

Ave Maria Care Ltd

Ave Maria Care Services

Inspection report

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Ratings

Overall rating for this service

Good 

Is the service safe?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 11 October 2016 and rated the service as 'Good' overall.

Since that inspection we received information about concerns in relation to the service. These related to people being not being supported safely by care workers. People's care calls were late or were missed. Some people's medicines had not been given on time or not at all and the service did not respond to people's complaints. As a result we undertook an unannounced focused inspection on 1 August 2017 to check whether people were safe and whether the service was well-led. This report only covers our findings in relation to these two key areas.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ave Maria Care Services on our website at www.cqc.org.uk.

Ave Maria Care Services is registered to provide personal care and support to people living in their own homes. At the time of our visit, the service provided care and support to 55 people.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered provider's, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us there was enough care staff to provide their care and they felt safe with them. People we spoke with told us overall, they were happy with the quality of service they received.

All staff had completed safeguarding adults training and they knew what action to take if they thought a person was at risk. The registered manager was aware of their responsibilities to keep people safe.

Staff had received training which provided them with the knowledge and skills needed to support people to move safely.

Risk assessments were in place but not all known risks had been assessed. Information in care records did not consistently provide staff with the information they needed to keep people and themselves safe when providing care to people. However, staff demonstrated their understanding of the risks associated with people's care and how these were to be managed.

People received their medicines when they needed them.

All the people we spoke with and records we reviewed showed people's care calls had taken place. However, some people were dissatisfied because care staff did not always arrive when they expected them.

The scheduling, planning and monitoring of calls requires improvement.

There were systems in place to monitor the quality and safety of the service provided to people. However, not all checks were effective.

Recorded complaints had been responded to in line with the provider's procedure.

The registered manager welcomed feedback from people and their families to improve the service they received.

Staff told us they had received awards for providing good quality care to people and were pleased their commitment and hard work was being recognised by the registered manager.

The registered manager was aware of which notifications they were required to send us by law so we were able to monitor any changes or issues at the service.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The 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 consistently safe.

People felt safe with the staff who provided their care. People received their medicines when they needed them. Staff had received training to support them to move people safely. Staff were aware of the risks associated with people's care. However, some known risks had not been assessed and the information available to staff to manage some risks required improvement.

Requires Improvement ●

Is the service well-led?

The service was not consistently Well-led.

The scheduling, planning and monitoring of calls requires further improvement. Some checks to monitor the safety and quality of the service were not effective. The registered manager welcomed feedback from people and their families to improve the service they received.

Requires Improvement ●

Ave Maria Care Services

Detailed findings

Background to this inspection

We undertook an unannounced focussed inspection of Ave Maria Care Services on 1 August 2017. This was because we had received information which gave us concern that people might not be safe and the service may not be well-led.

We inspected the service to assess compliance against the keys questions: Safe and Well Led. The team consisted of two inspectors 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.

Prior to our visit we spoke with eight people who used the service and two people's relatives via the telephone. We reviewed the information we had received about the service. We also spoke with local authority commissioners who funded the care some people received and safeguarding social workers. Commissioners informed us they had visited the service on 11 July 2017 and had made some recommendations to improve the service provided to people.

During our visit, we spoke with the registered manager, two care coordinators, one care worker and an administrator. Due to work commitments other care staff were not able to meet with us on the day of our visit. We were provided with contact details for 14 care workers and attempted to speak with them over the next seven days. However, only one was available to talk with us.

We reviewed four people's risk assessments and care records to see how people's care and support was planned and delivered. We looked at other records which included checks the management team completed to assure themselves that people received a good quality service.

Is the service safe?

Our findings

Since our comprehensive inspection we received information which alleged people were not safe.

We were made aware that one person required care from two care workers to maintain their safety. However, we were informed on a recent occasion only one care worker had supported them. We discussed this with the registered manager and they acknowledged that this had placed the person and the staff member at unnecessary risk. This had happened because one care worker was running late and the other had not waited for them to arrive before providing care. The registered manager had taken action to address this with the care workers involved in line with the provider's disciplinary policy.

We checked completed call records for all of the people who required two care workers to provide their care in the three weeks prior to our visit. Records confirmed two care workers had attended all calls.

