Surrey Childrens Service

Surrey Children's Domiciliary Care Service

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 17 November 2017 and was announced. Our last inspection was in July 2016 where we identified two breaches of regulations relating to risk assessments and governance. At this inspection, the provider had made improvements to meet the requirements of the regulations.

Surrey Children's Domiciliary Care Service provides support to children with a range of disabilities who have been assessed by a social care team as requiring a personal care service within the family home. Staff supported children with physical disabilities, learning disabilities, autism and managing their behaviours.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to children who live at home with their families. At the time of our inspection, the service was supporting 35 children.

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 children were routinely assessed with clear plans in place to keep them safe. There had been very few accidents or incidents, but staff responded appropriately where they occurred. Staff understood their roles in safeguarding children and we saw evidence of staff responding to concerns correctly. The service regularly played a role in multi-agency plans to keep children safe. Consent was sought from parents or children where they were old enough. Staff understood when the Mental Capacity Act (2005) could apply to the care that they delivered.

Staff worked alongside healthcare professionals and relevant agencies involved in children's care. Where staff administered medicines, they had been trained to do so and clear records were kept in this area. Children, families and staff had access to support in the event of a child receiving end of life care. Relatives told us that staff were on time and they observed staff following good infection control practice on visits.

Children's care was delivered in a way that met their needs, preferences and family routines. Staff supported children to attend schools and activities as well as to go on outings and to play. Children's care was regularly reviewed and any changes were actioned by staff. Children and their families were regularly consulted in the quality of the care that they received. The provider had a clear complaints policy and relatives knew what to do if they wished to raise concerns.

Staff had the training that they needed to support them in their roles. Staff spoke highly of the management at the service and said that they felt supported and had opportunities to make suggestions. The provider had systems in place to enable effective communication between staff and ensured staff had access to secure, up to date records.

Staff routinely ensured children and their families were involved in their care. Choices were offered in line with routines and preferences and relatives told us that staff were respectful when entering their homes. The management had a clear vision for the service and an ongoing plan was in place to improve the service and deliver high quality care.

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.

Risks to children were appropriately managed and staff responded appropriately to accidents or incidents. Staff raised escalated concerns to children's safeguarding teams where they identified them.

Staff were deployed in a way that meant they arrived on time. The provider carried out checks on new staff to ensure that they were suitable for their roles.

Children's medicines were managed and administered safely, by trained staff. Staff observed good practice to reduce the risk of the spread of infections.

Is the service effective?

Good

The service was effective.

Staff were trained to carry out their roles and received supervision and appraisals to provide support and monitor performance.

Children's needs and choices were clearly documented and children's nutritional needs were met in line with their dietary needs and preferences.

Staff worked alongside healthcare professionals and appropriate agencies to meet the needs of children and their families.

Consent was obtained from the appropriate people or children where they were old enough. Staff understood when the Mental Capacity Act (2005) may apply to the care they delivered.

Is the service caring?

Good

The service was caring.

We received positive feedback on the caring nature of staff and the provider had systems in place to monitor and ensure that staff were kind and compassionate.

Children were supported by regular staff that got to know them and their families well.

Children and their families were involved in the care that they received. Staff were respectful of privacy and dignity when providing support in children's homes.

Is the service responsive?

Good

The service was responsive.

Children received personalised care that matched their needs, preferences and family routines. Staff supported children to attend activities go on outings or play.

Regular reviews were conducted to identify changes in need and these were actioned by staff. Staff were trained in how to deliver end of life care.

A clear complaints policy was in place and relatives knew how to raise any concerns. Complaints were dealt with appropriately.

Is the service well-led?

Good

The service was well-led.

The provider carried out regular checks and audits. Records were kept up to date.

Staff felt supported by management and had regular meetings and systems in place to enable effective communication.

The provider had a clear vision for the service and an ongoing plan was in place to continue to improve and develop the service.

The provider worked with outside organisations and agencies to ensure that children received holistic care from trained staff.

Surrey Children's Domiciliary Care Service

Detailed findings

Background to this inspection

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

Inspection activity started on 17 November 2017 and ended on 03 January 2018. We visited the office location on 17 November 2017 to see the manager and office staff; and to review care records and policies and procedures. We conducted phone calls to relatives and staff after the office visit.

The inspection was carried out by one inspector, a nurse specialist in paediatric care 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.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

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.

