

Surrey Hills Home Help Services Ltd

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Inspection report

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Date of inspection visit:
14 November 2017

Date of publication:
24 January 2018

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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 14 November 2017. The inspection was announced. The provider was given two working days' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available at the locations office to see us. 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 older adults. There were eight people using the service who were receiving personal care at the time of the inspection. Surrey Hills are a domiciliary care agency based in Edenbridge who are registered to provide personal care to people living with dementia, older people, learning disabilities or autistic spectrum disorder, mental health, people with an eating disorder, physical disability, sensory impairment and younger adults. Surrey Hills Home Help Services Limited will be referred to in this report as Surrey Hills. Surrey Hills was registered with CQC in November 2016 and had not been inspected prior to this inspection.

At the time of our inspection there was a registered manager at the service. 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.

People were kept safe from abuse and harm and staff knew how to report concerns about abuse. Risks were minimised through the use of effective control measures to keep people safe whilst promoting their independence. There were sufficient numbers of staff deployed to meet people's needs and ensure their safety. People received their medicines when they needed them from staff who had been trained and had their competence checked. Staff understood the best practice procedures for reducing the risk of infection and carried a bag of protective equipment such as hand gel and shoe protectors on every care call. The service used incidents, accidents and near misses to learn from mistakes and drive improvements.

People had effective assessments of their needs prior to a service being offered. This meant that care outcomes were planned and staff understood what support each person required. Staff were trained in key areas and had the skills and knowledge to carry out their roles. People were supported to receive enough to eat and drink; staff used food and fluid charts to record intake for people at risk or malnourishment or dehydration.

The service worked in collaboration with other professionals such as district nursing and people's GP's to ensure care was effectively delivered. People maintained good health and had access to health and social care professionals. Environments were risk assessed to ensure people were safe in their homes and staff could work without the risk of danger. The principles of the Mental Capacity Act were being complied with and any restrictions were assessed to ensure they were lawful and the least restrictive option.

Staff treated people with kindness and compassion in their day to day care. Staff knew people's needs well and people told us they valued and liked their care staff. People and their relatives were consulted around their care and support and their views were acted upon. People's dignity and privacy was respected and

upheld and staff encouraged people to be as independent as safely possible.

People received a person centred service that was supportive of their needs. People's needs were fully assessed and care plans ensured that personal details were carried through to care delivery. There was a complaints policy and form, though no complaints had yet been received. Staff were open to any complaints and understood that responding to people's concerns was a part of good care. End of life care had been planned for people who wished to do so. The service worked with local hospices to implement their own end of life care policy and ensure people had a dignified death in the manner of their choosing.

There was an open and inclusive culture that was implemented by effective leadership from the registered manager. People and staff spoke of a 'family' care company that was small but caring. The registered manager had ensured that audits of quality were effective in highlighting and remedying shortfalls and the registered manager understood their regulatory responsibilities. People, their families and staff members were engaged in the running of the service. There was a culture of learning from best practice and of working collaboratively with other professionals and health providers to ensure partnership working resulted in good outcomes for people.

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 agency was safe.

People felt safe and were protected from the risk of potential harm or abuse.

Risks to people, staff and others had been assessed and appropriately managed. Procedures were in place for the event of an emergency.

There was a sufficient number of staff to ensure that people's needs were consistently met. Safe recruitment procedures were followed in practice.

People who received support with their medicines did so safely.

The risk of infection was controlled by staff who understood good practice and used protective equipment.

Is the service effective?

Good 

The agency was effective.

People received extensive assessments of their needs that ensured effective support outcomes were set and worked towards.

Staff received training to meet people's needs. An effective induction and training programme was in place for all staff.

People were supported to eat and drink enough to maintain good health and this was monitored where needed by staff.

Staff members worked effectively with other agencies and organisations to ensure the care people received was effective.

People were supported to remain as healthy as possible and had access to healthcare professionals.

Staff understood their responsibilities under the Mental Capacity Act and used these in their everyday practice. Staff understood the importance of gaining consent from people before they

delivered any care.

Is the service caring?

Good ●

The agency was caring.

People were supported by staff who were caring and respected their privacy and dignity.

People were involved in the development of their care plans. People's personal preferences were recorded.

Staff had access to people's likes and personal histories and used the information to support people in a way that upheld their dignity and protected their privacy.

Is the service responsive?

Good ●

The agency was responsive.

People's needs were assessed, recorded and reviewed.

