AVH Care

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: AVH Care is a domiciliary care agency, which provides personal care to people living in their own homes. The provider is a partnership, both partners work at the agency, one of whom is the registered manager. At the time of the inspection, the agency was providing care to six people, some of whom had complex care needs. At this inspection the service was rated as requires improvement.

People's experience of using this service:
People were at increased risk because the provider had not effectively assessed health and safety risks or done all that was reasonable to reduce identified risks. Risk assessments and care plans lacked detail, and were not up to date. Some risks had not been identified and there was a lack of detailed guidance for staff on how to meet people's care needs. The absence of this information meant staff did not have all the relevant information they needed to provide effective care and treatment.

Staff lacked the skills and knowledge they needed to undertake comprehensive assessments of people's care needs and develop detailed care plans to meet those needs. People's care records were poorly organised and were inconsistent. One person's care plan was very brief, another person's was missing, care records lacked relevant information and some were out of date. Documents were undated so it was not possible to see when they were created or were last updated. This increased risk people would not receive the care they needed.

However, staff knew more about people's care needs, and how to manage them safely, than was captured in people's care records. They worked closely with local health professionals, and followed their advice. Improvements had been made in including personalised information about people's backgrounds. Daily records were well completed about the care people received at each visit.

Improvements in staff training had been made. Staff had received safeguarding and moving and handling training. They knew about the different types of abuse, although two incidents which should have been notified to the Care Quality Commission (CQC), as required by the regulations had not been. Improvements in recruitment systems had been made to ensure the service employed fit and proper staff.

Some improvements in quality monitoring had been made, with the introduction of 'spot checks' of staff practice and use of surveys to seek feedback from people. However, further improvements in the agency's systems and processes and in record keeping were needed.

People said they felt safe and well cared for and said the service was reliable. One person said, "I'm very happy with the service," which others agreed with. People's concerns and complaints were listened and responded to.

People said they received personalised care. They said staff respected their privacy and treated them with dignity and respect. Staff developed positive and caring relationships with people.

People received their medicines safely and on time. Staff supported some people to eat and drink enough to maintain a balanced diet. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

For more details please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection: Requires improvement (report published on 5 January 2018). At that inspection we found four breaches of regulations which related to safe care and treatment, good governance, staffing, and about processes for employing fit and proper persons.

At this inspection the rating remains requires improvement, with four breaches of regulations relating to safe care and treatment, staffing, good governance and notification of incidents. You can see what action we told the provider to take at the back of the full version of the report.

Why we inspected: This was a planned inspection based on the rating at the last inspection to check if the required improvements had been made.

Enforcement: We have served a warning notice on the provider and registered manager. This requires them to comply with the more serious concerns by 28 May 2019.

Follow up: We will be meeting with the provider and commissioner to discuss our concerns, and will seek an improvement action plan to demonstrate how the improvements will be made. We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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 Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive . Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

AVH Care

Detailed findings

Background to this inspection

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

Inspection team: An inspector visited the service.

Service and service type: This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults, people with a physical and/or sensory disability and living with dementia.

The service had a manager registered with the Care Quality Commission, who was also a partner. This means that they, and the partnership are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was announced. 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. We visited the office location on 6 February 2019.

What we did: They provider sent us a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the service, such as the providers action plan following the previous inspection, and details of changes to the partnership.

During the inspection we spoke with three people and a relative and asked them about the care and support they received. We looked at those people's care records and at their medicine records.

We spoke with the registered manager, and the other partner in the business. We spoke with both care staff when we accompanied them on their lunchtime visits. We looked at two staff files around recruitment, supervision records and at staff training. We also looked at accident/incident reports and a quality

assurance survey. We sought feedback from commissioners, and health and social care professionals and received a response from four of them.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

There was an ongoing breach of regulations in safe care and treatment. This was because the provider had not effectively assessed risks to people's health and safety or done all that was reasonable to reduce identified risks. Improvements had been made in recruitment systems to ensure the service employed fit and proper staff.

