Avida Care Limited

aVida - Gloucester

Inspection report

1st Floor, 7a Mercia Road
Gloucester
Gloucestershire
GL1 2SQ

Tel: 01452415066
Website: www.avidacare.co.uk

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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

About the service: aVida – Gloucester provides personal care and support to people living in their own home. At the time of the inspection, the service was supporting 43 people who required personal care.

People's experience of using this service:
• People and their relatives told us they were happy with the service they received and felt safe amongst the staff who supported them.
• People highly praised the caring nature of staff and told us staff were polite and they respected people's dignity and privacy.
• People were involved in the assessment of their care and encouraged to retain their independence. Their care plans focused on people's abilities and desired outcomes and provided staff with the information they needed to support people.
• People's support needs were met. Staff always asked for people's consent before they supported them.
• Safe and responsive systems were in place for staff to report any incidents, near misses or when people were found missing from their home.
• There were sufficient staff available to ensure people were supported by familiar staff who understood their needs.
• People's support needs and risks had been assessed and were managed well.
• People received their medicines in a safe and timely manner and were referred to health care services when their needs changed.
• Staff were trained and supported to carry out their role and were knowledgeable about good care practices and their responsibilities to protect people from harm and abuse.
• Safe recruitment processes were in place to ensure people were cared for by suitable staff.
• Quality assurances systems were in place to monitor the quality of the service being provided and actions were being taken by the registered manager to address any shortfalls.
• We have made a recommendation relating to the communication from staff if they were running late and the introduction of new staff.

Rating at last inspection: Good (Last report was published on 13 July 2016.

Why we inspected: This was a planned inspection based on the previous rating at the last inspection.

Follow up: The rating of this inspection and the information and intelligence that we receive about the service will determine the timeframe of our next inspection.

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. Details are in our Safe findings below.	Good
Is the service effective? The service was effective. Details are in our Effective findings below.	Good
Is the service caring? The service was caring. Details are in our Caring findings below.	Good
Is the service responsive? The service was responsive. Details are in our Responsive findings below.	Good
Is the service well-led? The service was well-led. Details are in our Well-Led findings below.	Good

aVida - Gloucester

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:
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.

Service and service type:
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, younger disabled adults and people with learning disabilities and mental health conditions.

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

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

Inspection site visit activity started on 9th January 2019 and ended on 14th January 2019. We visited the office location on 9th and 14th January to see the registered manager and office staff; and to review care records and policies and procedures.

What we did:
Before the inspection we reviewed the 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. We also reviewed other information we held about the service as well as previous inspection reports and notifications we had received from the service. Notifications are information about important events that the service is legally required to submit to CQC.

During our visit to the service's office we looked at four people's care records and those files relating to staff development and the management of the service. We spoke with three care staff, the visit scheduler, the deputy manager and the registered manager. We also spoke with ten people and one relative by telephone and received feedback from three health care professionals.

Good

Is the service safe?

Our findings

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

People were safe and protected from avoidable harm. Legal requirements were met.

Assessing risk, safety monitoring and management and preventing and controlling infection.
• Risk assessments and management plans were in place to help identify and minimise any risks to people and provide staff with the guidance they needed to support people. For example, risks associated with people's mobility and risks of falls had been identified. Detailed guidance was in place which described how people should be supported when using mobility equipment and hoists.
• Protocols had been put into place for staff to follow when supporting people with their clinical needs such as catheter care. The protocols provided staff with guidance on how to support people and included actions staff should take if they were concerned about people's clinical well-being.
• Staff had reported any accidents and incidents. The registered manager regularly reviewed the reports to identify any trends or patterns. Action had been taken to prevent further injury or harm.
• Systems and guidance was in place for staff to access and enter people's homes safely. Staff had a clear understanding of the actions they should take if they found people unwell, on the floor or not answering their door.
• Arrangements were in place to manage the service and support people during adverse weather. Contingency plans were in place for those people who were at greatest risk if they did not receive support.
• Monitoring tools had been implemented where significant risks to people had been identified, such as the risk of choking or skin damage. We were told that the daily notes and monitoring tools were reviewed weekly to identify if, further monitoring was required or if for example, people needed to be referred to health care services.
• The safety and risks to staff when visiting people in their homes had been assessed, highlighted and were monitored.
• Staff were provided with a uniform and appropriate protective equipment such as aprons and gloves to help prevent the spread of infections. All staff had been trained in infection control.