People received personalised care and were included in decisions about their care and support.

A complaints policy and procedure was in place and available to people.

Where people received end of life care this was planned and provided sensitively.

Is the service well-led?

Good ●

The agency was well-led.

There was an open culture where staff were kept informed and able to suggest ideas to improve the service.

There were effective systems for assessing, monitoring and developing the quality of the service being provided to people.

Staff understood their responsibilities and knew who the management team were, and felt able to approach them.

The views of people and others were actively sought and acted on.

The service continuously learned and improved and staff were given opportunity to progress.

The service worked in partnership with other agencies.

Surrey Hills Home Help Services Limited

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 checked 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 gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection activity started on 13 November 2017 and ended on 14 November 2017. One inspector carried out this inspection. It included visiting the site office, visiting people in their homes with the registered manager present and speaking to people and their relatives on the phone which we did on 13 November. We visited the office location on 14 November 2017 to see the registered manager and office staff; and to review care records and policies and procedures. Not everyone using Surrey hills received personal care. CQC only inspects the service being received by people provided with 'personal care': help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. 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 the inspection we spoke with the registered manager, the administration assistant, a senior carer, one carer, four people using the service and three people's relatives. As some people who received a care package from Surrey hills were not able to tell us about their experiences, we observed the support being provided. We looked at a range of records about people's care and how the service was managed. We

looked at four people's care plans, medication administration records, risk assessments, moving and handling assessments, four staff files, accident and incident records, complaints records and quality audits that had been completed.

Surrey Hills Home Help Services Limited has not been inspected by CQC before.

Is the service safe?

Our findings

People and their relatives told us that they felt safe being cared for by Surrey hills. One person told us, "Surrey hills set up a key safe for us so that the carers could let themselves in and it works well." Another person commented, "I usually have the same carer, if not I do know who is coming." A relative told us, "He knows who is coming that makes him feel safe, he has a rapport with them." A second relative commented, "They make sure he takes his meds they will watch and then record it. They also go and collect his meds as the delivery is not reliable and they like to know he has them."

People were kept safe from abuse and harm and staff knew how to report suspicions around abuse. The provider had an up to date safeguarding policy that listed all current legislation and contained the most recent definitions of abuse including modern slavery and institutional abuse. The policy identified the registered manager as the safeguarding lead for the provider. Any safeguarding concerns had been recorded on a safeguarding log and on corresponding incident forms. We saw one incident where staff had been concerned for a person's safety and had called the police. Referrals had been made appropriately to the local authority safeguarding adults team and to CQC. We noted that a copy of the local authority multi-agency safeguarding adults policy and protocol was not available to staff and discussed this with the registered manager. By the end of our site visit this had been printed off and left in the office for staff to access and certain sections, such as flowcharts for reporting concerns had been discussed with staff members. Staff members spoke confidently about reporting suspected abuse. One staff member told us, "I report to [manager] but have authority to report safeguarding matters straight to the police and the local authority. I sit in on some safeguarding meetings. For example, I was involved in reporting, planning and resolving the case of a SU that was subject to financial abuse."

Risk assessments were effective in keeping people safe and used control measures to mitigate hazards whilst ensuring not to curtail people's choices unnecessarily. Risks were assessed as part of the care plan with identified needs described and a corresponding risk assessment produced. For example, we saw one assessed care need for someone who required support to manage breathlessness. They had been identified as being at risk during or immediately after a seizure. The plan had been reviewed seven times in the past 12 months. The corresponding risk assessment identified controls measures to reduce the potential hazard, such as ensuring the person was laid on their side during recovery from a seizure. Another person had been identified as at risk of kidney infection and their risk assessment gave clear action to manage this risk through a low salt diet. The reduction of potential hazards through sensible risk assessment ensured people could maintain a level of independence whilst remaining safe. When risks had been assessed they were given a new rating to reflect the reduced level of danger.

There were enough staff deployed to keep people safe and staffing levels were agreed at contract commencements. One person told us, "Our carer does vary from three to four different ones; they usually tell us before who is coming, they have a list and can tell me who is next to arrive and I am familiar with all of them." One relative commented, "He has a regular core of carers who come he is told in the morning who will be coming for the rest of the day." Surrey hills receive potential care packages from local authority social services teams and private referrals. At the commencement of the care package people are given allotted

times. The registered manager told us, "If it is personal care we usually allow for an hour in the morning; if we're not there for the whole time we charge for the time used." We reviewed four weekly rotas for the period prior to our inspection and saw that people were receiving the support they had been assessed for. The registered manager explained that where peoples' needs change the service increases hours, and showed us examples where this had happened. One staff member told us, "Sometimes we have 10 minutes to sit and talk to the client after all the jobs are done. There's enough time on each care call and if people are assessed as needing two staff then we always have two staff."

