

British Red Cross Society

# Support at Home Service in Great Yarmouth and Waveney

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Good** 

Is the service caring?

**Good** 

Is the service responsive?

**Good** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

The inspection took place on 8 February 2017. We contacted the service before we visited to announce the inspection. This was because the service supports people in their own homes. We wanted to ensure that we could access the service's office and speak with the manager and the volunteers.

Support at Home Great Yarmouth and Waveney provides support to people who require assistance with Saphena (anti-embolism) socks when they return home following surgery. Prior to fitting the Saphena socks volunteers supported with washing and applying cream to the area where the stockings would be fitted. As this involves personal care it is therefore a service which the Care Quality Commission (CQC) regulates.

The service was supporting two people in the Great Yarmouth and Waveney area when we inspected. From July 2016 to February 2017 the service had supported 7 people with their Saphena socks care. Support at Home Great Yarmouth and Waveney provided other volunteer services, however CQC do not regulate these. This report only relates to the Saphena sock care element of the service. People were supported by a group of volunteers. The service employed two coordinators and a manager. This was the service's first inspection.

There was not a registered manager in place. A registered manager is a person who has registered with the CQC 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. There had not been a registered manager for some time, although there was an acting manager.

When we contacted the service to announce our visit we were informed that the service was being provided from a different location to that registered with CQC. The provider had not informed us of this change and therefore the service was not registered correctly. We asked the provider to rectify this and shortly after this inspection CQC received an application from the provider to request changes to correct their registration.

The service was not monitoring the practice, skills, and knowledge of the volunteers who were performing the regulated activity, to ensure they were competent in this role.

The service was not completing internal audits to test the quality of the service. People's risk assessments and records were not being audited. There was a lack of systems in place to always ensure the service responded appropriately to maintain people's safety.

The provider's audit had not identified all of the issues that we identified in this inspection.

These issues all contributed to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The service was not completing robust risk assessments for the people the service supported. Volunteers were expected to complete risk assessments when they started to visit people, but they did not have training about how to do this. People's records did not demonstrate that people's needs and the potential risks which they faced had been fully explored by the service.

Volunteers and staff received an induction to the service and had on going training provided on a regular basis. The volunteers spoke positively of the training they received. The volunteers, staff and the manager were motivated to provide good care to people.

Volunteers understood the importance of responding to concerns about people's health. The service had a duty system to support volunteers. Volunteers said they felt confident to respond effectively in an emergency situation.

The volunteers demonstrated they understood how to protect people from the risk of abuse. Volunteers were aware of this potential issue and knew what to do if they had concerns.

People benefited from volunteers and staff who felt valued and important to the service. The volunteers spoke positively of the staff (coordinators) who supported them. They told us they found them approachable and supportive. The manager, staff and the volunteers had confidence in the service they were providing.

People said they saw the same volunteers at regular times and did not have missed care visits. People also told us that volunteers stayed longer at their care visits, if this was needed.

Volunteers understood the importance of promoting and protecting people's dignity, privacy and independence. People gave many positive examples of the caring and empathetic approach of the volunteers who supported them. People told us they were treated with dignity and in a caring and kind way.

Volunteers had received training in the Mental Capacity Act 2005 (MCA) and demonstrated they understood the importance of gaining people's consent, before assisting them.

People felt comfortable speaking with the volunteers and coordinators about any issues they had about the service. There was a complaints process in place for the service to respond to complaints.

## 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 not always safe.

The service was not completing robust risk assessments relating to the people the service supported.

Staff knew what to do if they had any concerns and they were confident in raising these.

**Requires Improvement** ●

### Is the service effective?

The service was effective.

However, the service did not have systems to monitor the competence of volunteers to ensure they were effective in their role after their induction.

The training and induction that volunteers received, contributed to the effective support people experienced.

People received care and support in the way they wanted because volunteers understood the importance of gaining people's consent.

**Good** ●

### Is the service caring?

The service was caring.

People benefited from having positive and caring relationships with the volunteers who supported them.

People felt respected and listened to.

People told us they would recommend the service and use it again if they needed to.