Staffing and recruitment.
• There were sufficient staff to meet people's needs. Most people reported that staff generally arrived within the expected allocated time and stayed for the scheduled amount of time. However, some people stated that staff, sometimes, arrived later than expected and they were not always informed that staff may arrive late. We raised this with the registered manager who reviewed their call monitoring reports. They confirmed that staff sometimes arrived late but arrived within half an hour of their contractual planned visit time. We contacted the local authority commissioners, to verify the registered manager's report but did not receive feedback from them about this. Therefore, we were unable to make an informed judgment of the consistency of the arrival times of staff, however the registered manager provided assurances that the staff arrival times were frequently monitored. The registered manager acknowledged that communication with people needed to improve if staff were running late.
• A dedicated member of staff was responsible for the scheduling of people's care visits. Staff arrival and

departure times were monitored by the office staff. The office was alerted by an electronic call monitoring system if staff had not arrived or failed to log in to the system. Any alerts or missed calls were immediately investigated. Reports of the call monitoring systems were shared with the local authority to ensure the service met their contractual agreement.
• The service continually evaluated their staffing capacity to meet people's needs. Senior staff met on a regular basis to review people's visit requirements, staff availability and predict any future staffing requirements. An effective on call system was in place to provide out of hours support to staff.
• Safe recruitment systems were being used which ensured that people were supported by staff who were of good character. The management carried out valued based interviewing techniques to help them recruit staff who would help them fulfil their vision and mission statement.
• New staff shadowed experienced staff, completed an induction programme and the Care Certificate when they started.

Using medicines safely.
• Those who required support with medicines received assistance by staff who had been trained and assessed as being competent to do so.
• Medicines and topical creams administrations charts had been integrated into the monthly daily record booklets for people. This ensured that all records relating to the administration of people's medicines and creams were centralised and could be easily monitored by senior staff.

Systems and processes to safeguard people from the risk of abuse; learning lessons when things go wrong.
• Staff had been trained in safeguarding people and were aware of their responsibility to report any safeguarding concerns. Staff confirmed that they would report any concerns to the office or the member of staff on call.
• Safeguarding incidents had been notified to the relevant organisations as required. The service had worked with other health care professionals to ensure people remained safe. For example, staff had worked with staff at the hospital to ensure people had safe and smooth discharge back home.
• The registered manager and staff had a proactively reviewed their systems when incidents occurred to help prevent future incidents. Any actions or changes in systems or processes were communicated to staff and reinforced during staff meetings.

Good

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.

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
• People's needs were assessed before they received care from the service to ensure staff had the skills and capacity to meet their needs.
• People, their relatives and the local authority (if the care package required funding by the local authority) were all involved in the assessment process. This helped to identify people's support needs, goals and levels of independence. The outcomes of the assessments then informed people's care plans and provided staff with the information they needed to effectively support people. One person said, "Yes, I'm very satisfied with the quality of care that I receive."

Staff support: induction, training, skills and experience.
• People were supported by staff who had been trained to carry out their role.
• Staff told us they felt well trained and had received relevant training either by E learning or by the in-house trainer to ensure their practices were current.
• An effective system was in place to monitor the training needs of staff and to ensure their knowledge remained up to date. The in-house trainer and staff who held champion roles in areas such as dementia care provided staff with further resources and guidance if they needed additional support.
• The provider was passionate about developing staff who showed potential in their role and provided them with opportunities to obtain additional qualifications in health and social care and in management.
• Staff told us their colleagues, senior staff and management were supportive. Records showed that staff received annual appraisals and regular supervisions meetings to discuss their well-being, professional development and training needs.