Assessing risk, safety monitoring and management

● People were at increased risk because risk assessments lacked detail, and were not up to date. Some risks had not been identified and there was a lack of detailed guidance for staff on minimising known risks. For example, one person had a pressure ulcer (known as bedsore) in the past. There was no risk assessment about this and no detailed care plan about preventative measures needed to prevent recurrence.

● Risk assessment tools available were not used to assess moving and handling, falls, malnutrition or skin damage risks. This meant risks to people`s health were not assessed, and may not be known or appropriately managed by staff. Also, opportunities to proactively identify and minimise risks by providing staff with detailed guidance about people's care, treatment and equipment needs were missed.

● Staff were reliant on other health professionals for risk assessment information. However, the advice given through regular calls, e mails and joint visits was not incorporated into updated risk assessments or care plans. This meant updated information about how to safely care for people wasn't available to staff. This increased the risk people would not receive safe care and treatment.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, staff knew more about people's risks and care needs, and how to manage them safely, than was captured in risk assessments or care plans. They worked closely with local professionals, and often visited together, so received up to date information about people's changing risks and their care and treatment needs.

● For example, in relation to a person with swallowing difficulties and choking risks, staff had obtained information from a speech and language therapist about how to prepare their food to a soft consistency. Also, about high risk foods the person should avoid eating. They demonstrated a knowledge of the importance of an upright position and encouraging the person to eat slowly and swallow each mouthful, before eating further.

● People, said they felt safe and well cared for. One person said they felt safe when staff used a hoist to help them move. Another person said staff reminded them about their posture, if they were not sitting in an upright position in their chair. People's comments included; "Couldn't be better" and "Very happy with their services."

● Environmental risk assessments identified risks for staff when working in someone's home. For example, about poorly lit areas or slippery paths. Staff were provided with torches, and glow jackets for their safety when working in the dark.
● On the day we visited, staff identified a person's electronic bed was not working. The registered manager arranged for it to be repaired later that day, which minimised moving and handling risks for the person and staff.

Systems and processes to safeguard people from the risk of abuse
● Staff had received safeguarding training and knew about the different types of abuse. They were confident concerns reported were listened and responded to.
● For example, where safeguarding concerns were identified, the registered manager reported their concerns to the local authority safeguarding team. They worked with them and local professionals to agree a safeguarding protection plan for the person.

Learning lessons when things go wrong
● Accident/incident forms were completed, although completed forms seen did not include details of any investigation or actions taken to reduce the risk of recurrence. This meant opportunities to identify learning and improvements might be missed.
● However, where incidents had occurred, there was evidence actions had been taken to make improvements. For example, staff told us about a person who received minor injuries, after falling out of bed. They sought advice from professionals about the best ways to reduce further falls risks for the person whilst minimising restrictions on their freedom. This included an electric bed, staff could lower to floor and a floor mattress, to prevent injury, in case the person rolled out of bed. This meant the person could remain safely at home.

Staffing and recruitment
● Improvements had been made in in recruitment systems and processes. Missing documents had been obtained which demonstrated background criminal checks had been carried out. Additional references were obtained to confirm existing employees were suitable to work with people who may be vulnerable. No new staff have been employed since the last inspection.
● People said the service was reliable. Staff arrived on time and stayed for the time agreed. Where two staff were needed, these were provided and there were no missed visits.
● Staffing levels were determined by the number of people using the service and their needs. New care packages were only accepted if enough staff with the right skills were available.
● The small team meant people received continuity of care and got to know staff well.

Using medicines safely
● People received their medicines safely and on time. Medicine administration records (MAR) were kept to record details of people's medicines, and when they were given. Where a person was prescribed 'as required' medicines, staff were aware of this, although they had no specific guidance about their use.
● Staff received training in medicines management. Regular checks of MAR were carried out to ensure safe practice, although no records of findings or actions taken were kept.

