Community of Refugees from Vietnam - East London

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Inspection report

Old Poplar Library
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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?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

The inspection took place at the provider's office on 27 May 2015 and was followed up by phone calls and home visits. The inspection was announced; it was carried out by a single inspector with assistance from an independent interpreter when speaking with people who used the service. The service had not been inspected previously.

At the time of the inspection the service supported three people of Vietnamese heritage who received a total of 21.5 hours personal care per week between them, mainly to assist with bathing and intimate care tasks. This service is known locally as the Vietnamese homecare service.

The provider also runs other services for the Vietnamese community, such as a lunch club for older people and an

Summary of findings

advice service. These activities are not regulated by the Care Quality Commission so they were not inspected. However, the same staff work across all parts of the service so people who use the homecare service see them in more than one role. Therefore staff and people who use the service knew each other well.

A registered manager was in place. 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 registered manager reported to a management committee.

We found people were provided with a personalised service in their own homes and staff went the 'extra mile' by providing informal interpreting services to ensure people could access healthcare services and by assisting them to deal with official letters sent in English. People spoke highly of the staff and the service they received and could not think of any way it could be improved.

People told us they made decisions for themselves and staff listened to their wishes. They said staff were kind, helpful and punctual. We found staff were well-informed and conscientious; they had all achieved a minimum national vocational training (NVQ) level 3 in health and social care.

The provider needed to improve record keeping. There was too much reliance on staff knowing people well; more information needed to be written down in case of any later queries. We have made a recommendation about this.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe. Staff were well informed about their responsibilities for safeguarding the well-being of people who used the service.

The service did not administer medicines as people who used the service did this themselves, but they had a policy in place to guide them if people's needs changed.

Risk assessments were in place and regularly reviewed.

Good

Is the service effective?
The service was effective. There was good staff retention so people always received care from staff they knew.

All staff had received training in health and social care to level 3 of the national vocational qualification (NVQ) in this area.

Staff used their language skills to help people to access healthcare.

Good

Is the service caring?
The service was caring. People who used the service said that staff were kind and helpful and treated them with respect.

Staff sought people's permission before carrying out care tasks.

A bi-lingual service users' handbook had been distributed to people who used the service.

Good

Is the service responsive?
The service was not responsive in one area. Information about how to care for someone was not always written down, it was just kept in staff members' heads.

However, people who used the service still received very consistent coordinated care. They were very well informed about how to make a complaint, but said they had no need to do so.

Requires improvement

Is the service well-led?
The service was well-led. Staff and people who used the service had opportunities to pass on their views and they were listened to.

The registered manager was highly visible and in regular contact with people who used the service.

Good

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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.

The inspection took place at the provider's office on 27 May 2015 where we spoke with the registered manager and the senior home care officer. This was followed up by telephone calls to two members of staff, a person who used the service and a relative, as well as home visits to two other people who used the service. We also spoke with a local authority member of staff to find out their views of the service.

The inspection was announced with 48 hours' notice because this was a small domiciliary care provider and we needed to be sure the office would be open. A single inspector carried out the inspection with assistance from an independent interpreter when speaking with people who used the service.

We checked the three care files and other records kept in the office, we looked at the staff records for all four members of staff, the provider's policies and procedures and the log books in two people's homes.

Good

Is the service safe?

Our findings

People who used the service told us they had no concerns for their safety. They were supported by staff who understood what to do if they were at risk of harm or suspected abuse. Both care workers separately described what they would do if they had any concerns about the safety of a person who used the service. They said they would contact the emergency services if there was an immediate risk, otherwise they would make a record of what they observed and report it to the registered manager, who would pass the information on to the local authority if it was a safeguarding matter.

The provider had appropriate safeguarding and whistleblowing policies in place to facilitate the reporting of any concerns. We asked one member of staff how this worked in a small organisation. They told us that if they had concerns about their line manager's response to a safeguarding incident they would report it directly to the local authority. They could refer other concerns about their line manager to the management committee if required, but they said they had never had any concerns to report.

People were protected from potential risks. Risk assessments and risk management plans were in place and regularly reviewed. Environmental hazards were assessed too. There was a fire safety policy detailing how staff should respond in the event of a fire in a person's home. If the provider identified risks to people such as social isolation, potential eviction or inadequate income, we saw evidence that they were referred on to other parts of the organisation, such as the lunch club or advice service.