As part of our inspection we spoke with five relatives. We spoke with the registered manager and four care staff. We read care plans for eight children, medicines records and the records of accidents and incidents, complaints and safeguarding. We looked at records of audits, surveys and the provider's development plan.

We looked at three staff recruitment files and records of staff training and supervision. We reviewed a selection of policies and procedures and health and safety audits. We also looked at minutes of staff meetings, records of spot checks and evidence of partnership working.

Good

Is the service safe?

Our findings

At our inspection in July 2016, we identified shortfalls in the safety of the care that children received. There were not always clear plans in place to manage identified risks and actions taken in response to accidents and incidents were not always robust. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014). At this inspection, the provider had taken appropriate action to meet the legal requirements of the regulation.

Relatives told us that the care provided to children was safe. One relative told us, "I do feel that [child] is safe, the support worker can see when he is struggling and will spot that." Another relative said, "I feel very safe with [staff member]. I'm happy leaving [child] with her and she will always check if she's uncertain about anything, which makes me feel confident."

Risks were routinely assessed and plans were implemented to ensure children's safety. One relative told us, "If the hoist breaks down [staff member] helps me; she is quick to respond." Care records contained evidence of risk assessments. Assessments were holistic and anticipated risks children might face in areas such as moving and handling, behaviour or medicines. One child was supported with hoisting equipment as they were unable to weight bear fully. A risk assessment identified how staff should support the child safely to get out of the bath. It documented that sometimes the child may refuse to get out of the bath, which presented a risk. There was a detailed guide for how staff were to use a harness and hoist to physically assist the child from the bath, if they were unable to use positive persuasion techniques to encourage them to step out. Where staff supported a child with risks relating to their behaviour, staff told us how they supported the child safely using positive strategies such as distracting the child with toys or allowing the child time to calm before supporting them. Where children had specific medical conditions, such as epilepsy, clear plans were in place to manage the risks associated with them.

Where accidents or incidents occurred, appropriate actions were taken by staff to ensure that children were safe. Since our last inspection, the registered manager had introduced a new system to ensure they had oversight of any incidents that occurred and could follow up on any actions being taken in response. The registered manager now documented all accidents, incidents, safeguarding concerns and complaints on a central spread sheet which they analysed each month, as well as reviewing any incident records when they occurred. This ensured that a system was in place to analyse accidents and incidents, meaning the provider could learn from any trends that they may identify.

Records showed that there were very few accidents or incidents but where they had occurred, staff responded appropriately. For example, a child had tripped over and sustained a minor injury whilst out on an activity with staff. The staff member informed management immediately and completed a body map to document the injury. The child's care plan and risk assessment were reviewed and they had not suffered a similar accident since.

Children were supported by staff that understood their roles in safeguarding them from abuse. Staff had been trained in how to identify safeguarding concerns and they knew who to contact if they suspected that

abuse had occurred. A staff member told us, "I'd call the office straight away or the out of hours number. I could also go straight through to the Emergency Duty Team (social services), which I have had to do before." Records showed that staff raised safeguarding concerns appropriately where they identified them. We also saw evidence that staff worked alongside children's social services teams where their support had been identified as a measure to ensure children's safety following child in need assessments.

Staff were deployed in a way that meant that they arrived punctually. One relative told us, "The support worker always arrives on time. Except once when she had a flat tyre; she phoned me before the emergency services, she's always good." The provider arranged calls in a way that took into account where children lived and travel time. The provider's audits and surveys monitored punctuality and records showed that children and their relatives were happy with the time that staff arrived. One survey form written by a child said, 'I can't tell the time but mum said she (staff) is on time.'

Appropriate checks were carried out to ensure that staff were suitable for their roles. Staff files contained evidence of references, work histories, proof of right to work in the UK and health checks. The provider also routinely carried out checks with the Disclosure & Barring Service (DBS). This is used to identify potential staff who would not be appropriate to work within social care.

Medicines were administered safely. Children's care records contained information about their medical conditions and any medicines that they had been prescribed. Where medicines were administered by relatives, this was clearly recorded in children's records. Where staff administered medicines, details of what medicines were to be administered and how children received them were documented in care plans. Where children were prescribed PRN (as required) medicines, there were protocols for when to administer these. For example, one child had epilepsy and was prescribed emergency medicines to be taken in the event of a seizure. Information on how and when to administer this medicine was clearly documented in the child's records and a staff member had a good understanding of this.