Preventing and controlling infection
● People were protected from cross infection because infection control procedures were in place.
● Staff used personal protective equipment to prevent cross infection when assisting people with personal care. For example, gloves and aprons.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Some improvements in staff training had been made, however, there was an ongoing breach of regulations in relation to staff skills.

Staff support: induction, training, skills and experience; Assessing people's needs and choices; delivering care in line with standards, guidance and the law.

- People remained at risk, because staff did not have skills and knowledge needed to undertake comprehensive assessments of people's care needs or to develop detailed care plans to meet those needs.
- Staff had not been trained to use the evidence based assessment tools available, and were not using these tools. For example, to assess people's risk of pressure ulcers, their moving and handling and nutritional needs and any falls risks. This meant the information provided for staff about people's care needs was not comprehensive. For example, about the moving and handling needs of a person who needed hoisting.
- These lack of skills and knowledge meant staff could not reassess when people's needs changed. For example, about skin breakdown. This meant they relied on other health professionals for this, so were not proactive in responding to those changes.
- Some people's medical needs had not been identified or included in their care plans. For example, one person had diabetes and another person had a serious heart and lung condition. The absence of this information in their care plan meant staff did not have all the relevant information they needed to provide those people with effective care and treatment. For example, there was no information about how to support them with those conditions, or signs which might indicate they needed medical attention.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Other aspects of staff training had improved since we last visited. Three staff had undertaken a range of online training, such as first aid, infection control, Mental Capacity Act (2005), food hygiene, fire safety and person-centred care. Training records showed all four staff had undertaken safeguarding and moving and handling training.
- The registered manager had introduced regular 'spot checks' of staff employed by the agency to monitor care practices met required standards. Although the agency had no formal supervision arrangements, staff had informal opportunities to discuss practice and identify any training and development needs. This was through working alongside the registered manager in people's homes, and discussions during staff meetings.
- The registered manager confirmed any new staff employed would receive training and induction and

would be required to complete the Care Certificate. This is a nationally agreed set of standards for care staff about the knowledge, skills and behaviours needed.

Supporting people to eat and drink enough to maintain a balanced diet
● People said staff offered them drinks and meal choices, and made sure they had drinks and snacks within reach before leaving.
● Staff supported some people with meal preparation and were aware of people's likes and dislikes.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Health professionals were confident care staff recognised changes in people's needs, and contacted them appropriately for advice. They said staff worked closely with them and did joint visits in people's homes. For example, about a person's moving and handling needs re use of hoist and the use of a high/low electric bed and bed rail to prevent them falling out of bed. A health professional said, "When I visited the person at home, carers were present, they seemed knowledgeable and on the ball."
● However, a health professional described an occasion where they had to prompt staff to follow their updated pressure area and skin care advice. This was because staff continued to follow out of date advice applying a cream to a person's skin after it was discontinued. This could increase the risk of skin damage. The professional said, "Their paper work is a bit hit and miss. They don't always record what was said."
● Staff spoke knowledgeably about people's medicines, the importance of good hydration and avoiding constipation for helping people keep well. Also, about the impact of a person's neurological condition causing daily fluctuations in their mobility, cognition and emotional wellbeing.

Ensuring consent to care and treatment in line with law and guidance
● People said they were offered choices and staff sought their consent before delivering any care or treatment. Where a person needed equipment for their safety and security, that might restrict their freedom, this was discussed and agreed with them.
● The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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.
● Staff demonstrated an understanding of the principles underpinning the legislation. For example, about a person's right to make choices, that others might consider unwise. Staff sought professional advice, and arranged for a mental capacity assessment to be undertaken. This confirmed the person had the capacity to understand the risks and benefits in making their choices.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

- People and relatives said staff were caring and compassionate and treated them with dignity and respect. Comments included, "They listen to me," "They know what I like." A person appreciated that staff fed their cat, and took it to the vets for appointments, so they could continue to keep their pet. Referring to the registered manager, a relative wrote, "I feel extremely lucky that we managed to find someone so efficient, kind and caring who treats the person with such respect."
- Health professionals said staff provided caring and compassionate care. Comments included; "They are kind, caring and provide personalised care," and "Staff are keen to do their best for people they care for."
- Staff knew people well, and had developed good relationships with them. Staff demonstrated a positive regard for people in their interactions with them.
- Staff knew about people's cultural and religious needs. For example, about the importance of certain items of clothing to a person's faith needs.

