Ave Maria Care Ltd

Ave Maria Care (Edgbaston)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Ave Maria Care (Edgbaston) is a domiciliary care agency registered to provide personal care to people living in their own homes. Not 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. At the time of the inspection, the service supported 22 people.

People's experience of using this service and what we found
Some people had experienced multiple missed care calls or care calls attended by insufficient staff to meet their needs safely. This meant these people's needs had not been consistently met, and they had been placed at increased risk of avoidable harm. The provider had not followed their safeguarding policy. Safeguarding incidents had not always been reported to the local authority's safeguarding team or effective actions taken to keep people safe. The provider's governance systems were not effective, and the information recorded about some people's care was not accurate, up-to-date or complete. We were told that all care records would be reviewed. We sampled two care records that were person-centred, and the area manager told us all care records would be reviewed.

Staff had not received consistent supervision. Missed care calls meant people's health needs had not been consistently monitored, and some people had not received consistent support to prepare meals. This did not reflect a caring approach. People and their relatives were not always confident that the provider would act on concerns and complaints. People's preferences for their care and their interests and aspirations had not been consistently assessed or recorded.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Enough staff were employed to meet people's needs and prospective staff underwent pre-employment to ensure they were suitable to support people in their own homes. Steps were taken to protect people, their relatives and staff from the risk of infections.

People's care needs were assessed before their care started. Staff completed induction and training designed to give them the knowledge and skills needed to meet people's care needs. Staff understood and promoted people's independence and their right to make their own decisions.

People's individual communication needs were assessed and taken into consideration. Staff felt supported by the management team. Systems were in place to gather people's and relatives' feedback on the service.

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

Rating at last inspection
The last rating for this service was good (published 13 March 2020).

Why we inspected
This inspection was prompted by a review of the information we held about this service. This included whistle-blowing information received about missed care visits, insufficient numbers of staff attending care calls and falsified entries by staff on the provider's systems confirming visits as completed.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well Led sections of this full report.

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 safe care, protecting people from abuse and the governance of the service.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work alongside the provider and local authority to monitor progress. We will continue to monitor the information we receive about the service, which will help inform us when we next inspect.

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 always well-led. Details are in our well-led findings below.	**Requires Improvement**

Ave Maria Care (Edgbaston)

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

Inspection team
The inspection team consisted of 3 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience 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.

Registered Manager
This provider must 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 (CQC) to manage the service. Registered managers and providers are legally responsible for how the service is run, the quality and safety of the care provided and compliance with regulations. At the time of this inspection, a registered manager was in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it was a small service, and we needed to be sure that the provider or registered manager would be available to support the inspection.

Inspection activity started on 18 December 2022 when an Expert by Experience spoke to people and relatives by telephone. Visits to the service's office took place on 10 and 16 January 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection; this included whistle-

blowing information. We sought feedback from the local authority.

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 reviewed a range of records. This included 7 people's care records to see how their care and treatment were delivered. Other information we looked at included 4 staff recruitment files and training records. We also looked at documents relating to service management and the provider's electronic operating system. We spoke with 2 people, 6 relatives and 6 staff, including the registered manager, regional manager, compliance manager and IT manager and 3 care staff.

Inadequate

Is the service safe?

Our findings

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

At our last inspection, we rated this key question Good. At this inspection, the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

- Risks to people were not consistently managed to support them to stay safe.
- Some people had experienced a number of missed care calls or care calls attended by 1 staff member instead of the 2 staff members required. This meant their care needs had not been consistently or safely met and their health had not been monitored, placing them at increased risk of harm. For example, 1 person who required support with their personal care, medicines and to prepare meals had experienced multiple missed care calls between October 2022 and January 2023. Another person who required 2 staff members to meet their personal care and mobility needs had been supported by 1 staff member on multiple occasions in October 2022.
- People had not always received their medicines as prescribed due to missed care calls, placing them at increased risk of deterioration in their health. For example,1 person had not received support with their medicines from staff on 6 occasions in October 2022 as a result of missed care calls.
- In October 2022, the provider became aware the information recorded, by some staff members, on their electronic operating system about people's care calls was inaccurate, indicating care calls had taken place when they had not. Although the provider had investigated these concerns and an apology was given to the people who had experienced missed care calls,

The provider had not informed the local authority or taken effective action to prevent further misuse of this system, which continued until January 2023.

The provider had failed to manage risks relating to the health, safety and welfare of people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Known risks to people had been assessed and recorded in their care plans, including risks associated with their health needs.
- People's medicines were administered by trained staff who underwent medicine competency checks.
- The provider had developed a system for staff to record accidents and incidents involving people, and the staff we spoke with understood how to use this to report any concerns

Systems and processes to safeguard people from abuse

- The provider's systems and processes to protect people from abuse were not effective, and they had not always followed their own safeguarding policy.
- When people's care needs had not been met due to missed care calls or care calls attended by insufficient staff, the provider had not raised safeguarding alerts with the local authority's safeguarding team. This meant there had been no external review or investigation to ensure people were fully protected from any

further neglect or abuse.
● The provider's decisions not to report safeguarding concerns to the local authority's safeguarding team were based on risk assessments completed by the area manager. However, these risk assessments were not referred to in the provider's safeguarding policy and had not resulted in effective action to protect people from their care needs not being met. This included the increased risk to people associated with their long-term health conditions not being consistently monitored.

