Ave Maria Care Ltd

Ave Maria Care (Leicester)

Inspection report

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Date of inspection visit:
15 November 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Ave Maria Care (Leicester) is a domiciliary care service providing the regulated activity of personal care to people living in their own homes. The service provides support to older people or people with long term health conditions. At the time of our inspection there were 5 people using the service.

Everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
People were placed at risk of harm or experienced harm. Medicines were not always managed safely. Risk assessments did not provide robust guidance for staff on ways to reduce risks to people. Staff lacked knowledge and competency in some areas of care delivery.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this poor practice.

People were not always well treated and supported appropriately and feedback was mixed regarding people being able to express their views and be involved in decisions about their care.

People did not find it easy to raise concerns with the provider. This meant the provider could not be assured that complaints were logged and dealt with appropriately. The provider had a good understanding in relation to the Accessible Information Standard.

The service lacked governance and was not run smoothly. Managers were not clear about their roles, and issues identified at the inspection had not been picked up in audits completed by the provider.

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

Rating at last inspection
This service was registered with us on 10 October 2020 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement

We have identified breaches in relation to the safety of medicines, risks to people not being managed safely, and a lack of leadership within the service this inspection.

Please see the action we have told the provider to take at the end of this report.

Due to the concerns found during this inspection, we have sent the provider warning notices. This gives the provider a specified amount of time to make improvements at the service.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe. Details are in our safe findings below.	**Inadequate**
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 not always caring. Details are in our caring findings below.	**Requires Improvement**
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 well-led. Details are in our well-led findings below.	**Inadequate**

Ave Maria Care (Leicester)

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was completed by 1 inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
We gave the service a short period of notice of the inspection. This was because it is a small service and we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 15 November 2022 and ended on 18 November 2022. We visited the location's office on 15 November 2022.

What we did before inspection
We reviewed information we had received about the service. We used information gathered as part of our

monitoring activity that took place on 27 October 2022 to help plan the inspection and inform our judgements. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with 4 staff including the manager and the compliance manager. We spoke with 1 person who used the service, and 1 relative.

We reviewed a range of documents including care plans, risk assessments, investigation reports, complaints logs, medicine records, staff recruitment files along with a number of the provider's policies and procedures.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People had experienced avoidable harm. One person had experienced 5 consecutive care calls where a staff member had not turned up. This had meant the person did not receive food, drinks or personal care for almost 48 hours. Over this period, the person had experienced 3 falls and required admission into hospital. The manager was on call at the time and had failed to identify the person' care call had been missed.
- Another person had been exposed to increased risk of avoidable harm on 49 days between 1 August 2022 and 15 November 2022 when their care staff had administered medication without the minimum 4-hour gap. This placed the person at risk of severe liver damage. We have raised a safeguarding alert to the local authority's safeguarding team in relation to this concern following our inspection.

The provider had failed to keep people safe from avoidable harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were able to describe some types of abuse and the process they would follow to keep people safe.

Assessing risk, safety monitoring and management

- Safety concerns were not always identified. For example, one person had been diagnosed with dementia, and had bed rails on their bed. People with dementia are at higher risk of entrapment from bedrails. The provider had failed to complete a risk assessment in relation to this risk surrounding bedrails for this person to assess their suitability.
- Risks to people had not always been assessed and plans put in place to manage these. For example, the provider had assessed 1 person as being at high risk of slips, trips and falls, however the provider had not put effective measures in place to reduce this risk.
- Full information surrounding risks to people was not always available for staff. One person was identified to be at risk of spitting their medicine out or throwing it in the bin. There was no guidance for staff on what actions to take in the event this happened, or risk reduction measures in place to prevent the incident occurring to begin with. We spoke with 2 staff who both told us they felt care plans and risk assessment needed to contain more information to help them do their job safely.
- Staff were not sufficiently competent in all areas of people's care. One person had been diagnosed with diabetes. Both regular staff who attended the person's care visits were unable to describe the symptoms of high blood sugar or low blood sugar. One of the staff members was not aware the person had diabetes. This placed the person at risk of harm in that staff would be unable to identify if they were becoming unwell with diabetic complications.

Using medicines safely

● People did not receive their medicines safely. Not all prescribed medicines had been recorded on people's medication administration records (MAR). A review of a person's daily records identified staff applying prescribed creams without them being added to the person's MAR chart posing a risk they could be applied incorrectly.