Volunteers understood the importance of maintaining people's dignity and privacy and worked in a way that promoted and protected this.

**Good** ●

### Is the service responsive?

**Good** ●

The service was responsive.

People saw a regular volunteer at their agreed times.

People received care and support that was individual to their needs.

People were supported to avoid social isolation.

**Is the service well-led?**

The service was not always well led.

The service did not have a registered manager and there were issues with how the service was registered with the CQC.

There was limited quality monitoring of staff practice and records.

Audits were not always effective.

There was a positive and open culture at the service.

**Requires Improvement** ●

# Support at Home Service in Great Yarmouth and Waveney

## **Detailed findings**

### Background to this inspection

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

The inspection took place on the 8 February 2017 and was announced. The provider was given 48 hours' notice because the location provides a homecare service. Notice was given as the manager was not present at the service each day and we needed to make sure we could access the office. The inspection was carried out by one inspector 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 viewed the information we had about the service. We also contacted the local quality assurance team and local authority safeguarding team for their views on the service.

The manager had 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.

During the inspection we visited the service's office, spoke with six people who used the service. We also spoke with the manager two coordinators, and four volunteers.

We looked at the care records of three people who used the service. We also viewed records relating to the management of the service. These included risk assessments, three staff recruitment files, training records,

and compliments.

# Is the service safe?

## Our findings

People who used the Support At Home at Great Yarmouth and Waveney service for their Saphena (anti-embolism) socks did not receive robust risk assessments.

When the service received referrals from the James Paget Hospital, they relied on the health and social care professionals to complete a risk assessment of people's needs. We were told by a coordinator that they would check if there were any risks relating to the person, that the service needed to know about. We were shown a list of possible questions and risks the coordinator would ask the health or social care professional. These generally related to safeguarding concerns. They did not consider other risks such as those relating to the environment or risks associated with putting the Saphena socks on. In addition, there was no assessment and plan of how the volunteer would deal with an emergency if no one answered the door or if the person fell during their visit.

We looked at the referrals which the office coordinators completed. Often the risk section was left blank. We were told this was because the professionals had not identified any risks. When the volunteer visited they were asked to complete a further risk assessment. This was in case the previous health and social care assessment had not identified all the risks that people faced. However, the form used by volunteers did not guide volunteers as to what these risks could be. No member of staff employed by the service completed a risk assessment by speaking to the person themselves. Volunteers did not receive risk assessment training. We concluded this was not a robust way to identify people's individual risks and needs.

In people's care records which would be kept in people's homes to guide volunteers; there was sometimes a lack of health professional contact details. The purpose of gathering this information would be to enable a volunteer to call a person's GP for example if the person needed health or medical intervention quickly.

At the end of each visit the volunteer was required to complete a section relating to whether the person had ongoing risks. The form promoted volunteers to call the coordinator or the out of hour's duty worker if they had concerns during their involvement with the person. We looked at a sample of these documents and found the volunteers had completed these records stating no concerns were identified. When we spoke with volunteers most told us they were mindful of potential risks to themselves and the people they supported.

The coordinators and most of the volunteers understood how to protect people from the potential risk of harm and abuse. Volunteers were able to identify what the potential signs of abuse were. Volunteers told us that they would contact the coordinators if they had any concerns. The coordinators said they had confidence the volunteers would do this as they had regular contact with them. One volunteer said if a person was distressed or presenting as withdrawn, "You would have a conversation."

We were shown a list of staff from the Red Cross naming the safeguarding leads, with their telephone numbers. This was for the coordinators to contact if they had concerns that a person had been or was being harmed in some way. We were told that if they spoke with one of these colleagues it would initiate their

internal safeguarding process.

We spoke with one of these safeguarding leads. They told us they would start to complete an investigation unless it was very urgent, in that case they would call the police. However, neither this member of staff nor the coordinators knew that they should contact the local authority safeguarding team in the first instance, if they had concerns a person was being harmed. From our conversations we concluded that there could be a risk that the service engaged with their internal investigations first, rather than calling the local authority safeguarding team. This meant there could be delays in reporting concerns to the local authority safeguarding team in the future.