The provider had failed to ensure people were always protected from abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received training to help them understand how to recognise and respond to abuse. We saw evidence of staff members having raised concerns about potential neglect, due to missed care calls, through the provider's electronic operating system.

Staffing and recruitment
● The provider employed sufficient staff to meet people's current care needs. However, some people had experienced multiple missed care calls or care calls attended by insufficient staff.
● People and their relatives expressed mixed views on staffing levels, and the reliability and punctuality of the service.
● Staff were recruited safely and in line with the provider's recruitment policy. Pre-employment checks were carried out on prospective staff to ensure they were suitable to support people, including Disclosure and Barring Service (DBS) checks. DBS checks provide information about any convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions. At The time of the inspection, a new manager was in the post who had the experience to ensure action was taken in relation to our findings. in the post

Preventing and controlling infection
● The provider had taken steps to protect people from the risk of infections.
● Staff had access to personal protective equipment (PPE) when needed and used this in line with good practice. People and staff spoken with confirmed this. A staff member said, "Before we run out (of PPE), we go to the office and grab more gloves, aprons and masks if needed."

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 the best available evidence.

At our last inspection, we rated this key question Good. At this inspection, the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment, and support did not consistently achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People and their relatives expressed mixed views about staff knowledge, skills and experience. One relative told us, "The agency was using irregular care workers at the weekend and sent young inexperienced staff or no care staff which is problematic." Another person said, "Definitely, the regular ones are trained. I have no concerns; they let me know if anything is wrong or they have any concerns. They are on the ball."

Staff had not received regular supervision from the previous manager. This meant missed opportunities to monitor and address staff performance issues. The provider had identified this concern and commenced a new programme of staff supervision.

- New staff received an induction to help them understand and settle into their roles. This included computer-based courses and a period of shadowing experienced staff. One staff member told us, "I had my induction, which meant I shadowed another staff member until I felt confident."
- Staff participated in a range of training designed to enable them to safely and effectively meet people's needs. The provider-maintained oversight of staff training needs. Staff we spoke with were knowledgeable in the areas they had trained in.

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 agencies such as the district nursing service and community occupational therapists to ensure people's health needs were monitored and met. Staff monitored people's skin conditions for changes and reported back to district nurses if any changes had occurred. Staff also communicated with occupational therapists regarding the need for any additional moving and handling equipment.
- However, people had experienced missed care calls, which had impacted on their health needs being monitored and met. This had not been reported to the community health professionals involved.
- People's care and support was arranged flexibly, ensuring people had access to other health care services such as doctors appointments. One person told us, "My visit was rearranged to accommodate my doctors appointment."

Supporting people to eat and drink enough to maintain a balanced diet

- The support people needed to prepare meals, and eat or drink had been assessed and recorded.
- However, missed care calls had meant that people had not always received consistent support to prepare their meals and drinks, and so maintain a balanced diet.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care needs were assessed with them and, where appropriate, their relatives before their care started and kept under review. This included consideration of people's health needs.
● Care plans were developed to meet people's assessed needs. Staff we spoke with were aware of people's care plans and the need to follow these. One staff member told us, "They (care plans) give enough detail and we read previous notes about the client."

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack the mental capacity to take 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.
● Staff told us they had been trained in the principles of the MCA, and the records we saw confirmed this. A staff member told us, "Sometimes people can make basic decisions, like what they want to drink or eat, or they may struggle with bigger decisions and may need help understanding these."
● Staff sought people's consent before care was provided. One person told us, "The carer will ask, 'do you want to wear this or do you want this in the wash? What do you want to do today? Would you like a shower?' They ask what I want for breakfast."

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.

At our last inspection, we rated this key question Good. At this inspection the rating has changed to 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; Respecting and promoting people's privacy, dignity and independence

- Some people had experienced multiple missed care calls or care calls attended by insufficient staff. This meant their care needs had not been consistently met, and their dignity was not always promoted, which did not reflect a caring approach. For example, one person had not always received the support needed from staff with their continence care, which had led to them being left in undignified circumstances.
- People and relatives expressed mixed views on whether staff treated people well. Some people spoke about the impact of missed care calls. For example, one relative said, "I don't think they (provider) always let us know when there is a problem which means we can be left high and dry, not knowing if they are coming. I am not sure they appreciate how significant it is for me. Not knowing is the worst bit."
- Other people and relatives felt staff treated people well. A relative told us, "They (staff) do anything that makes sure [name of person] is safe [and] help with personal hygiene. If we ask them to do certain things, they will. [Name of person] is always clean and tidy and has never said anything about anyone making them feel awkward."
- Staff told us how they protected people's dignity, respect and independence during care calls. One staff member said, "I make sure the curtains are closed, clothes are within reach and ask if they (person) need any support." A relative described how staff had promoted one person's independence. They told us, "They (staff) encourage [name of person] to do things around the house. I have seen them change the bed, and they help rather than take over. When [name of person] is in the shower, they do it more or less themselves doing what they can, and staff help when necessary."