We also received information which alleged care workers practices did not demonstrate they had received sufficient training to manage risks associated with people's care. For example, safely operating a hoist to move people. (A hoist is equipment that is used to move a person. For example, from an armchair into a bed.) This presented a risk which could have caused harm to people and care workers. The registered manager was aware of this information but assured us staff had completed the training they required to move people safely. The registered manager had completed a 'moving and handling train the trainer' qualification and delivered all moving and handling training to care staff. Records confirmed that on 20 July 2017, 16 staff had attended manual handling training to refresh their knowledge. Another training session was planned to take place the week following our visit to re-train staff who had not been able to attend on 20 July due to other work commitments.

We reviewed risk assessments and care plans for four people who used the service, to check staff had the information they needed to provide safe care. We looked at the information provided to us and we found some known risks had not been assessed and the detail recorded did not consistently provide staff with the information they needed to keep people and themselves safe. For example, one person had 'moisture lesions' (damage to the skin) and was receiving support from a specialist nurse. Whilst the specialist nurse had overall responsibility to care for these lesions, staff were required to, 'check skin integrity on each visit, help with personal hygiene and apply any prescribed creams'. Although the records provided on the day of the office visit were not specific to this person's care needs, following our visit the registered manager sent us additional records which did contain information for staff specific to the person's needs.

Another person was at risk of choking because they had a medical condition which meant they had difficulty swallowing food. At the time of our office visit a risk assessment had not been completed and a detailed care plan was not in place. We discussed this with the registered manager during our visit and they told us they would add further information to the person's risk assessment and care plan. Following our visit they sent us this information. This showed us the risk had been identified however, sufficient guidance to inform staff what action they needed to take if the person choked had not been added. This is despite us viewing written information from a health professional confirming that the person was at risk of choking.

Despite omissions in records staff demonstrated they had an understanding of the risks associated with people's care and how these were to be managed. A care co-ordinator told us, "We always talk to carers before they go to a new call, or if something changes to make sure they have all the information they need, including any risks and what they need to do." A care worker confirmed this happened they said, "I read people's paperwork and the office staff phone me to give me details of what I need to do."

We had received information that alleged on occasions staff did not always complete people's care calls. This presented a risk because some people may not have been provided with the care that they needed. All of the people we spoke with told us their care calls had taken place. We discussed this with the registered manager and two care co-ordinators. They told us no care calls to people had been missed. We checked records of the care that had been provided to four people in the three weeks prior to our visit. These records confirmed all scheduled calls had taken place.

People told us there was enough care staff to provide their care and they felt safe with them. Comments included, "I do feel safe with the staff, they do respect me." and, "I feel safe with the staff, there is enough." Care staff confirmed they had completed safeguarding adults training and they knew what action to take if they thought a person was at risk. Our discussions with the registered manager assured us they were aware of their responsibilities to keep people safe. Records showed they knew how to correctly report any safeguarding concerns which meant allegations of abuse could be investigated.

Prior to our visit we were informed some people's medicines had not been given on time or not at all. During this inspection people spoke positively about the way their medicines were administered by the staff. Comments included, "I have my medication and the staff put on cream to stop bed sores." And, "The staff do remind me; in the morning about my medication they keep an eye on me." Care workers confirmed they had received medication administration training and a member of the management team observed their practice to ensure they remained competent to do so.

We looked at three people's medication administration records (MAR) which showed medicines had been administered at the correct time. This assured us people had received their medicines when they needed them. The registered manager completed a series of checks so if any errors were identified prompt action could be taken. We looked at the checks that had been completed for the three months prior to our visit and no errors had been identified.

Is the service well-led?

Our findings

At our last comprehensive inspection 'well led' was rated as requires improvement. At this inspection the rating remains as requires improvement.

During our last inspection we identified the electronic call scheduling and monitoring system was not effective because people had experienced late calls. Since our comprehensive inspection we received information which alleged staff continued not arrive at the time people expected them to provide their care. This meant sufficient improvement had not been made.

During this inspection many people told us they remained dissatisfied because care staff did not always arrive when they expected them. One person said, "The staff are always running late." Another person told us they panicked when care workers were late because they thought they had been forgotten about. A person's relative explained inconsistent call times caused their relation to feel anxious and worried because they did not know if or when care workers were coming.

We discussed this with the registered manager and they acknowledged some people's calls continued to be late despite an allocation of 30 minutes either side of the scheduled time of arrival. They told us this was because staff had got stuck in traffic or their previous call had overrun for longer than expected. Some staff had also not followed the correct procedure of telephoning the office staff when they were running late. We identified this was happening at our last inspection which meant office staff continued to be unaware they needed to let people know their call would be late.

