existing experience in staff's prior employment was also recognised so that training was individualised. All staff that provided personal care to people had a Diploma in Health and Social Care (Adults) level two or above, with many staff undertaking QCF level three or even higher level qualifications. We found staff participated in regular supervision sessions with their manager and annual goal setting and performance appraisals. We looked at three examples of supervisions between staff and their manager and saw evidence that indicated a collaborative approach between the two parties, recognition of strengths and documented areas for improvement. Weekly and monthly staff meetings also occurred with a focus on quality as well as operational topics. Staff were often provided with short presentations or learning and development during the staff meetings, to ensure their knowledge was expanded. The assistant manager demonstrated the training booking and records scheme to us during the inspection. We could see that individual staff training was catered for, that the provider knew what upcoming opportunities for training were available and which staff had attended training. People who used the service received care from staff that were knowledgeable and skilled and this ensured that quality care was provided. An example of this was that staff had received training in dementia care. When staff visited people who had existing dementia, they were able to provide better personal care because they understood the ways in which dementia affected behaviour. Staff were

also vigilant because when they visited to provide care, if they detected a person who was confused they questioned why the confusion had developed. Where necessary, staff would call back to the office to seek advice about the person's health condition and also organise calls by community health professionals like GPs and district nurses.

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. We checked whether the service was working within the principles of the MCA. Four people we spoke with confirmed that their consent was obtained verbally and in writing by staff.

We spoke with the registered manager about consent, the MCA and best interest decision making at the service. We also interviewed four staff where we checked their knowledge and practice in people's provision of consent and best interest decision making. We found consent for the commencement of the personal care provided to people by the service was obtained at the point of the referral to the Short Term Support and Rehabilitation Team, usually by third party organisations. This included, for example GPs, hospitals and occasionally social workers or other health professionals. Once consent was communicated by outside agencies to the service, they visited the person in their home and completed the 'first visit pack'. The pack contained information for the person relevant to the start of personal care and included the service user guide, aims of the service and explanation of the care that could be provided. The support worker would then hold a conversation with the person to ensure they were enabled to make an informed decision about whether to receive care from the service. The person was able to refuse the service if they wanted and this choice was respected by the staff and management. If the person had the capacity to make the decision at the time of the first visit, they were asked to sign a consent form. The consent form also flagged to staff to check whether the person had an advance directive to refuse treatment, a do not attempt resuscitation order (DNACPR) or a 'living will'. There was also the opportunity for an interpreter to assist with gaining the person's consent in cases where this was necessary.

The provider used two different consent forms; one for people who had the capacity to consent, and a different form for people who did not have the capacity to consent. At the inspection, we asked the registered manager about the consent form for people who were assessed as not having the capacity to consent. The registered manager told us that prior to our inspection, the provider had assessed that one of the consent forms they used was not in line with the Code of Practice for the MCA. The service immediately stopped using this version of the consent form. The registered manager confirmed that a better approach was required by the service for people who did not have the capacity to consent. The registered manager told us the service was introducing documentation that recorded the capacity of people to consent, and better recording of best-interest decisions for people who were unable to consent. The service had consulted the local authority's MCA team in order to help make improvements in their documentation and consent for people. We confirmed this with the local authority's MCA team via the telephone after the inspection. The provider also had additional staff training regarding the MCA planned and other tools like pocket cards for staff to refer to regarding decision making and consent principles. Management were aware of the function of the Court of Protection and could gain assistance from the local authority MCA team when necessary. People who used the service confirmed that they were always asked for consent. People told us their consent was obtained in writing and that staff had explained the reasons for gaining consent. People we spoke with also stated that staff always asked for consent before entering their house, and also asked for consent to commence personal care. This meant people were able to refuse a visit from the support workers

and also had the right to refuse any care during the visit. People's rights about refusing any personal care were respected by the service and individual staff members.

Some people who used the service received support with eating and drinking and the preparation of their meals. Staff we interviewed realised the importance of diet in recovery and rehabilitation and had good knowledge about this. Where necessary, the person was encouraged to be as independent as possible in heating, cooking and eating their meals. We found staff also ensured, as part of their routine in the visits, that people had access to food and drink when they were concluding their call to the homes. In daily records of care provided, we observed that one person who used the service consistently had soup for dinner. As such, this evening meal did not provide sufficient protein or calories for the person. However, staff had noted that the person did not experience health effects from this routine and this was a lifestyle choice. Other calls during the day to the person showed they were supported with nutritionally balanced meals. Staff were also aware that referrals to GPs and dieticians could be made if needed, but this was only in circumstances where the person was at high risk of malnutrition. One staff member we spoke with told us about the respect they displayed for a person who made an unusual choice regarding their breakfast. The staff member explained that the person requested breakfast cereal with cranberry juice on it and not milk. The staff member questioned the person's choice, and the person stated 'that's the way I like it'. The staff member assisted the person with their breakfast by placing cranberry juice on the breakfast cereal. The staff member also updated the personal care records so that if other staff visited, they would know this was how the person liked their breakfast. This showed that staff were conscious of people's decisions and changed planned care in line with preferences and dislikes.