Supporting people to eat and drink enough to maintain a balanced diet.
• For those that needed support with their meals, staff provided people with choice and encouraged them to have a healthy diet. Staff told us they were familiar with people's dietary requirements and preferences.
• People's swallowing difficulties and risks of choking were closely monitored by staff. Staff worked in collaboration with people, their families and health care professionals to ensure people's dietary needs were met.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support.
• Staff worked with other health care services and professionals to help prevent unnecessary hospital admissions. Staff told us they reported any changes in people's well-being directly to the office and sought advice and direction.
• People told us staff were responsive if there was a change in their health and well-being. For example, one

person said, "Once they had to get an ambulance for me and they've also contacted the District Nurse." Health care professionals felt staff were responsive to their recommendations.

Ensuring consent to care and treatment in line with law and guidance.
• People were involved in decisions about their care from aVida – Gloucester. They told us they were in control of the care they received.
• Staff supported people to make informed choices about their day to day care such as choices about the clothes and their meals.
• Records showed that the principles of the Mental Capacity Act 2005 had been considered when people had been assessed as lacking capacity to make significant decisions about their care and well-being.

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.
• We received many positive comments from people and their relatives about the caring nature and kindness of staff. When we asked people if they felt staff were kind and caring towards them, their comments included "Oh yes. They know what to do and they'll sit and talk for a few minutes because that means a lot when you're on your own"; "One won't leave me until she's absolutely sure I have everything I need" and "Yes, I think they are. They always ask me how I am. They always take care when rolling me and make sure nothing's hurting."
• Staff spoke about people in a respectful and caring manner. They clearly knew people well and showed a genuine interest in their well-being and that of others who looked after them and their family members.
• People told us that staff spoke to them appropriately and were aware of people's individual communication needs, such as giving people time to express themselves.
• Relatives also spoke fondly about staff.
• People's care plans reflected their diversity and protected characteristics under the Equality Act. The service was updating their service user guide to provide additional information about local and diverse groups and resources in the community, including the local Lesbian Gay Bisexual Transgender group (LGBT). The registered manager was on a national LGBT working party to help raise awareness of this community in the health and social care sector.
• The registered manager told us their staff had developed a more diverse understanding of people's religious and cultural preferences, for example supporting people in the local Muslim community.

Supporting people to express their views and be involved in making decisions about their care; respecting and promoting people's privacy, dignity and independence.
• People were involved in making decisions and planning their care. Their wishes, preferences and expectations were explored with them, and where appropriate, with their families.
• Staff provided people with information about their care and treatment to help them make informed decisions.
• People's individual communication needs were assessed and the support staff needed to provide with these was recorded in people's care plans. This helped to ensure the service met the Accessible Information Standards (AIS). AIS sets out a specific, consistent approach to identify, record, flag, share and meet the information and communication support needs of people with a disability, impairment or sensory loss. For example, rotas of the times and names of staff supporting them were sent to some people with visual impairments in a large print format. Picture cards had been produced to help communication with people who were unable to communicate in English.
• People told us their dignity was maintained and respected when staff supported them with personal care, for example, when showering or having a strip wash. People said, "Oh yes, they help me a lot. They put

towels round me when I'm showering"; "Definitely. [Name of staff member] only does what I can't reach" and "Curtains are pulled and they cover me with a towel. They make sure that nothing's exposed that doesn't need to be exposed."
• Staff were aware of supporting people in a dignified and respectful manner. One staff member explained how they used a person's towels to ensure they remained covered while they assisted them with washing.
• People were asked which gender of staff they preferred to support them with their personal care. Their views were documented in their care plans.
• Staff supported people respectfully and encouraged people to retain their independence. People told us staff supported people to do what they could for themselves. One person said "Oh yes, of course. I try and keep going myself. I just get them to do what I can't." A relative commented about their family member and said, "She hasn't got a lot of independence anymore, but they guide her as far as they can."

Good

Is the service responsive?