The service followed safer recruitment practices, although there was a reliance on personal recommendations from within the community served rather than references from previous employers. The provider told us this was due to staff not always having had previous employment in the UK. However, the provider had excellent retention rates so they had not recruited for several years.

There were sufficient care staff to provide care to people who currently used the service. Care staff absence was covered by office based staff who also had appropriate training for the role. The same office staff also provided on-call support, if needed, outside office hours. People who used the service told us that their families often stepped in to cover the care staff holidays, but if they could not, the service provided an alternative care worker.

Although the provider had a policy to guide staff in respect of medicines administration, at the time of the inspection people who used the service did not require staff to administer medicines for them. This was confirmed by a member of staff who said a person they supported managed their own medicines, but had asked for a prompt if the staff member saw they had not been taken. People who used the service also confirmed this.

There were procedures in place to report accidents and incidents, but none had occurred within the service. Each person had an accident log book in their home, we looked at two, but they were blank. People who used the service confirmed that this was because no accidents or incidents had taken place.

Infection control was well managed. The provider had a policy which covered infection and control and staff induction covered this topic. Records showed that some staff had also received additional training in this area. Personal protective equipment was available for staff use.

Good

Is the service effective?

Our findings

People who used the service told us that they made decisions for themselves and staff respected their wishes.

The provider told us they had no cause to believe people who received the service did not have capacity to make their own decisions, so long as an interpreter was available when needed. This was confirmed by information within the care files. Therefore no one had been referred for an assessment of their capacity. However, in anticipation of this one day becoming a need, the provider was starting to put a policy together so that staff knew how to respond if they thought capacity was becoming an issue. It was planned that it would also guide staff undertaking care reviews so they could identify if any restrictions were in place within people's homes and, if they were, whether or not the person had actively consented to them. The registered manager had undertaken a day's training in the Mental Capacity Act 2005 and their new policy would take account of the Supreme Court judgement in 2014.

The service employed people who spoke Vietnamese, the first language of those who used the service. Staff understood the cultural background of the people they supported. A member of office staff told us they kept up with best care practice by keeping a check on various professional websites.

People were supported by care staff who had appropriate skills and knowledge. An up-to-date induction programme was in place for any new staff appointed. We saw it addressed relevant topics. Staff had been issued with a handbook which contained the provider's policies and procedures and a code of conduct. The code of conduct was also available in Vietnamese and Chinese. The policies required a little updating to reflect the new regulations which came into force in April 2015.

There were detailed training records for all staff members, which were backed up by certificates of attendance. The registered manager had qualified as a trainer in moving and assisting people, so he was equipped to assess people's needs in this area and to support and train other staff members.

Care workers employed by the service had achieved national vocational training in health and social care at level 3. The senior home care officer had recently achieved level 5 in leadership for health and social care. The registered manager had level 4 in management and had started the level 5 course. In addition all staff had attended occasional short courses in different aspects of care, as well as health and safety related topics. Refresher training was slightly overdue for some staff in the areas of first aid and safeguarding adults. A staff member told us the registered manager was helpful in finding appropriate courses if a new training need was identified.

Due to the continuity of care that the service had been able to provide, we found that both care and office staff knew people who used the service very well. One person had received a service for around 10 years with minimal changes of staff.

Records showed that staff received quarterly supervision sessions from the registered manager, as well as annual appraisals. In practice they told us they could raise any issues at any time.

The registered manager told us that, so far, anyone who used the service and needed end of life care opted for admission to a hospice. However, he said the service would seek advice and support from local palliative care professionals if someone preferred to stay at home.

Staff told us they did not currently support people in regard to eating and drinking. However, they saw some people who used the service at their separate lunch club so they thought they would pick up on any need for support in that area. If a need was identified they said they would refer the person to the local authority for re-assessment.

We saw evidence that care staff ensured that people received support if they had to attend GP or hospital appointments. The registered manager told us that this meant the service always knew about hospital discharges before the hospital itself informed them, so they were able to prepare for people's homecomings. We saw that staff liaised with district nurses, occupational therapists and others whenever the need arose. They were well-informed about other services due to another of the provider's roles – the advice service. There were also links, when needed, to a mental health worker for the Vietnamese community. The registered manager had attended a level 1 course in smoking cessation, as support to stop smoking had been identified as a healthcare need within the community.

Good

Is the service caring?

Our findings

People who used the service described the staff as “kind and helpful”. One added that their care worker was “cheerful”. One person said, “They treat me as they would their parent.” They indicated that this meant that they were given respect as an elder of the community. People said that if they had a problem, staff members would assist them, for example, a care worker would stay longer if they needed to attend a doctor’s appointment.