Recruitment systems were robust and made sure that the right staff were recruited to support people to stay safe. We checked the recruitment files for four members of staff. In all cases thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. The registered provider had consistently tracked the employment history of each newly recruited person to maintain the safety of the recruitment process. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff members were appointed and references were obtained from the most recent employer where possible.

Medicines were managed safely and people were trained and their competence checked by the registered manager. People's medicines and their medical histories were tracked from the initial assessment through their care plans. Where staff supported people to take their medicines they recorded this on medicine administration record (MAR) charts. Staff were actively monitoring people's medicines. On the day of our inspection a staff member had flagged to the registered manager that a person had been discharged from hospital with a change to their prescription and this had not been actioned by the local surgery. The registered manager had ensured that a new prescription was issued for the person. We noted that MAR charts had been completed by hand for new clients where a pharmacy chart was unavailable. These MAR charts had been completed and signed by one staff. We advised the registered manager that it is best practice to have a second staff member check the details entered on hand written MAR charts until a pharmacy printed chart can be obtained. The registered manager told us that this would be implemented immediately and requested staff to double check and sign any hand written MAR charts. There was a set of medicines policies which contained up to date and relevant information and set out the correct procedures for, amongst other things, how to manage controlled drugs, how to manage covert medicine administration and medicines errors and near misses.

The risk from infection had been assessed for each person and the risk of infection was reduced by staff who were knowledgeable and used their training to keep people safe. Staff members had access to personal protective equipment (PPE) such as gloves, aprons, alcohol gel and foot covers. Staff told us that they used PPE correctly when supporting people. One member of staff said, "At times the service ensures that only selective staff care for people with an infection, i.e. the same, selected staff provide care to a person with an infection so as not to spread the infection to other people." People we spoke with confirmed that the staff were careful and clean when providing care in their homes. People had cleaning schedules in their care plans that staff completed every week. These could be personalised for each person and staff signed to indicate that they had completed tasks, such as clean the toilet, empty the bins and clean the hob/oven.

Surrey Hills learned from incidents and accidents and used the learning to make improvements to service delivery. We reviewed the accident and incident file and saw that incidents had been recorded where staff members had experienced concerns. On each occasion we saw that the incident had been recorded clearly and factually and had been reported appropriately. The registered manager had conducted an investigation into the cause of each incident and where there were changes that could be made to increase people's

safety these had been implemented. For example, one incident related to medicines that had been found to be missing from a pack and not given. In this instance all staff concerned were re-trained, the matter was discussed in a team meeting and the performance management procedure was followed.

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they had the training and skills to meet their needs effectively. One person told us, "Oh yes, they seem to know how to change my dressing: they can do it much better than me" One relative commented, "They called 101 before as they found X unwell, the paramedics came out and her sugar levels were low. This was communicated to Surrey hills and it was agreed that the calls should be increased." A relative said, "They look out for my brother like for instance, when they were helping him in the shower they noticed a change in his breathing: they called me and told me it didn't seem right, so we called his GP and turned out he had a chest infection. This gives me great confidence in their training and competence."

There were assessments of people's needs prior to a service being provided. The assessments identified a range of people's needs from which support plans were drawn up and worked to accordingly. Each person's care plan was used as an initial assessment of their needs, where the registered manager would fill the care plan in initially with the person or their relative and complete each service user risk assessment. People's needs were assessed in different areas such as continence; infection; lifestyle; medication; mental health, and mobility amongst other areas. People's life histories were examined and included information about close family members, such as grandchildren or children, and different places the person had lived in. Assessments also contained information about people who support the person, for example, district nurses; details of the person's property such as where the fire alarms are to be found, adaptive equipment, pets and any wishes for end of life care. The assessments enabled the registered manager to produce personalised and detailed care plans that contained relevant information and enabled staff to meet peoples' outcomes, such as always having their personal care at a certain time, or receiving their meals in the way, and at the time, of their choosing.