● Staff did not always have information and guidance on how to administer people's medicines. For example, one person's medicines record did not clarify whether prescribed pain relief was to be taken regularly or as and when required.

● Medicine induction training did not include 'right to refuse'. This is an integral part of training surrounding medicines, to ensure staff are delivering care in a person-centred way and respecting people's choices.

Preventing and controlling infection

● We were not assured the provider was using personal protective equipment (PPE) effectively and safely. People told us staff did not always wear face masks when conducting their visits. One staff member confirmed this. The provider had failed to adequately protect people from the risks associated with the spread of infection. For example, staff were not wearing masks whilst supporting 1 person and there was no risk assessment in place in relation to this.

Risks to people were not identified and acted upon, medicines were not managed safely and the provider failed to ensure the proper use of personal protective equipment (PPE). This is a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured the provider's infection prevention and control policy was up to date.

Staffing and recruitment

● Recruitment checks had not been consistently carried out on prospective staff. One staff member did not have enough previous employment references in their file to meet the provider's own policy stipulations. This meant the provider could not be assured they were recruiting staff who could demonstrate they were of good character and suitable for the role.

● There were enough numbers of staff to provide the required support to people. People told us they received care when they needed it. Records confirmed this.

Learning lessons when things go wrong

● Staff did not always recognise or record concerns or incidents. This included medicine administration errors. This meant we were not assured staff would be able to recognise incidents and report them in the correct way meaning that lessons would not be learnt.

● When staff did raise a concern, it was not always dealt with effectively by the manager. One staff member told us they had raised concerns with the manager about the standard of care a colleague was providing. We did not see any records where the manager had logged this concern, and the staff member advised the issue had not been resolved by the manager.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

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

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

- Mental capacity assessments had not always been undertaken when required. Those that were in place lacked detail of which decision people lacked capacity for. This meant the provider had failed to work within the principles of the MCA and it was difficult for staff to ensure they had consent or were acting in the person's best interests, to provide the appropriate level of support.
- Staff lacked knowledge and understanding around mental capacity. None of the staff we spoke with were able to describe what a best interests decision meant. This meant people were at risk of having decisions made on their behalf which were not in their best interests.

The failure to work within the principles of the Mental Capacity Act 2005 and associated code of practice is a breach of Regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- Not all staff had up to date training. We reviewed the provider's training matrix which showed one staff member lacking training in areas such as pressure area care, dementia and basic life support.
- Competency checks were not robust in determining staff knowledge levels. We saw competency check

paperwork had been completed for staff in relation to catheter care and administration of eye drops, however no one at the service had a catheter or required eye drops administering.

● Staff induction training covered a range of topics such as health and safety, infection control, medication and dementia awareness, however we are not assured that this training was of good quality due to the lack of staff competence in these areas and concerns found during our visit.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

● Care assessments did not consider the full range of people's diverse needs. Some care records we reviewed contained contradictory information. This meant there was insufficient guidance for staff on how to meet people's needs.

● People were supported to eat and drink enough. People told us staff prepared food in a way which they liked.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The manager advised currently they were not working with any healthcare partners, however in the past had worked closely with the Home Enteral Nutrition Service (HENS) to help support people who require a medical device to provide nutrition if they cannot eat and/or swallow food.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- We were not assured that people were always well treated and supported appropriately. For example, not all staff had the skills and knowledge to support people safely.
- People's religious views were recorded in their care plan, however, there was a lack of guidance for staff on how the person could be supported with their faith.
- One person was very happy with the care they received. They told us, "The carers are outstanding every time they come round."