Medicine administration records (MARs) were up to date and there were no gaps. The provider regularly checked these as a part of their audits and records showed that they had identified no concerns. Staff had been trained in how to manage medicines and their competency had been assessed before they administered medicines to children.

Children were protected against the risk of the spread of infection. One relative told us, "The support worker is good about washing her hands and she uses gloves." Relatives said they observed staff following good practice in infection control; washing their hands regularly and wearing gloves where appropriate. Staff had received training in infection control and this had been regularly refreshed.

The provider had clear plans in place to follow in the event of an emergency such as extreme weather or disease pandemic. The plan identified how potential emergencies could impact on care delivery and plans were identified to be implemented should they become necessary.

Good

Is the service effective?

Our findings

Relatives told us that children were supported by staff that were trained to carry out their roles. One relative told us, "The support worker is not frightened by anything; the epileptic seizures, the wheelchair and the hoist." Another relative said, "My son has a very rare condition and [staff member] has experience of working with others that have the same condition. He uses a specific communication process and [staff member] is a practitioner of that."

Staff told us that they received an induction before starting working with children. One staff member told us, "I did a comprehensive induction when I started." Staff attended training courses as well as shadowing experienced staff members when they started work for the service. Induction training included mandatory areas such as safeguarding children, moving and handling, infection control and health and safety. The provider kept a record of training completed and ensured training was regularly refreshed. Staff told us that they found this training useful and that they also received training specific to children's needs. For example, one child used a medical device for feeding and medicines. The device required specialist training to operate and we saw records that showed that the staff who supported the child had been trained by a healthcare professional in how to use the device safely. Where staff supported children with specific conditions such as epilepsy and diabetes, records showed that they had received training in these areas. Where staff had backgrounds or expertise in particular areas, such as autism or behavioural support, they told us that the provider matched them with children who had those needs.

Staff received regular support from their supervisors to enable them to carry out their roles. Records showed that staff received regular one to one supervision meetings. These were used to discuss children's needs as well as to discuss any areas they may require more training in. The provider also carried out regular observed practice to measure staff performance. Records of these showed that observations were thorough and were used to identify any learning needs for staff. There was an appraisal process in place which staff followed. Appraisals were used to measure staff performance and staff set themselves goals for the coming year. These included enrolling on specialist training courses as well as completing additional qualifications that the provider arranged for staff.

Children's needs were assessed and staff supported children and their relatives to make choices about their care. One relative told us, "The support worker offers my daughter choices, for example they'll talk about which talc or deodorant spray to use, there's lots of laughter and giggling." Records showed that assessments were carried out which captured children's preferences as well as the routines of their families. Staff supported children to make choices in ways that were suitable to their needs. For example, one child used a specialist communication device, as well as facial expressions, to communicate. Their records contained detailed information about how this worked. Staff referred to these in their daily notes which showed that this method of communicating was enabling the child to express choices.

Children were supported to eat balanced and nutritious meals in line with their preferences and their parent's wishes. Care records contained information about the types of foods children liked. One child particularly liked ketchup, which they referred to as 'red jelly' and this information was clear in their care

plan. Another child's records clearly documented that they had swallowing difficulties and really liked eating banana as this was easy for them to swallow. One child used a specific medical device to feed and this was clear in their records. Their relatives told us that staff supported this child to feed using the device competently.

Staff worked alongside healthcare professionals to ensure children's needs were met. Records contained information from school nurses, health visitors and social workers. Staff attended important meetings where children's needs were discussed. One child had been referred to the service through a local scheme to support children living with disabilities. Their records contained detailed information from healthcare professionals involved in the child's care and staff attended regular meetings to discuss this child's development. Children's records also contained evidence of staff communication with schools and colleges that children attended.

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 applies to people over the age of 16. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At the time of inspection, there were no children being supported who were subject to the MCA. The provider did support children over the age of 16 and showed us historic examples of where they had applied the MCA when supporting children. Staff had received training in the MCA and were aware that whilst it would not apply to the majority of children that they supported, there may be times when a mental capacity assessment is required for a child over the age of 16. Records showed that where children were old enough and able to, they had signed their consent forms. Where children were of a younger age, parents or guardians had signed consent on their behalf.

Good

Is the service caring?