Staff were trained and their knowledge was checked by the registered manager. However, we noted that staff did not have a scheduled training plan, although they were receiving training in key areas. This meant that it was not easy to track when people's training had expired. We discussed this with the registered manager who took immediate action and sent confirmation that all training had been booked and planned, via an external provider, by the end of our inspection process. Staff told us they had the training to carry out their roles and people felt their staff knew how to look after them. One member of staff told us, "We are always updating our training online. In staff meetings we discuss training and extra training is provided if necessary." Staff received moving and handling training from two trainers and staff members practised using the lifting and hoisting equipment. Where people were discharged from hospital with new equipment there were two staff members, who had the correct level of training, that trained other staff how to use the equipment correctly. New staff members had been signed up to the Care Certificate. The Care Certificate is a nationally recognised set of standards that social care and health workers work towards every day.

Where people had a need around nutrition or hydration this was assessed and support planned with the person. Fluid, food and urine output charts were used where appropriate. One staff member told us, "If we're concerned we put food and fluid charts in place. Some people we leave to eat and then record what is left when we return. If we feel people aren't eating and drinking enough we encourage them and can also

get nutrition drinks from their GP." Care plans contained nutrition and hydration plans for people with a need in this area. One person who required a specialised diet due to an ongoing health issue had a care plan and risk assessment for nutrition and hydration. The plan ensured the person was supported to make choices that were beneficial to their health and gave staff information about choices that were healthy. For example, there was an NHS information booklet about the type of diet the person needed and staff had guidance about what types of food to buy and avoid when doing the persons food shopping. The person had fluid charts in place to monitor their input which was essential for their health. Through use of this information staff were able to support the person to eat and drink sufficient quantities of the correct types of food to maintain good health. One person told us, "My carer is a very talented cook; she follows recipes to the letter. She cooks everything from fresh; I will choose what I want her to cook and get it all ready for her and she's very happy to cook it. The other day she cooked a lovely apple pie from scratch."

Surrey Hills worked closely with the local hospital, social services and health agencies to ensure effective care is delivered to people in the community when they transfer from services. The registered manager explained that when referrals were received from the local hospital discharge team for patients Surrey hills worked collaboratively with the hospital to fully assess the person, liaise with occupational therapy about any equipment needed to enable the person to live in their own home and district nursing if the person had an ongoing, but non-urgent nursing need.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. People were monitored effectively and where necessary healthcare services were contacted and people were seen by professionals. A social worker told us, "Carers from Surrey hills called 101 for my client as they found her unwell; the paramedics came out and her sugar levels were low, this was communicated to Surrey hills and it was agreed that the calls should be increased to meet her needs." Healthcare needs had been tracked through peoples support plans. For example, one person was assessed as being at risk from a bacterial skin infection that could impede their mobility and exacerbate other pre-existing health conditions. The person's corresponding care plan and risk assessment directed staff regularly soak and wash and dry the person's feet, ensure they had clean socks, ensure they had two bottles of drink available after every call and walk around to improve circulation. Staff were directed to seek help from the senior carer if there were any signs of change in the person's feet, and this was actioned in the risk assessment.

People were asked for their consent before care was given and they were supported and enabled to make their own decisions. 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. In domiciliary care, these safeguards are only available through the Court of Protection. No one was subject to an order of the Court of Protection. However, people's consent was not consistently being documented as clearly as it needed to be. Although people's consent had been checked and best interest meetings had occurred with relatives where necessary, the process had not been recorded clearly on MCA or best interest meeting forms. We raised this with the registered manager and by the end of our site visit the registered manager had implemented a MCA/BI form in line with national guidance and had appropriately carried out assessments. We saw that one person had completed a consent form to show that they had the mental capacity to make the decision to go against medical advice around their diet. Staff had a good understanding of the Mental Capacity Act. One staff member told us, "X had to go to hospital to have a cataract operation and they repeatedly refused it. The doctor wanted to do the procedure under general anaesthetic so we completed a mental capacity

assessment to show they lacked capacity to understand the decision and held a best interest meeting to show it was in their best interest to have the operation."

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care and spoke highly of the staff supporting them. One person said, "I am thrilled, they are a cut above what we expected: all very nice and polite and lots of banter." Another person told us, "I like the quality of the girls who come, they are all cheerful and lively: they speak nicely to him and me, and we will miss them when he no longer needs help with the dressing." One relative commented, "I am so much more confident now that my brother is being well looked after, with another care agency I was always having to keep a check on him now I don't feel I have to worry, I feel confident that they know his needs well and he likes them, he tells me they speak to him in a nice way and I am confident that they will call me if there is a problem" A second relative told us, "We are two sisters and recently we both went away at the same time. We felt confident in doing this because of Surry Hills and on our return [loved one] was well looked after and happy."