The personal care and rehabilitation service was provided to people for up to six weeks. However, there was an exceptional promotion of good health maintenance and continued support implemented for people who used the service throughout their care and afterwards. The Short Term Support and Rehabilitation Team maintained links with the nearby community health NHS Trust. A number of staff from the Trust were seconded in their role to work side by side the staff who provided the personal care. At the commencement of the service, people could be referred to physiotherapists and occupational therapists and the provision of personal care ran parallel to the support from the multidisciplinary team. Referrals were made quickly to a wide range of other health professionals when it was necessary.

An example of effective care was highlighted by one of the healthcare professionals we contacted in relation to the service. The service referred a person to the community NHS Trust because of concerns with their health during personal care. Staff had detected an unusual presentation and serious decline in this person's physical condition. When the community physiotherapists and occupational therapist became involved in the person's care, an urgent assessment was completed. The person's condition during personal care in their home indicated a rarer, as yet, undiagnosed neurological disease. This led to a speech and language therapist (SALT), GP and a neurologist also being consulted and involved. During the following week the person experienced further deterioration in their ability to assist or undertake personal care. More equipment was required and an increased level of care was implemented by support workers. Referral to other health professionals also led to social worker support from children's services. The service and their joined up working with community healthcare professionals meant the person could remain in their own home, with their family and receive the appropriate personal care they needed.

The provider maintained accurate records of their effectiveness in the provision of personal care to people who used the service. As one purpose of the service was to prevent hospital admissions and contribute to speedier discharge from hospitals by providing prompt personal care, we examined how responsive the service was to people's needs. We looked at data provided by the service and checked what health care professionals who had been involved in some aspect had to say. For a 12 month period we saw that a total

of 1,179 people had received personal care. Out of the total amount of people who received this care, more than 50 percent of people were independent of any adult social care at the point they stopped using the service. A further 17 percent of people who had used the service remained in their own home with support from community rehabilitation services, the resumption of domiciliary care they had previously received or the commencement of a long term package of personal care from another provider. Out of all the people who used the service in that one year we examined, less than one percent of people required admission to a care home at the end of their personal care. Some people did have to return to hospital for admission during the receipt of personal care or after the package of care had finished. However the provider was working to reduce this occurring. Community healthcare professionals told us that referrals from the service were prompt and allowed them to implement care, support and obtain equipment that the service did not provide itself.

Is the service caring?

Our findings

Many people and relatives we asked gave us feedback about the kindness and compassion displayed by the support workers from the service. Comments from people we interviewed or surveyed included: "Friendly staff", "All the carers were all very friendly and polite" and "I was pleased with the service provided". We surveyed and interviewed staff to gauge their opinion of whether the service was caring in its provision of personal care. Staff we had contact with were consistently passionate about the caring relationships they developed with people who used the service during the short timeframe of the care provision. They demonstrated genuine concern for people's welfare, they wanted nothing to be beyond their remit and that they wanted to always be professional in their approach. One staff member explained to us: "The service we provide does not allow for the RCA (support worker) to be introduced to the SU (service user) before making a visit; we are usually the first person in when someone comes out of hospital or a referral comes in from a doctor or district nurse. We need to be caring right from the very start". We also received a large number of responses to our request for feedback from community healthcare professionals who worked with or had contact with the service. Their response was similar in nature to that of the people and staff we spoke with or interviewed. When asked by us, one GP stated: "Yes they are consistently helpful and good quality in their response to patient's needs. I am happy with the service". Another GP surgery's practice manager commented: "The service has a very positive impact on the care of our patients".