Supporting people to express their views and be involved in making decisions about their care

- People confirmed they were involved in day to day decisions about their care, such as whether they wanted a wash or shower, and about what clothes they would like to wear.
- When people started using the service, a member of staff met with people and their relatives to discuss the person's needs and any preferences for care. For example, that a person wanted staff to call out as they entered to let them know they had arrived.
- Staff communicated well with people and involved them in decisions. For example, they knelt by the side of the bed of a person who was sleepy, touched their arm to get their attention and made good eye contact before speaking with them. They discussed whether the person wished to have a medicine prescribed 'as required' for them.

Respecting and promoting people's privacy, dignity and independence

- People confirmed staff treated them with dignity and respect. People were asked about their preferences for male or female care staff and their choices respected.
- Staff protected people's privacy and supported them sensitively with their personal care needs. For example, closing curtains and covering people with a towel, and ensuring a person had some time alone in the bathroom.
- Care plans included details about aspects of care people could undertake independently, and those they needed care staff support with. For example, one person's care plan said, "Assist [person's name] to put her clothes on, she is very able to help."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. There was an ongoing breach of regulations in good governance in relation to standards of record keeping.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People's care records were not accurate, detailed and up to date about all their care and treatment needs. There were no detailed care plans about people's moving and handling or skin care needs. Although a care plan had been developed in September 2018 about a person's swallowing/choking risks, it had not been completed or made available to staff.
- In their home, each person had a care folder with an index, and separate sections. However, the index had not been completed so it was not clear what records should be in each section. Risk assessments and care plans were undated so it was not possible to see when they were created or were last updated.
- One person had no care plan in their home, to guide staff about their care needs. When we asked about this, it was later found in the agency's office. Another person had an out of date contingency plan in their home, which differed from the office version. This meant instructions for staff about who to contact and actions to take in the event of a sudden deterioration in the person's health were incorrect.
- People's care plans differed. For example, one person with very complex needs only had a brief bullet point list of the tasks care workers needed to complete for them at each visit. Two other care records we saw had more personalised details about people's preferences, and how they liked to be supported. However, care plans all lacked relevant health information or detailed instructions for staff about how to meet people's needs.
- They registered manager confirmed the staff team knew all the people they supported well and had a good understanding of their needs, which people and professionals confirmed. However, we were concerned staff did not have access to accurate and up to date information when they needed it.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Improvements had been made in seeking personalised information about people's background and about what was important to them. Daily records were well completed with detailed information about care people received at each visit, about any concerns and actions taken in response.
- People received personalised care in response to their needs and preferences. For example, staff calmed and reassured a person who was anxious about receiving personal care by explaining in detail to them what they were going to do.
- Health professionals praised flexibility of staff in undertaking extra visits, for a person when they became anxious and needed extra support. Where a person needed more care hours because of deteriorating health, staff recognised this and made commissioners aware.
- We looked at how the provider complied with the Accessible Information Standard (AIS). This is a legal requirement to ensure people with a disability or sensory loss can access and understand information they

are given.
● People's care plans lacked information about their individual communication needs. For example, in relation to vision or hearing loss. The registered manager said they would be able to provide information in a format suitable to people's needs, if required.