People told us that they valued their care service and liked their carers and staff members described positive interactions. One staff member told us, "One lady was refusing a shower and any personal care. I started going to see her and built up trust and eventually supported her to shower. The person wouldn't tell her family if she was ill as it would worry them so she told me instead. I started going to see her just for social calls. She wanted to go to the local hairdresser, where she used to go, and when I took her there she absolutely loved it. The more I took her out, the more the person started to walk again." Other professionals also spoke to us about Surrey hills' caring staff and how the positive interactions staff had with people achieved good outcomes. One social worker said, "Surrey hills have made a massive improvement to X's quality of life. X had a history of self-neglect and this had been very difficult for the carers; however, they have dealt with it in a very professional and caring manner taking baby steps. They base what they can do on the day: initially X would not allow them to wash her but now they can help X to wash her hands which is a big achievement."

Care workers had built up positive and caring relationships with people they were supporting. Staff knew how to communicate with different people and where people had a communication need this was explained in their care plan. One relative told us, "They have a good interaction with him, they talk about family or football and they talk to him in a respectful manner." One person had hearing difficulties and staff members had been instructed in their care plan on how to ensure the person's hearing aids were used and working. Another person with learning difficulties had a communication plan that directed staff to ensure that the person had understood what had been said to them. Staff members knew people's preferences and were able to provide support in the way they wanted. For example, one person who was living alone had been spending a lot of their time asleep during the day. Staff had spoken to the person and found out that they liked to do puzzles, crosswords and listen to the radio and encouraged the person to engage with these activities on their visits: this ensured that the person was more alert and interested in their support.

People were able to input in to their care plan, and where they were not able to do so their family and relatives are invited to participate in care planning. During the initial assessment stage people and their relatives were involved in the extensive and detailed assessment process. One person told us, "I got Surrey hills on a recommendation. I spoke with the manager and she met me and my brother and they did an

assessment." We saw that care plans had been signed by people or their relative on their behalf where appropriate. One staff member commented, "I talk to people and ask them what they want. For new people I always say, 'you tell me what you want me to do' and slowly we get to know exactly how people like things. We use a form for reviews that asks if they're happy or want to change anything, and some people sign it off."

Staff were aware of people's privacy and dignity and worked in a way that maintained their rights. One person told us, "They [staff] close the door and always have the towels ready to protect my dignity when I'm getting out." We noted that staff took care to provide personal care to people in a dignified manner that maintained their privacy. People told us that staff spoke to them in a dignified manner when supporting them. Staff were careful to treat people with dignity. One staff member commented, "If we're washing someone we make sure the door and curtains are closed. I put a towel over them and ask them what they want me to do. If they're in the bathroom already I always knock and ask for permission to come in."

People's independence was encouraged by staff who followed care plans to enable people to do things for themselves where possible. One person said, "They [staff] are so helpful, they are helping me with my movements in the shower. They are guided by me on the day. I will tell them what I can manage and they will help with what I can't do. My confidence is growing and they will say, 'I think you can manage that today let's see', and they will be there in case I can't do it." Care plans were written to enable people to re-learn skills or improve physical movement with a view to gaining greater independence. For example one person's care plan included stretching exercises for a person with a degenerative illness. Staff were instructed how to support the person and to allow the person to choose which exercises suited them best on the day.

Is the service responsive?

Our findings

People's relatives and staff described a person centred approach to care delivery. One person said, "At the start of our care we were given the girls names who would be coming." One relative told us, "They will talk to my brother about cars as that is his interest; they are fully focused on him." A social worker commented, "I recommend Surrey hills as I have known them in the past and they are very good at dealing with difficult situations." One staff member explained, "Each care plan is done for that person, so when support starts you get to know that client. For example, one person has a favourite mug for tea in the morning and a cup for Horlicks in the evening and knowing that helps us give a personalised service."