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 not always cared for in the least restrictive way. One person's relative advised the person could wash most of their body independently. Records described how staff had provided all personal care. This demonstrated that care was not always provided encouraging independence.
- One person told us they felt respected by care staff; however, feedback was mixed regarding people being able to express their views and be involved in decisions about their care. One person was pleased at their level of involvement with the service they received, another person felt communication was lacking and could be improved.
- Staff respected people's privacy. One person told us, "They help me get undressed, then [staff member] says give me a call when you're ready. I get the privacy to shower and the support when needed."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- People did not find it easy to raise concerns with the service. One relative told us they had been trying to make a complaint via telephone, however it was very hard to get hold of staff in the provider's office. The relative asked for a face to face meeting, and the manager agreed however, the meeting offered was in a place which was not easily accessible to the relative.
- The manager told us they were completing wellbeing telephone calls. This was to provide an opportunity for people to report any concerns they may have. A wellbeing call was recorded as being undertaken with a person using the service. The form recorded there were no complaints after speaking to the person receiving care. However, this person's relative told us that the person would be unable to answer the telephone therefore we are not assured that this call took place. This meant the provider could not be assured that complaints were logged and dealt with appropriately.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's views varied in response to whether they felt involved in decisions about their care. One person told us they felt very involved, however a relative, who holds a Lasting Power of Attorney (which means they can make decisions about some aspects of their family members care), felt they were rarely consulted.
- The manager had updated care plans and risk assessments when people's needs changed. However, these were found to contain contradictory information. This meant it was difficult for staff to know how to provide care in a way that met the person's needs and preferences.
- The manager advised staff helped people maintain relationships by supporting them to telephone their family members. Care staff also told us they spent time chatting with people during their care visits, and people confirmed this.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The provider had a good understanding in relation to the Accessible Information Standard. The provider

told us they could adapt care plans, and other means of communicating with people in a way that would best meet their needs. For example, in large print, braille, or different languages. At the time of the inspection, no one using the service required their communication to be delivered in any of these ways.

End of life care and support

● At the time of the inspection, no one using the service required end of life care and support. One person had a DNACPR in place; however, they had declined to discuss their end of life wishes with staff.

Inadequate

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There was no registered manager in post at the time of the inspection, and there had not been for some months prior to the inspection. This meant covering managers from other areas were supporting the branch. This lack of consistent management and oversight meant the service did not run smoothly.
- The provider had attempted to recruit a replacement manager, however advised they had struggled to find a candidate of sufficient competency. The provider had recently been successful and appointed a person to fill the registered manager role, however they were not due to start until after the inspection.
- At the point of registration with CQC the provider confirmed that robust processes would be in place for care planning, medication, staff recruitment, staff training and management of complaints. This inspection found these processes had not been implemented as needed to meet regulatory requirements.
- The provider failed to complete meaningful audits of the service to identify where improvements needed to be made. We found concerns around care plans, risk assessments, training, recruitment and the MCA. Not all of these areas had been audited by the provider. Where audits were taking place, they were not effective in identifying shortfalls, for example in relation to MAR charts and medicine errors.
- The provider had failed to identify that people's care records were inaccurate. This meant staff did not have access to consistent and accurate information about people and their support needs, and placed people at risk of not receiving their required and assessed care.
- The provider understood the need to notify us about relevant changes, events and incidents affecting the service and people who used it. However, we found systems were not always robust and did not identify when their processes had not been followed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider's systems and processes failed to ensure the quality and safety of the service. For example, one person's care plan described how they liked to be as independent as possible with some staff support. Daily care notes recorded by staff did not demonstrate the person had been independent at all and read as though staff had completed all tasks for the person. The provider had failed to identify this prior to our inspection or raise this issue with care staff.
- It was unclear from the provider's systems how they had ensured their policies were being implemented and their vision and values were being maintained across the service. From our observations and talking

with staff, people and their relatives, we found there was not a coherent and collaborative approach to the management of the service.

The failure to assess, monitor and improve the quality and safety of the service is a breach of Regulation 17 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Feedback from both staff and people described how it was not always easy to be able to speak to someone in the office in Leicester. We were told how some phone calls were being diverted to Birmingham offices.
- The provider told us they regularly telephoned people to conduct wellbeing checks and seek their views on care. Records we reviewed did demonstrate these calls had been made, however, they were not always effective in identifying concerns.

Continuous learning and improving care

- Complaints were not dealt with in an open and transparent way. One complaint had been logged by the provider, in relation to missed calls. This had been investigated; however, the investigation did not examine all aspects of failure. This meant the provider could not be assured lessons would be learnt and the same incident would not reoccur.

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 placed at risk of harm or experienced harm. Medicines were not always managed safely. Risk assessments did not provide robust guidance for staff on ways to reduce risks to people. Staff lacked knowledge and competency in some areas of care delivery.

The enforcement action we took:

We issued a warning notice to the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service lacked governance and was not run smoothly. Managers were not clear about their roles, and issues identified at the inspection had not been picked up in audits completed by the provider.

The enforcement action we took:

We issued a warning notice to the provider.