Each member of staff spoke thoughtfully and respectfully of the people who used the service. One staff member said they always checked with the person before they carried out any personal care tasks and, because they knew people who used the service well, they could usually tell if the person was not happy about it by the expression on their face; the person did not always need to speak. If they saw this happening they adjusted or temporarily abandoned what they were doing, returning to the task later if need be.

People were supported to consent to day-to-day care tasks. Staff told us how they sought permission from people before they did anything new, like calling their GP, unless it was an emergency situation. People who used the service confirmed that staff routinely asked for their permission before undertaking any task.

Staff described how they would communicate with people who had difficulty understanding them. They explained how they would speak slowly and re-phrase what they were saying. Both care workers stressed to the inspector that a big part of building trusting relationships was careful listening. From what people who used the service told us, they had fallen into a routine with their care worker which suited them and an understanding had developed between them and the care workers. Discussion was only required when a change was needed.

One person who used the service showed us a bi-lingual service users’ handbook which explained all about the service and how to contact the office.

Requires improvement

Is the service responsive?

Our findings

We found that people's written care plans were under-developed; they did not list people's preferences or detail how they liked to be supported with their personal care. The registered manager said staff were fully aware of this information, but it was not written down. The same applied to the daily log kept in people's homes. The entries did not always fully describe the tasks that had been carried out. This was important in case any queries later arose.

People who used the service benefitted from having care and support from people who knew or were involved in the story of the arrival and settlement of Vietnamese people in the UK. Recent history was documented on the provider's website.

People were assured they would receive consistent coordinated, person-centred care when they used different services because staff members were involved in coordinating this, due to the need for someone to be present at meetings who could translate between English and Vietnamese. Advocacy on behalf of people who used the service by the same staff could be arranged through the provider's advice service.

People's needs were assessed by the referring agency, usually the local authority. They were then formally reviewed on a quarterly basis by the registered manager. We saw evidence of this in the care files. Any change of needs was then referred back to the local authority for re-assessment. People's needs were assessed by the referring agency, usually the local authority. In practice the registered manager saw people frequently at informal events, such as the lunch club.

The service worked hard to ensure people who used the service were involved in community meetings and events whenever they wished to participate. We also found staff could often be flexible about the hours they worked, for example, they adjusted their visits to fit in with people's medical appointments.

People told us they could get support to raise concerns and complaints about the service if the need arose. The service had appropriate policies and procedures in place to respond to any complaints, but they had not received any. The registered manager put this down to the frequent contact all staff had with people who used the service which enabled them to deal with any issues before they developed into complaints. People who used the service had leaflets telling them how to complain to the local authority, as well as a bi-lingual service user's handbook which told them how to complain direct to the service. People confirmed they had no cause to complain, but they were very clear about how to do so if they needed to.

We recommend the provider seeks appropriate support or guidance from a reputable source to further develop their written care plans and daily log books.

Good

Is the service well-led?

Our findings

All the people who used the service knew the registered manager was in charge of the service and said they saw him “often”, either in their own homes when he carried out a review of their care or at community events. He was the first person they contacted if they had any problem within office hours.

There was an open culture at the service which promoted effective communication between staff. Staff told us that the registered manager was supportive and could easily be contacted. One staff member said, “He tells me new information so I can do better care”. We found the registered manager to be open and honest about any gaps in knowledge or records. Quarterly staff meeting minutes were brief, but showed staff had the opportunity to discuss challenges facing the service. Staff members confirmed this to us.

When we checked with the local authority we were told they had “no concerns” about the service provided. Links with the local Vietnamese community and other voluntary organisations were strong and the registered manager was well-informed about sources of potential support for people who used the service. The annual report included a case study showing how staff facilitated a referral for an emergency alarm. This had resulted in prompt attention when the person later fell at home.

Questionnaires were issued quarterly to each person who used the service so they could rate their experience of the service. We saw feedback was universally good; however, the provider’s staff helped them to complete the satisfaction questionnaires, which may have made it difficult for people to indicate their true feelings, although when we spoke with them with an independent interpreter we received only positive feedback too.

Apart from the care plans and log books which needed further development, we found that the other records kept by the service were up-to-date and clear, for example, if office staff were involved in following something up on behalf of a person who used the service they kept a note of their actions in the person’s file.

An annual report on the service was approved by the trustees who formed the service’s management committee. The trustees included two people who represented Vietnamese elders.