The service measured their ability at being caring. A service satisfaction questionnaire was provided to all people who received personal care at the end of their engagement with the service. The satisfaction survey measured people's reactions to 11 aspects of care, including whether people felt staff were caring, supportive and their privacy and dignity were respected. We observed statistics in the provider's office as part of the inspection and reviewed them after the inspection pertaining to people's opinion of the personal care provided by staff and overall satisfaction. Scores from people surveyed consistently indicated that their opinion was that the service was caring. For the period 1 January 2015 to 29 February 2016, 264 people completed the satisfaction survey from the service. Out of the responses, 255 people indicated they were extremely satisfied or satisfied with the care. This meant people felt the service was consistently caring and that a caring approach was sustained over a long period of time.

We reviewed people's care to ascertain their level of involvement in planning, making choices and being able to change the care if they wanted. We found people who had the ability to and were free to make changes to their care when and if they desired. Where people's conditions meant they may not be as involved in the planning or execution of personal care, relatives and healthcare professionals were also consulted to ensure that the person received the best possible care based on preference and likes. The service also took into account that people often disliked very early morning visits for their personal care. Where possible they arranged calls which accommodated people's requests whilst not interfering with the delivery of care by the support workers for the remainder of their shift. We saw evidence from care documentation that frequent consultation with people by the office and support workers was undertaken to ensure that people felt listened to. At the time of the inspection, no one who used the service required an advocate to support them make choices or arrange their care, but there was the ability to have one if a person needed it.

We did not visit people in their homes as part of this inspection. However, we still found that people received personal care which was dignified and respectful. When we asked people and relatives during telephone interviews whether privacy and dignity was respected by staff during visits, they all responded that they agreed. The service offered and delivered person-centred care in a way that helped people to maintain a good level of independence, make choices and enable people to do as much for themselves as possible. The point of receiving personal care from the service was to ensure, as far as possible, that people could leave hospital sooner, return to their own home and regain the abilities they may have lost as a result of illness or surgery. When we interviewed support workers, two of them told us they had a passion to help the person in every respect. They explained that they had to "sit on their hands" and not intervene in people's independence, but only provide personal care when the person required the staff member's support. When personal care was provided, staff explained they maintained people's privacy and closed bedroom doors and closed curtains in people's homes. Confidentiality in all formats was maintained, especially in electronic communications. The portable devices that staff carried with them during their visits had encryption and if lost or stolen, effectively protected people's confidential personal information. Paper based folders in people's homes contained a device that would indicate to the office whether the folder was inappropriately removed from the house, and action could be taken by the service.

We found the service had provided end of life care to people for approximately five years. The service had identified that one aspect of their personal care that could be expanded on was people's end of life care, which meant more people could receive this type of personal care. The registered manager explained there had been an increased demand for people to be supported in their own home rather than inappropriately in a hospital or other locations where the person did not live. We saw evidence that even some people who had been admitted to care homes and hospitals were able to return to their own home safely to receive end of life care, surrounded by their friends and family. This meant the service was compassionate to people who did not want to pass away in a clinical or care environment. This also demonstrated that privacy and dignity after the person had passed away could be maintained as the end of life arrangements were protected by the person being in their own residence. The staff members confirmed they respected the person's and the family's decisions about what to do once someone had passed away. The choices people had made about arrangements after death were documented in care plans stored in the person's house for staff to refer to.

Ten staff had received additional recent training in end of life principles, and we reviewed the evidence of this during our inspection. A staff member we spoke with explained that in 2015 staff studied a bespoke course at a nearby college in end of life care. They told us they were guided by palliative care nurses in their learning, and they were required to research end of life care. Lectures were also provided to the staff undertaking the course from well-known national end of life organisations. The staff member we spoke with said: "The end of life course taught me about emotions of the service users, families and my own personal emotions as a staff member in providing this care". The staff member also stated: "We are only a short term team but sometimes you never know. We are able to access additional funding when it is needed to ensure our personal care can continue for people until they no longer require our support". A further ten staff were either booked or selected as ready to undertake training in end of life care. Another staff member we spoke with explained the ability of the service to set up end of life care rapidly. Health professionals we contacted confirmed this had occurred. Where necessary, the service referred to other community based healthcare professionals to ensure the person received a comfortable and spiritual death.

Is the service responsive?

Our findings

We asked four people if the service was responsive to their needs. All of these people expressed that the service met their needs and was flexible to them. Two relatives we interviewed agreed that their loved one received personalised care during the duration of the service provided.