Since our last inspection some action had been taken in an attempt to make improvements. The registered manager said, "Carers have had supervision sessions where they are reminded about reporting lateness. Carers will receive written warnings." Records also showed in June 2017 all staff had been reminded of the importance of contacting the office if they were going to be late for calls. However, despite this action being taken, further improvement was required.

One person felt their calls were often late because care workers were not allocated 'travel time.' We asked to see a sample of care staff rotas during our visit to see how people's care was planned. We could see by looking at these that time was not allocated between calls to support staff to travel from one person's home to another. Care staff felt the lack of travel time placed extra pressure on them because sometimes they had to drive for ten minutes to get to their next call which made them late. Following our visit the registered manager informed us because some people perceived their calls as being late; they were in the process of reviewing the scheduling of calls to make improvements.

The registered manager acknowledged care workers not arriving at the expected time could cause people to be dissatisfied. They said, "We have discussed it in team meetings. Staff said they didn't want travel time because it meant they were late home. But we will be reviewing this." We also identified this issue at our last inspection. Therefore, the action taken in an attempt to make improvements had not been effective.

There were systems in place to monitor the quality of the service provided to people. The registered manager told us they were, "Always looking at ways to make things better." We looked at a selection of completed checks including safe medicine handling and care plan audits. However, not all checks were effective because some people continued to be dissatisfied with the service they received and identified risks associated with people's care had not always been assessed.

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

People we spoke with told us overall, they were happy with the leadership and the quality of service they received despite the inconsistencies in the arrival times of care workers. One person said, "The agency listened to what was needed, and they are good." Another person told us, "It is ok overall the carers are nice and the office staff are available if I need them."

Before this inspection we received information that alleged the service did not respond to people's complaints. In response to this the registered manager told us, "If we receive a complaint then we do respond to put it right." The complaints log showed us that recorded complaints had been responded to in line with the provider's procedure. A care coordinator added, "I am not aware of anyone being unhappy at the moment."

The registered manager welcomed feedback from people and their families to improve the service they received. In April 2017 questionnaires had been sent to people and 18 responses had been received. Overall, the feedback was positive but some people had commented that often their care workers arrived late. We saw people's comments had been responded to by the registered manager. However, we could not be sure sufficient action had been taken to address people's comments because some people remained dissatisfied with the time of the care calls. 'Well-being' telephone calls were also made to people to gather their views. In June 2017 records showed people were happy with the care they received.

A newsletter was issued quarterly to people who used the service and their families. The purpose of these was to keep people up to date about what was happening at the service and share good news stories.

Staff told us they had received awards and were pleased their commitment and hard work was recognised by the registered manager. They felt supported in their roles and were confident to speak to their managers if they had any concerns. One said, "I do speak up if I am unhappy about something, the managers do listen." Another said, "I am confident to tell someone in the office if I am worried or concerned."

The registered manager and care coordinators completed frequent 'spot checks' of care workers practices to gain an overview of how they provided care to people. In May 2017 the checks identified some care workers were not correctly following the infection control procedure. At a team meeting in June 2017 the importance of following the procedure was discussed. Care workers confirmed they had opportunities to attend team meetings every few months. This made them feel involved and one said, "It's a good way to share good news stories and best practice."

Staff told us the registered manager and care coordinators provided advice over the telephone or they could go into the office and speak face to face with them if they needed to. An 'out of hour's' system was in place for when the office was closed. This ensured a member of the management team was always available if staff needed support. A care co-ordinator told us, "We share the on-call to make sure we are available if the staff need us."

The registered manager told us which notifications they were required to send us by law so we were able to monitor any changes or issues at the service. We had received the required number of notifications from them. They understood the importance of us receiving these promptly. This had improved since our last inspection when we had not been informed when one person had been placed at potential risk of harm.

It is a legal requirement for the provider to display their rating so that people are able to see these. We found their rating was displayed on their website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	<p data-bbox="837 544 1449 618">Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p data-bbox="837 651 1425 763">The provider did not have established and effective processes to operate effectively to ensure compliance.</p> <p data-bbox="837 813 1469 965">The provider was not ensuring that risks were assessed and monitored relating to the health, safety and welfare of people who used the service.</p>