Improving care quality in response to complaints or concerns
● There was a complaints system in place and people were given information about the complaints system when they started using the service. People said they would feel able to raise a complaint, if necessary.
● We followed up a complaint CQC were aware of. There was evidence it had been investigated and dealt with appropriately, with improvements made in response.

End of life care and support
● People were supported at the end of their life to have a comfortable, dignified and pain free death.
● Staff were knowledgeable about end of life care needs. Although there were no detailed end of life care plans for people, staff had information about people's advance wishes about resuscitation and treatment. Staff worked with the community nurses, and GP's to provide people with end of life care. A professional said, "No concerns at all, they are really good."

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Some improvements in quality monitoring had been made but there was an ongoing breach of regulations in relation good governance. This was because quality monitoring systems and processes were not fully effective in assessing, monitoring and improving the quality and safety of people's care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

- In the provider information return the registered manager wrote, "Action planning should be at the heart of processes at AVH Care and will take place at every level of governance and management." However, we found the provider was not following their own quality monitoring policies and procedures. Audit tools and action plans provided for quality monitoring were not used to make continuous improvements.
- For example, a partner described how they checked medicine administration charts each week by looking at entries, and signing medicine administration records. However, there were no records of what was checked or of any actions taken in response to findings. They were not aware the medicines management policy included a medicine audit tool for this purpose. They said they would use this in future.
- Care records were not routinely audited to help ensure they contained all the relevant information and were up to date. This meant gaps in risk assessments, care plans and missing or out of date documents in care records were not identified or addressed.
- The registered manager and partner each had a computer but there were no clear systems for saving and managing electronic documents, at the agency's office. A lack of structured systems meant documents could not easily be located. For example, care plan, risk assessments and reports of incidents staff told us about.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some improvements in quality monitoring had been made since the last inspection. For example, a training matrix system had been introduced for monitoring staff training, and a survey of people and relatives had been carried out.
- People, relatives and professionals were satisfied with the quality of care.
- Staff knew people well, care was person-centred and focused on people's health and well-being. Staff worked well as a team, and felt well supported.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

● The manager was not aware of their responsibilities to notify CQC about safeguarding concerns, and accidents resulting in injuries.
● We identified two incidents the registered manager should have notified the CQC about. This meant opportunities to identify and follow up risks related to those incidents were missed.

This was a breach of regulation 18 of the Registration Regulations 2009.

We discussed this with the registered manager, and sent them the relevant guidance about notifications.

● The registered manager and partner promoted person centred care, dignity and equality for all, and staff had received training in these areas.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Further improvements were needed in capturing information about people's individual communication needs, and any related support needs.
● People were consulted and provided feedback through day to day contact with the registered manager and partner. A recent survey showed people and relatives were happy with the service, and had not identified any areas for improvement.
● Staff were consulted and involved in decision making and regular staff meetings were held. They were encouraged to raise issues, and meeting minutes showed action was taken in response.

Continuous learning and improving care; Working in partnership with others
● When the registered manager registered with CQC in 2016, they undertook to gain a qualification in leadership and management as part of their development needed for the role. However, they had not yet commenced this qualification.
● Staff kept up to date with developments in practice through training and working alongside local health and social care professionals.
● Following bad weather last year, the agency had purchased a four-wheel-drive vehicle to ensure they could visit people they supported in bad weather.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Commission about incidents that affected the health, safety and welfare of service users. (1) (2) (a) (e)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have the required skills and knowledge in undertaking risk assessments and developing detailed care plans to meet people's care and treatment needs. (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at increased risk because the provider had not effectively assessed risks to people's health and safety and done all that was reasonably practicable to mitigate identified risks. (1)(2)(a)(b)

The enforcement action we took:

We served a warning notice to be met by (date tba).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers systems and processes were not fully effective in assessing, monitoring and improving the quality and safety of the services provided. Accurate, complete and contemporaneous records in respect of each service user were not maintained. (1)(2)(a)(b)(c)(d)(e)

The enforcement action we took:

We served a warning notice to be met by (date tba)