Our findings

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

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
• People's personal care and their treatment was assessed and planned with their involvement or, where appropriate, with the involvement of a representative and someone who knew them well. Staff confirmed that people's care plans provided them with the information they needed to support people. This included information about what was important to people and how their diagnosis may affect their abilities and the support they required. We found the care plans were person centred and provided staff with details about people's preferred care routines.
• As part of the initial assessment, people were asked to self-assess and score their personal well-being and pain. These scores were regularly reviewed to assess people's well-being and action was taken if people's self-assessment score had declined.
• The service was in the process of updating people's care plans and introducing a new care plan format. This provided clearer information for staff about people's support needs, levels of independence their goals and how staff should help people to achieve better outcomes. People's care files and a summary sheet highlighted people's main support requirement and risks.
• Staff had been responsive to people's changing needs and provided people with additional support when required. For example, the registered manager had arranged for staff to be available to support hospital staff when one person required additional support in hospital. This provided additional reassurance for the person and gave staff the opportunity to share their experience of supporting this person with the hospital staff and helped provide continuity of care.
• Staff told us they were mainly introduced to new people and informed of people's care plans and support requirements before they started visiting them. However, some people told us they had on occasions, been supported by staff who had not been introduced to them. We raised this with the registered manager who stated they would review how people were introduced to staff and to new members of the staff team, so that a consistent approach was adopted.

Improving care quality in response to complaints or concerns.
• People and their relative's concerns and feedback about the service were taken seriously and acted on by the registered manager and senior staff.
• People told us they were confident that any complaints would be taken seriously and immediately addressed.
• Records showed that complaints had been investigated and acted on in accordance with the provider's policy and procedures.

End of life care and support.
• At the time of inspection no one was receiving end of life care from the service. However, we were given examples of how the service had previously provided additional support, to people who required end of life

care in their own homes. Staff had supported people's relatives and worked jointly with other health care professionals to ensure people had a comfortable, dignified and pain-free death, including helping people to fulfil their final wishes.

• People's end of life wishes were explored and recorded during the initial assessment so staff had guidance they needed if people wanted to receive end of life care at home.

• Plans were in place for staff to receive further training in end of life care.

Good

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.

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; working in partnership with others.
• The registered manager had a good understanding of the needs of the people the service supported. Senior staff frequently worked alongside staff and carried out spot checks to observe the conduct of staff and assess their skills and competencies when caring for people. This also provided an opportunity for senior staff to monitor people's well-being.
• The registered manager and staff had strong values and were fully committed to ensuring people received safe and effective care in their own homes. Staff worked in partnership with people, their relatives and other health care services to achieve this.
• Regulatory requirements were understood by the registered manager including their meeting current legislation and, completing notifications to the Care Quality Commission (CQC). The registered manager had raised concerns to the appropriate authorities where they had identified poor care from other health care services to ensure people remained safe, for example, unsafe hospital discharge plans.
• Staff told us they felt supported by the management team and could raise any concerns to them and felt confident that any issues or suggestions on improving the delivery of service would be welcomed and acted on.
• People received appropriate care and treatment according to their assessed needs. The staff team had a clear understanding of people's needs and how they should be supported. However, the systems to monitor and manage people's visit times; communication if staff were running late and the introduction of new staff needed to improve to ensure there was a consistent approach. We received mixed comments from people about the communication from the office.

We recommend that the service considers more effective systems to improve the management and communication of people's visit times and the introduction of new staff to people.

• Quality assurance checks were frequently carried by the registered manager and senior staff to help monitor the service provided to people. The registered manager had a robust continuous improvement plan which helped direct the focus of the service and drive improvement.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.
• The registered manager and staff were committed to ensuring people were treated equally and their views were valued and acted on.

• A recent customer survey received positive comments and feedback from people about the support they received.

Continuous learning and improving care
• The registered manager was involved in local and national health and social care forums and groups. They explained that attending the groups had helped them to remain current in their practices and be aware of and help influence changes in the health and social care sector, both locally and nationally.
• There was an open approach in investigating and learning from accidents, incidents and near misses. The managers were open to new challenges and learning to help improve the quality of the service they delivered.