People received an individualised care service that was tailored to their needs. People's assessments contained information specific to them that had been carried through to their care plans. We reviewed five care plans and they had identified individual needs, such as a person requiring specific assistance with mobility, or a person requiring personal care in a set way and at a specific time. These identified needs were tracked through to individual care plans, were risk assessed for the specific person and evidenced in daily notes. Each person had a daily schedule outlining the key tasks to complete each day. One staff member told us, "A daily schedule or routine that is person-centred is laminated and left in the person's home. It is almost like a tick chart, so that nothing gets missed off of it. The idea is that if a new carer went into the home they would be able to provide care in the ways the person has stipulated." One person had been initially assessed as being at risk from pressure wounds. The care plan had identified that this would be monitored by staff who were directed to examine specific parts of the person's body that were most of risk of skin breakdown and record the checks on a chart. This had been risk assessed and the daily notes evidenced how the personalised approach to supporting the person had resulted in them maintaining healthy skin.

People's care was delivered in a way that met their individual needs. Daily care notes that recorded what staff had done at each care call demonstrated that people had their assessed care needs met by staff. One person who required assistance with cooking their meals and applying a topical medicine had been supported to do this. We saw that staff had provided a variety of different meals and had consistently recorded the medicine as applied to the person's body. Another person was assessed as requiring support with personal care. The exact support that they wanted was recorded in detail in their care plan. Staff were told what parts of care the person could manage themselves and what they needed to do. There was detailed information on the persons care routine, such as how they liked to wash, which products to use, what clothes they liked and which domestic tasks needed to be done at different times of the day. This meant that people were receiving care and support suited to their needs and in the way they preferred.

Although the service had not received any formal complaints there was a policy and system in place to monitor any complaints that may arrive. There was a complaints file containing a complaints policy which had been recently reviewed. The complaints policy set out responsibilities and stated clearly who the lead manager was for complaints. The complaints procedure which contained a complaints forms and template letter was sent to people at the start of service with the 'terms and conditions relating to supply of care' document. A range of ways to complain was available for people either through, e-mail, phone, in person or

written. There was a clear process for resolving complaints and if the complainant was not satisfied with the outcome they were correctly signposted to the local government ombudsman. There were no official complaints recorded in the file and people and relatives we spoke with told us that they had never had reason to complain. One relative told us, "I am happy and confident that should I have cause to raise an issue I would be listened to and it would be dealt with." There were blank complaints forms in the office for staff to use when the need arose. Verbal complaints or 'niggles' and comments were being recorded but all of these had been positive in nature. Staff members understood the complaints policy and the importance of recognising when people were not happy about an issue.

People were supported in a sensitive and compassionate way at the end of their life to ensure they experienced a comfortable, dignified and pain free death. The registered manager was passionate about good, caring, and person centred palliative care. For people who were approaching the end of their life Surrey Hills implemented additional checks. We saw pressure area charts that documented people's skin in key areas such as sacrum and hips. There were palliative weekly record sheets that recorded re-positioning of people at five times of the day (or more if required), and information about people's continence needs. There were pain relief charts recording the medicine, reason for administration, dosage and signature of staff; GP home visit record sheet, and a fluid input and output chart that also recorded extra detail for people using catheters (a urinary catheter is a flexible tube used to empty the bladder and collect urine in a drainage bag). The registered manager told us, "We also wash, dress and lay people out for their families, if that is their wish. We do this free of charge out of respect." The registered manager had gained an end of life care certificate from the Open University. The registered manager told us, "I train staff to give mouth care at every visit, including looking out for signs of oral breakdown. It's important to support families. There's a stigma around death and opioid pain relief but it's about us being honest and answering their questions. We support people's relatives after death and keep in contact and always attend funerals."

People had DNACPR forms in their files and there were end of life care plans in place for people who wanted them. There was nobody receiving end of life care during our inspection. We saw plans for people who wished to make future arrangements for their death. People had set out whether they would like to die at home, in a hospice, and what their funeral arrangements would be. The registered manager explained that they would work closely with local community hospices to ensure that people could spend their final days in the manner of their choosing. Where people chose to remain at home the registered manager told us they would ensure that their support would continue where appropriate. There was an end of life policy to guide staff on how to provide good care in people's last days. This covered topics such as discussions as the end of life approaches, best practice in the dying phase, and care after death.

Is the service well-led?

Our findings

The registered manager provided effective leadership to the service and people, their relatives, and staff members spoke in positive terms about the management of the service. One person told us, "I do speak to the manager on the phone, she keeps me up to date with any changes" A relative commented, "We called Surrey hills and the manager came round and we liked her; she was professional and chatty she did an assessment." One staff members told us, "[Manager] is a good boss, she is a good listener, she is fair and she is always available." A second member of staff said, "[Manager] s very helpful we moved a client and had to change doctors but there's a form to fill in and capacity issues, so [manager] is helping me."