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

- People and relatives felt able to express their views but were not always confident these would be taken into account by management. For example, one relative told us, "I haven't the confidence in asking them (provider) to change anything, but I would speak to the carers direct."
- People and relatives did not feel they were always consulted when changes occurred in their care.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection, we rated this key question Good. At this inspection, the rating has changed to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People and their relatives were enabled to contribute towards assessments and care planning. However, limited information had been recorded on assessments and care reviews about people's stated preferences for their care and no information had been recorded on people's personal history, interests and aspirations. This did not fully support person-centred care.
- People's care plans were kept under review to ensure these reflected people's current care needs and were accessible to staff.

Improving care quality in response to complaints or concerns

- People and their relatives knew how to make a complaint. However, we received mixed feedback from people and their relatives about the effectiveness of the provider's complaints handling. One person told us, "I put an email complaint to the finance department when they said they had been (to attend care call), and no one had come but we were charged for it, but did not have a reply." Another person said, "I have always dealt with the office staff or area manager and have been satisfied with the outcome."
- The provider had a system in place for recording and handling complaints. Complaints records indicated the compliance manager had investigated complaints in line with the provider's complaints policy and people received a written response to their concerns.
- However, analysis of themes and trends in complaints had not taken place, to enable preventative work or service improvements to be identified.

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. 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.

- People's individual communication needs were assessed and taken into consideration. The area manager told us, "We ensure we match individuals with care staff that speak their native language, if required, in order to reduce language barriers. We are also able to offer written information if preferred. We will also use flash cards where this is required to overcome any barriers."

End-of-life care and support

- End-of-life care and support was considered in care plans sampled. This information included people's preferences in how they would like to be cared for and family involvement.

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.

At our last inspection, we rated this key question Good. At this inspection, the rating has changed to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems to assess the safety and quality of people's care and to manage risk had not always been effectively operated. These systems had not enabled the provider to identify and address in a timely manner the concerns identified at this inspection. This meant the provider and registered manager did not have effective oversight of the service.
- The provider's quality assurance systems had not enabled them to address the misuse of their electronic operating system by some staff, resulting in false records being made of care visits which had not taken place. This meant people's care records were not accurate, up-to-date or complete and risks to people had not been managed.
- The provider's quality assurance systems had not enabled them to identify their safeguarding policy was not being followed, safeguarding alerts were not being made as required, and risk mitigation was ineffective and failed to consider people's existing medical conditions. This meant people were left at continuing risk of harm.

The provider's governance systems were not effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

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

- Some staff had recorded misleading and inaccurate information on the provider's electronic operating system in relation to the completion of people's care calls and care tasks. This did not reflect a positive or person-centred culture, and impacted on people's outcomes.
- We received mixed views from people and their relatives about the office staff and the effectiveness of communication with the service. One relative told us, "I feel admin and office side of things is quite poor. Somethings have improved, but that is my main concern." Another relative said, "Communication is good with the girls in the office. [They are] very pleasant, always call if something doesn't sound right, and Ave Marie will help.".
- Staff told us how approachable the management team were. One member of staff said, "The manager is very supportive, and we can contact them at any time. [They are] very helpful."

How the registered managers understood and acted on their duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong. At the time of the inspection,

a new management team were in post, this included a new registered manager who was registered with the Care Quality Commission and a regional manager to support them.

● The regional manager and manager we spoke with understood the duty of candour. As part of the investigation completed into the multiple missed care calls, all people identified as having missed visits received an apology.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Systems were in place to gain feedback from people and their relatives on their experiences of care.

● People were invited to take part in monthly feedback surveys and the results of these were analysed by the provider.

● However, one person raised concerns about the questions posed on the feedback survey. They told us, "They (staff) have left a tick sheet, but I find these questions very difficult to answer, all yes or no answers, but it is more complex than that. I have fed that back to the agency, and they said, 'yes, we know". This was a couple of years ago and they haven't changed since."

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 The provider had failed to manage risks to people's health, safety and welfare.

The enforcement action we took:

We have imposed a condition on the provider's registration requring them to submit monthly reports to infrom of actions taken and improvements made.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's safeguarding procedures were not effective and safeguarding concerns had not been consistently reported to the relevant agencies.

The enforcement action we took:

We have imposed a condition on the provider's registration requiring them to submit monthly reports to inform of actions taken and improvements made.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's governance systems were not effective.

The enforcement action we took:

We have imposed a condition on the provider's registration requiring them to submit monthly reports to inform of actions taken and improvements made.