The service had emergency plans if an event occurred which prevented the service from operating. This plan was shared with other services within The Red Cross. However, these plans did not include a response if the service's office was unavailable or if the majority of the volunteers were unable to support people with their Saphena socks. We spoke with the manager about this who said they would address this issue and revise the contingency plan.

Volunteers completed a Disclosure and Barring Service (DBS) check before they started to support people. This is a system to ensure volunteers or staff were suitable to work with vulnerable people. We looked at records which confirmed that the service completed new DBS checks for existing volunteers every three years. We looked at a sample of volunteer personnel records and saw that references were obtained. However, when we looked at volunteers applications the volunteers had not been asked to give their full employment histories. There was also no record that the service had confirmed the volunteer's identities. We spoke with the manager about this who said they would address these issues in order to ensure volunteer recruitment checks were fully robust.

People who used the service told us they felt safe with the support from the volunteers. One person said, "The service was excellent. I felt very safe with [volunteer]." Another person said, "Yes certainly do. Very much so. [Volunteer] is very obliging and nice." A further person told us, "Yes I do. [Volunteer] is a smashing [person]."

When people started with the service they were sent information relevant to the time of year offering advice and information. The purpose of this was to support people to keep them safe in extreme weather conditions.

We were told by a coordinator what action they took if they and the volunteers had concerns about people managing important daily routines and if people were putting their own safety at risk. We were shown a record relating to one person who the coordinators felt was at risk. The document showed the conversations the coordinator had with social services, in order to share their concerns about this individual.

The service had a system to respond to accidents and incidents. We were told the service had not had any incidents relating to the people who used the service. However, we were told by the coordinators if a person experienced an injury they would speak with the person and ensure they received support either via a health or social care professional.

The service ensured there were sufficient numbers of volunteers to support the people who used the service. A coordinator told us that they kept in contact with existing volunteers who would assist people with their Saphena socks and there was an on going recruitment process for volunteers. This was to ensure there were volunteers available to support people with this service. We were also told both coordinators were trained to

provide this support. We concluded the service had volunteers and systems in place to ensure people's care needs would be met.

## Is the service effective?

### Our findings

The service was effective but it did not have systems in place which tested whether volunteers were competent and knowledgeable in their role.

Volunteers did not receive supervisions or appraisals. Volunteers were not observed or tested to ensure their knowledge was up to date and they were effective in their practice. Some volunteers had worked for the service for many years, but their competency had not been checked. For example, we spoke with one volunteer who did not understand how a safeguarding concern would be relevant to an older person.

We spoke with one coordinator who said they often had conversations with volunteers and the service needed to be mindful of the fact that volunteers were not being paid to support people. However, volunteers in this capacity were performing a regulated activity and the provider did not have systems to ensure the volunteers were effective and supported in this role. We spoke with the manager about this who said they would address this issue. The manager and a coordinator started to make plans about how they would do this during our visit.

People told us that they felt the volunteers were effective when they received support with their Saphena socks. One person said, "[Volunteer] was first class, knew exactly what to do and always asked if I needed anything." Another person told us, "[Volunteer] was marvellous; she knew what she was doing, yes certainly."

Volunteers told us that they received a good induction to the service. New volunteers completed on line training which was then checked by a co-ordinator that a suitable pass mark had been obtained. New volunteers would then complete a three day course where they would complete training in safeguarding, dementia awareness, first aid, mental capacity and fluid and nutrition. Volunteers would then receive training on how to safely and effectively support people with their Saphena socks. This was in the form of a DVD and hands on training provided by a coordinator. After completing this training volunteers were asked to complete a questionnaire which was designed to test their understanding of this training. A coordinator would check the questionnaire to ensure the questions had been answered appropriately. We looked at the training plan which confirmed volunteers had received training within the last three years in these areas.

When volunteers started in their role they would complete the care certificate. This is a set of standards outlining what good care looks like. Volunteers also completed additional training and refresher training. Volunteers told us the range of training they had recently completed or intended to undertake. One volunteer told us, "I'm completing training in multiple sclerosis and motor neuron disease this year."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We found that service was working within the principles of the MCA.