There was an open and inclusive culture in the service. The service was person centred and each person was supported according to their own needs. Staff and people confirmed that there was an individualised approach to people's care. The registered manager told us, "Although we are small we are bespoke and very caring. We take pride in what we do and all staff go the extra mile and we're hands on with all clients and families." This approach of individualised care delivered a close knit staff team was carried through by staff. People's relatives and staff told us the culture in the service was caring and supportive. One staff member told us, "It is a very friendly place to work and we all support each other. This weekend was my weekend off but my colleague was at hospital with their child so I was on-call." The registered manager told us that the service was aiming to promote peoples independence so that they felt included, cherished, valued and integrated in their local communities. The registered manager spoke about their plans to achieve this aim in the service by promoting relationship centred care, as a 'follow on' from person centred care. The registered manager explained, "We look at it like the client, the carer and the family as the three points of a triangle. It's a holistic approach based on creating an enriched environment: about security, belonging and continuity. Primarily the client is the focus, but we also need to ensure that the carers and the families feel valued for the support to be successful."

The registered manager was monitoring the quality of service delivered with regular audits and spot checks. Although we saw that spot checks were happening we noted that not all of the spot checks were being recorded or monitored in a planned fashion. We raised this with the registered manager who explained that as the company was new they had started doing ad hoc checks and this had continued. However, they agreed that this system could be organised and managed more effectively. By the end of the inspection the registered manager had completed a spot check tracker to plan which services would be checked in the future (and when and by whom) and record those that had been checked and any actions taken. The registered manager had implemented checks on new clients within the first month of the service commencing to make sure that the care being delivered met people's expectations. Checks of health and safety, such as looking at trip hazards and fire safety had been completed. We saw audits of the office that checked on stocks of equipment needed by staff such as protective aprons and gloves. This audit also looked at client files to see if they were complete and in good order; at staff files to check they were up to date and kept locked away and the team leaders had completed care plan updates. We reviewed the spot checks that had been completed and saw that services had been visited, carers work had been evaluated and where shortfalls were found action had been taken. For example, one spot check had identified that some housework tasks had not been completed. This was followed up with the staff member in question

and a letter was sent to them requesting a response.

People their families and staff were involved in the service and regular feedback was sought through questionnaires. We saw client feedback forms completed by people and family members that contained very positive feedback. The registered manager had contacted a local politician so that people who received a service from Surrey hills, their families and staff could have the chance to discuss any issues relating to care or their lives. The registered manager told us, "I contacted the local MP and invited him to meet his constituents at the Surrey hills office, to meet people and understand what carers are facing."

The service was continuously learning and improving and learning is shared with staff. Staff were encouraged to take on new responsibilities. The registered manager recognised that Surrey hills will be providing care to a greater proportion of people with dementia. The registered manager had approached a university department that was a leader in dementia research and requested a bespoke training package for the service. The registered manager commented, "Unfortunately, the cost was too high for our business at present so I am writing my own dementia training programme to include things like engaging people in daily living activities, understanding behaviours and how to create a more supportive environment." The registered manager had signed up with Surrey County Council dementia friendly community scheme, promoting dementia awareness in the community. Surrey hills had also linked up with a local group to support a memory café in Caterham. The registered manager told us, "We support it by donating tea and coffee and we bring reminiscence objects for people with memory loss, Alzheimer's or other dementias." Surrey hills was part of a group called 'musical memories' that was held every other week in Lingfield and Oxted.

The registered manager had a good working relationship with the local hospital, occupational therapist, district nursing team and GP's surgeries to ensure people's services were effective. The registered manager explained that the district nursing team worked closely with the service to around catheter care, skin integrity and palliative care. The registered manager told us, "We have a very good relationship with the nurses as they know we are hot on checking skin and can call them at any time if we have concerns." The registered manager described a recent case where the service had worked closely with the local authority safeguarding adult's team, the police and the local authority adult social care team to provide a service for a person who was being neglected. The registered manager described how the service worked in partnership with other agencies to deliver outcomes for people. They told us, "We work with the occupational therapist to do assessments and get the right equipment for people if they are frail. We also work closely with the first community health team based at Caterham Dene Hospital: they monitor bloods, eating and drinking and help us to liaise with people's GP's."

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered managers confirmed that no incidents had met the threshold for Duty of Candour.