Our findings

Relatives told us that children were supported by caring staff that were committed to their roles. One relative said, "[Staff member] is amazing, I couldn't ask for a better carer. I wouldn't want to let her go." Another relative said, "The carer listens to my son, she will have conversations with him and is interested in what he has to say. She ticks all the boxes and is very friendly."

The feedback on the caring nature of staff was all positive. Relatives told us that children were supported by consistent staff that got along well with them. Relatives gave us examples of how their trust and satisfaction with the caring nature of staff had impacted positively on their lives. One relative told us that their allocated staff member fitted in well with the whole family and they enjoyed activities together. Another relative told us how the member of staff engaged really well with all their children and created a positive atmosphere during visits.

The provider also monitored the caring nature of staff through their checks. The provider conducted regular surveys in which children and relatives were asked about the staff that supported them. Records showed that the feedback received was all positive and showed that relatives were provided with opportunities to give feedback and make changes if they wished. In a recent survey a child had written, 'I get very excited about [staff member]'s visits and ask about her often.'

Calls were planned in a way that ensured consistency of staff which impacted positively on the that was care delivered. Each child had an allocated support worker. The support worker was a dedicated member of staff that oversaw care and worked closely with children to get to know their needs and preferences well. Support workers took the lead on supporting children and got to know them and their relatives. Children were involved in choosing and considering what they wanted from a support worker. We saw evidence of a recent project entitled 'My support worker is…'. This project involved children making pictures and collages that represented what they wanted from a support worker, which also encouraged them to feedback on the care they received. The provider produced pictorial sheets for children detailing who their support worker was and what they could help them with. Staff had a good knowledge of children's needs and preferences and told us that the provider had systems in place to ensure they got to know them well. One staff member said, "Families often ask us for advice and we provide them with reassurance. We are constantly updating our information as we build up more knowledge."

Systems were in place to enable children and their relatives to express their views. Records showed that at reviews children and relatives were regularly asked about their preferences and any choices that they wished to make. Records contained information such as children's favourite foods, what cartoons they enjoyed watching and what toys they liked to play with. Staff were knowledgeable about these which showed that where children made choices, these were acted upon by staff. Where children had specific communication needs, staff enabled them to make choices in line with these needs. One relative said, "The carer offers [child] choices, he uses his left or right hand to indicate what he would like. The carer will ask, 'Do you want to be good or naughty?' He's helped me discipline my son better."

Care was provided in a way that respected the privacy and dignity of children and their families. A relative said, "[Staff member] is very respectful. She'll make sure he's covered up when one area is done." Staff had received training in privacy and dignity and records showed it was also discussed at spot checks and supervisions. All relatives told us that staff were respectful when entering their homes and providing care. Staff showed a good knowledge of how to provide care in a way that promoted children's privacy and dignity. One staff member said, "I always tell the child what we're going to do and make sure the room is warm enough for personal care. I use a towel to cover them and will speak with the parents if there are any issues."

Good

Is the service responsive?

Our findings

Relatives told us that their children received care that was personalised to their preferences and routines. One relative said, "We've agreed a set routine to provide continuity, [staff member] is very good and just gets on with it." Another relative said, "Before the support worker started to work with [child] the manager came and we had a two hour consultation about [child] and any likes or dislikes."

Care plans were detailed and clearly outlined what was important to children and their families. Information about preferences and routines were clear for staff. For example, one child sometimes had problems getting to sleep. There was particular music and songs that they liked to listen to before bed which helped them to relax. This information was clearly outlined for staff in their care plan. Another child liked to play video games with siblings and liked to visit particular local parks. These were listed in their care plan and daily notes showed that staff regularly supported the child to go to the places that they enjoyed visiting. Where one child's mobility limited the amount they could play, the provider had drawn up a detailed plan of items the child liked to touch and songs that they liked staff to sing to them.

Staff told us that they had access to the information that they needed to provide personalised care. One staff member said, "The care plans are fundamental. Some parents have difficulties themselves so we encourage activities that are appropriate for the family situation." Care plans were also produced in a pictorial format through social stories that were accessible for children. These were also used by staff to inform children of what they were doing and to provide them with opportunities to make suggestions or give feedback on their care. Records showed that care plans were regularly reviewed and discussed with relatives and children.

Regular reviews were used as an opportunity to identify changes in need, as well as for children and their families to provide feedback. At a recent review of one child, care staff identified a need to change the timing of one of their calls due to a new after school club. This had been documented and actioned in a timely manner. Another child had recently expressed a desire to go swimming. The provider and the child's family had arranged this and staff prepared pictures to support the child to communicate and identify items at the swimming pool. All care plans contained evidence of a thorough assessment that involved children, their families and relevant healthcare professionals or agencies involved in their care.