We found staff had strong opinions about whether the service was responsive to people's needs. One staff member told us: "As a short term reablement focussed service we often take people being discharged from hospital at short notice or 2 hour responses from a GP to prevent an admission. In these instances I am not able to be introduced to a new client but I have received training and skills in delivering care on a first visit and how to carry out basic risk assessments in these circumstances. I believe the service provides individuals one of the best care in the area where it allows individuals to be as independent as possible in their own homes...". Another staff member commented: "Providing care to the residents of RBWM (the Royal Borough of Windsor and Maidenhead) is a very fulfilling job. This means we can provide a service which is responsive to their individual needs; in essence, tailoring the service to their needs rather than time. Calls can be increased if necessary due to any fluctuations in condition. Calls can be set up in 2 hours if needed due to emergencies that arise in the community via the GP and district nurse".

One responsive aspect in the provision of personal care was ensuring staff knew how specialised equipment from community healthcare professionals worked in people's homes. Support workers and management explained that they frequently referred people to external professionals because a person required adaptation of their home or equipment that supported the person being independent. When specialised equipment was introduced in people's homes to assist or enable the completion of personal care, the service determined that staff may not have had the knowledge of how to appropriately manage the appliance. The registered manager told us that the registered nurse from the equipment service would be asked to attend the office and demonstrate the correct functioning of the equipment. This ensured that the service was responsive to people's individual needs and ensured that person's independence.

The location had a complaints policy and procedure. Staff were made aware of this during induction and we observed a copy was easily available for office staff and support workers to access. Four staff we spoke with knew where the policy was and the steps it explained if a person needed to make a complaint. The policy and procedure contained the information for various staff members regarding their role in listening to and managing complaints. There was the ability to escalate complaints within the organisation if people felt their complaint was not handled well. We viewed the location's complaints register during the inspection and found a low number of complaints which were professionally handled. The manager and assistant manager's approach to complaints management was that people's concerns should not have to escalate into a formal complaint.

There was an open culture to concerns and complaints about the care at the service. People, relatives and others were always provided the opportunity to share their concerns or feedback, through multiple channels. They could telephone the service, e-mail the service, write to the service, express concerns with support workers during a visit to people's homes or complete a concern form. During the inspection, we

found evidence that people, relatives and healthcare professionals we contacted were, in limited situations, not always satisfied with the provision of care from the service. Examples of concerns were that the timing of the call was not what the person wanted, or the support people wanted did not fall within the kind of support the service provided. When we further reviewed people's feedback, we found that they experienced the service listening to and acting on their concerns promptly and appropriately. The service also showed that they took internal actions to limit the number of concerns they received from people who used the service. For example, rather than state specific times for a daily call or calls, the service communicated there was a call 'window' which meant that the personal care visit may be slightly earlier or later than expected. There was an expectation that staff who were majorly delayed would call the person and if necessary their relative, to inform them whether possible. When we reviewed these findings, we found they were supported by evidence in the office. When we interviewed support workers, they were clear about concerns and complaints should be handled.

Coincidentally, during the inspection we observed the registered manager deal with a concern from a relative who had telephoned the service. The relative was dissatisfied with a certain aspect of the personal care provided to their loved one and wanted a change in the care provided. We witnessed the registered manager remain calm and empathetic to the relative, offering their apology and acknowledgment that the situation for the person who received personal care was not suitable. The registered manager took notes throughout and ended the call by stating the actions they would take to rectify the concern from the relative. Soon after this, the registered manager spoke with staff who could change the care for the person in their home to be more suitable. They agreed to think laterally about how the person's and the relative's individual feedback could lead to an immediate change so that the service remained caring and had acted on the concern. This was implemented immediately, although we were unable to ascertain the relative's feedback regarding the changes in personal care provided by the service.

We found regular reviews of people's care were completed by the service's staff. Progress reviews for people's care and abilities were conducted on a frequent, regular basis. We looked at examples of weekly meetings involving support workers, weekly meetings for physiotherapists and monthly meetings for all staff where the care of people was reviewed. Staff were able to share pertinent information about people with their colleagues and review when changes in care may be required. Staff also discussed progress towards people's goals of regaining their independence or, whether referral to other services may be needed. The health professionals were able to ask questions of the support workers about how people were managing with their personal care. The health professionals received information from the review meetings that helped them to determine whether changes in their interventions were required to further assist people's recovery. We found an example of where a routine review of people's support led to more effective care for a person. A ramp was installed outside the front door of a person's house after their discharge from hospital. However, support workers found during visits that the person's ability to manage walking on the installed ramp was not independent, and required assistance from the staff each time. One support worker suggested during a review meeting of people's progress that the ramp at the house should be reconsidered. The staff member asked about alternatives and liaised with the occupational therapists who worked with the service. A different ramp at the person's house was installed, and this enabled the person to walk out of their front door safely and without any assistance. This meant that the person's independence was promoted through reviewing when care was not effective.