The people we spoke with told us that volunteers asked their permission before they assisted them with their Saphena socks. One person said, "Yes I'm on my fifth week with them now [volunteer] always asks first if I am ready and alright." Another person said, "Yes [volunteer] always asked to see first if I'm ok."

The volunteers we spoke with had a good understanding about mental capacity and the need to gain people's consent before they supported them. One volunteer said, "I make sure people understand what I am doing and what is happening before I start." Another volunteer said, "I always call and arrange a time to visit." A coordinator we spoke with confirmed this practice.

We looked at people's records and the information packs sent out to people and we could see that people completed a consent form agreeing to the support they would receive.

People told us that they hadn't needed the volunteers to call their GP or respond when they had been unwell. However, people felt confident that the volunteers would if they needed them to. One person said, "I am sure [volunteer] would if she came and saw me unwell." Another person told us, "I feel sure that they would have done so."

Some of the volunteers we spoke with gave us examples when they had advised a person to call their GP. Most volunteers explained to us they were conscious of a change in a person's health needs. They told us that they felt confident they would be able to take action if a person presented as unwell, or if they were in an emergency situation.

## Is the service caring?

### Our findings

People who we spoke with told us that the volunteers treated them with kindness and in a caring way. One person said, "I was very impressed, in fact it was excellent. [Volunteer] was very caring and friendly, we talked and she was so, so nice." Another person said, "Very good indeed. She was very careful and careful with me." A further person told us, "[Volunteer] is wonderful. Very obliging, very chatty."

People and the volunteers we spoke with told us how they built relationships with one another during the time people were being supported. Volunteers told us how they would have a chat first and after to check the person was okay and find out if they needed further support. The people we spoke with confirmed this practice.

The Volunteers told us how they involved people in the support they received. On the first visit volunteers said they would explain the purpose of their visits. They would ask individuals if they wanted further support and assistance with the care of their legs and feet. Some volunteers also told us how they would continue talking and checking the person felt comfortable and was free from discomfort, while they supported them with their Saphena socks. One volunteer told us, "I want to make sure people are safe and happy with what I am doing."

People told us that volunteers treated them with dignity and respect. One person said, "We always had a good chat together, she was lovely and yes, very respectful of my position I was in." Another person said, "[Volunteer] was very good and yes, very respectful of me." People also told us how the volunteers treated their homes with respect.

The volunteers we spoke with told us how they promoted people's dignity and privacy. Volunteers explained that when they visited a person and there were other people in their house, they would ensure they supported the person in a private room. Volunteers told us they ensured doors and curtains were closed when they supported people.

Volunteers and the coordinators told us how they gave information and directed people to other services if people were struggling with elements of their daily lives.

People spoke positively of the impact that the service had on maintaining their independence. One person explained to us how their volunteer assisted them to obtain equipment to assist with their mobility. We saw in one person's record a referral was made to an equipment service. We also heard a coordinator advising a relative how they could obtain some short term equipment for a person the service supported.

People's confidential information was protected by the service. Volunteers spoke to us of the importance of this. It was explained to us by a coordinator and volunteers how information was confidentially disposed of when the service was no longer involved with people. We saw that the service kept people's information stored in a secure way.

## Is the service responsive?

### Our findings

People received support which was person centred and responsive to their needs.

People told us that they felt involved in their care and the support they received and they felt listened to. One person said, "Absolutely marvellous like I've said. [Volunteer] stayed a good half hour and ensured all was done before [they] left." We asked one person if they felt the volunteers responded to their needs, they said, "Yes, that's why they got me that [equipment]."

A coordinator told us that technically there was no medical need to remove people's Saphena socks for six weeks. However, they explained that practice would not be very person centred, so that was why the volunteers assisted with the additional care tasks on a weekly basis for people who were advised to wear Saphena socks.

People told us that they did not have missed or late visits. People told us that the volunteers visited them at the times which they wanted them to. People saw one regular volunteer for the duration of their time with the service. People also told us that they felt fully supported and not rushed. Most of the people we spoke with said the volunteers always checked if they needed further assistance with daily tasks before they left.