At the time of inspection, no children were receiving end of life care. The registered manager told us that the staff had training in bereavement and loss as they had supported children with life limiting conditions in the past. The provider had links with healthcare professionals and voluntary organisations to ensure children, their families and staff had appropriate support to provide care at these times.

Relatives were aware of how to raise a complaint if they were not happy with their child's care. One relative said, "I've not had to make any complaint, if I had to I'd check the leaflets with the information in." Another relative told us, "I've no need to complain, but do know how to complain. I'd talk to the carer first but I can't imagine it would happen." Relatives were provided with information that informed them of the provider's complaints procedure. The provider kept a record of all complaints and the actions that they had taken in

response. There had been two complaints since our last inspection and records showed that these had been handled appropriately and the provider checked that complainants were satisfied with the outcome.

Good

Is the service well-led?

Our findings

At our inspection in July 2016, we found a lack of systems in place to monitor and audit the quality of care that children received. We also identified shortfalls in the security of records staff used in the field. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014). At this inspection, the provider had made the necessary improvements to meet the requirements of this regulation.

Relatives told us that they felt the service was well-led. One relative told us, "The management are open and honest, they came out and did an assessment." Another relative said, "The manager regularly checks how things are, if I'm worried I can contact her, I don't have to wait for her to contact me." Another relative told us, "They're easy to get hold of and very friendly. They meet people and respond to emails and over the phone. They're very approachable."

After our last inspection, the provider introduced additional audits to ensure regular appropriate checks were undertaken on the quality of the care that children received. The provider regularly audited their documentation to ensure care records were up to date and accurate. The provider carried out regular spot checks where they telephoned families to ask about the care that staff delivered. The provider conducted two surveys each year, one for children and one for their families. Children's surveys used pictures and language suited to their age group. Records of these showed they were effective in providing children with an opportunity to give their feedback. Comments from a recent survey included, 'Enjoy going out with my support worker' and '[Staff member] is an angel'. Comments from families were equally as complimentary. Where one family member had fed back that there had been problems with the timing of calls, this had been addressed by the provider.

The provider maintained accurate and up to date records securely. Since our last inspection the provider had introduced protected electronic smartphones to ensure records that staff used whilst on calls were secure. During this inspection we observed that care plans had been recently reviewed and reflected the current needs of children and their families. Daily notes were completed for each visit and reviews were documented in a timely manner. For example, one child had been reviewed the day before the inspection and by the time of our visit the information from the review and changes to a risk assessment had been actioned. Records were stored securely in the provider's office.

Staff told us that they felt supported by management. One staff member said, "It's very well managed. We can always get hold of them." There were systems in place to ensure good communication between staff. The smart phones that were introduced for staff enabled improved communication. Staff all had individual email addresses and these were used to disseminate important information and newsletters. A newsletter kept staff informed of important information such as training dates and workshops. Staff had regular meetings and they told us that these were both informative and an opportunity to make suggestions to improve the service. A staff member told us that they fed back that they did not always know who the out of hours manager was. In response to this, the provider had made sure this information was clear and available to staff who worked out of hours.

The provider had a vision for the service and was implementing improvements to achieve this. A new registered manager was in post since our last inspection and they had introduced ideas to the service. There was a development plan in place that the provider used to document and track improvements at the service. Actions taken by the provider were designed to improve the care experience of children and their families. For example, recent improvements included providing accessible pen portraits of staff to enable children to get to know them and become familiar with them when they started working with them. Another recent improvement involved changes to staff observations. The forms had been revised and linked to CQC's key questions. Records showed that observing staff practice in this way had resulted in holistic and robust checks on staff practice. Records showed that the observations went into a lot of detail and included children's responses to staff and feedback from relatives.

The service worked well with outside organisations to improve the quality of the care that children received. For example, we saw evidence of the agency working with Barnardo's to arrange an information workshop for children and their families, as well as staff. These were delivered by staff from Barnardo's who had learning disabilities and provided important information to children and families about engaging with services. Throughout all records seen we saw examples of consultation with healthcare professionals and joint working. A recent message from one professional in a provider survey said, 'Please keep up the great work, as I know the families I work with appreciate it very much.'