When people's care was transferred to another service at the end of the personal care package by the service, they were assured that relevant information about their needs was communicated and shared with the other service. This was completed by the sharing of pertinent information like demographic information, but more importantly through the copying of 'first visit' packs, risk assessments, care plans and referral information to community healthcare professionals. The service could also seek information from relevant

external healthcare professionals to provide to the new service provider. This process ensured that consistency in the provision of social care to the person could be maintained. In limited cases, the service had to continue the care for the person beyond the routine six weeks of care. Where this occurred, the information held by the provider was utilised to ensure that the person had gained functional independence or referred to alternative support care. When people's care needed to be transferred to other services at the end of their care package, the new service had the necessary information to ensure that people's care was coordinated. A staff member told us about an instance where a person in their home wanted to move to a hospice for their end of life care. The service copied all of the information they had about the care for the person's move to the hospice. The service also provided a verbal handover about the person's care to the hospice staff. The support worker from the service went to the hospice to ensure the person had comfortably settled in and checked whether staff had any questions about the person's care. This ensured that the service had taken all reasonable steps they could to ensure the person's change in care circumstances and location were as person-centred as possible.

Is the service well-led?

Our findings

The importance of a well-led service for this provider was paramount to the functioning of the team who provided personal care to people. This was necessary because people sometimes commenced care in challenging situations, for example when nearby hospitals had no spare beds and people needed to be quickly discharged back to the community. On other occasions, end of life care may have started where relatives were emotionally upset about the rapid deterioration in the health of their loved one. These factors, coupled with an abundance of referrals and the relatively short term nature of a personal care package for people meant there was complexity in the management of the service. Despite these factors, our inspection found the service was well-led and achieved the type of care that people in their own homes needed.

People surveyed prior to the inspection and interviewed by telephone during the inspection agreed that the service was well-led. Relatives were unable to give us their opinions about whether the Short Term Support and Rehabilitation Team was well-led, as they stated they did not have knowledge of or involvement with this aspect of the care provided. Staff were complimentary of the registered manager and deputy manager when we asked. Comments from staff included: "The team are very well trained, and managers very supportive; best team I have ever worked with" and "I feel this team is well-led and well supported by the team manager (registered manager) and assistant team manager (deputy manager). I am always able to gain advice and support when needed and despite working outside of office hours regularly I am always able to gain that support should it be needed". Four staff we interviewed at the office of the service agreed that the leadership had a continual focus on improvement, and that there was embracement of change. Again, healthcare professionals we contacted as part of the inspection agreed that the service was well-led. One stated: "[There is] good direction and support from the registered manager and assistant manager (deputy manager) who foster a caring and holistic ethos in order to meet the needs of the service users".

The provider had strong and clear visions about the type of service they aspired to and what they wanted for people who used the service. These were mapped out clearly in different types of literature the provider used. There were overall goals and values on printed brochures and on the location's website. The statement of purpose also clearly stated the aims and objectives of the service. Staff we spoke with knew the purpose of the service and the benefits for people gained from the personal care they received. People and relatives were openly encouraged to contribute to the development of the service. The service maintained strong ties with other departments in the local authority, commissioners and members of various multi-disciplinary teams also.

People held high opinions about the registered manager and deputy manager. The inspection method meant a significant portion of our time was spent with the registered manager and deputy manager asking questions and examining evidence. We found the registered manager and deputy manager of the service transparent, approachable and knowledgeable. In all circumstances, the two managers were able to provide evidence that the service was well-led, as well as safe, effective, caring and responsive. The provider had a registered manager in post who was well respected and liked, and worked at the service for many years. There was genuine continuity in the leadership at the service with a single registered manager since

registration of the provider's location under the Health and Social Care Act 2008. In all aspects of the management, they had oversight and were able to provide detailed information about the staff team, people who used the service, areas of strength and items for improvement. When we spoke with staff about involvement of management, they told us the two managers had an 'open door' approach, and constantly liaised with staff.

Due to the type of service provided, there were a limited amount of times that the provider needed to legally notify us of certain events in the service. However, we found the registered manager complied with the regulatory requirements to notify us regarding the running of the service, and always provided accurate and transparent information.

Providers are required to comply with the duty of candour statutory requirements. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity. The registered manager was familiar with the requirements of the duty of candour to people. The provider had a policy about duty of candour last reviewed in January 2016. The registered manager was able to clearly explain their legal obligations in the duty of candour process. The provider did not yet have an occasion where the duty of candour requirements needed to be utilised.