We asked one person if the volunteer stayed for their allotted time, they said, "Every bit. Never rushed, so friendly. I was so grateful for their visit." Another person told us, "Oh yes [volunteer] never rushes. We have a good chat together."

When we looked at people's records we could see there was a section which the volunteer completed with the person, which talked about their goals and what they wanted to achieve from this support. From looking at this information recorded we could see the service was involving the person in the care and treatment they were receiving.

Volunteers told us how they took practical action to support people who were feeling socially isolated or distressed. Volunteers said they took the time chatting to people about subjects which the person was interested in. For some of the volunteers they told us this was a motivation about joining the service. One volunteer said, "I enjoy meeting people and hearing their stories." Another volunteer said, "I am happy to chat and make cups of tea." This volunteer told us how they gave information to one person about a local social club and the bus they would need to take in order to get there.

People told us that the service respected their individual choices regarding the gender of the volunteers who supported them. A coordinator told us that they were always conscious of this issue and that they checked with the person before the visit took place.

The service had a complaints process. When people started with the service an information pack was sent to them which included a card with the Red Cross's complaints contact details on it. When we spoke with

people who used the service, all said they didn't have a complaint to make but if they did they would contact the service's office.

The service included a questionnaire in people's introduction packs. We saw that people completed these forms and the service analysed this information.

# Is the service well-led?

## Our findings

The service was not always well led.

The service did not have effective systems in place to ensure the risks to people's health and welfare were identified and minimised. The documents used by coordinators and the volunteers did not guide them to risk assess people's needs in a strong way. The service and provider had not audited or reviewed these documents effectively.

The competency and knowledge of volunteers was not being tested by the service. Volunteers did not have supervisions and their practice was not being checked by the service. People did not receive reviews on the care and support they received.

The provider had completed an audit of the service in December but they had not identified the issues that we had found. The manager had told us that they had looked at this audit the day before we had visited.

The service had not had a registered manager for over six months. We spoke in December 2016 with the acting manager who had confirmed they intended to apply for the position as registered manager. However when we visited the service in February 2017 an application had not been made, but the acting manager told us that they still intended to apply.

The provider has a responsibility by law to notify the CQC about certain events. However, the manager and the coordinators did not fully know what these were and in what circumstances they should notify us. The acting manager did not know of the regulations which the CQC expects the service to comply with. Without this knowledge there could be a risk that the CQC are not informed of important events, which effects people's safety in the future.

The provider had also failed to check that the service was correctly registered. The service was registered at a location some miles away from where the regulated activity, personal care, was being managed from. We asked the provider to rectify this and an application to make changes to the providers registration was received by CQC shortly after the inspection.

When we spoke about the service's contingency plan, there were parts of this plan which were not robust as certain scenarios had not been considered and planned for. This plan had not been robustly reviewed.

There was a lack of understanding and awareness of the external safeguarding processes to the service. When we spoke with the manager and coordinators there was a focus on the service's internal procedures. There was a lack of knowledge about the external local authority safeguarding team, where concerns should be reported to. There was also a lack of understanding by the manager of what would constitute a safeguarding concern.

Recruitment checks of volunteers were not as robust as they could have been. Full employment histories were not obtained and there were no records that volunteer's identities were checked by the service.

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

The volunteers spoke extremely positively about the support they received from the coordinators of the service. One volunteer said, "We have been lucky (with the coordinators) we are a happy ship." Another volunteer said, "The main reason is the support, without the support of [names of coordinators] we wouldn't do it."

There was an open culture at the service. The volunteers we spoke with were focused on providing a person centred service to the people they supported. Volunteers were confident about raising any concerns they had with the coordinators. Volunteers were encouraged to make contact with the office and, when they did, they told us that they found it a positive and useful experience.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance</p> <p>The management of the service had failed to have effective systems and processes in place to monitor and improve the safety of the service provided.</p> <p>Regulation 17 (1) and (2) (a) (b) and (c).</p>