Lotus Home Care Limited

Lotus Home Care Wakefield

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Lotus Home Care Wakefield is a domiciliary care agency providing personal care to people living in their own homes. At the time of our inspection the service was providing personal care to 168 people.

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.

People's experience of using this service and what we found
The provider and registered manager were failing to effectively assess, monitor and improve the quality and safety of the service and failing to assess and manage a range of potential risks to people's safety and welfare. The leadership, management and governance arrangements did not provide assurance the service was well-led. Quality assurance and governance arrangements had not been reliable or effective in identifying shortfalls in the service. Risk assessments and moving and handling assessments were sometimes missing or out of date. People's care plans were not always updated when their needs had changed and contained contradictory information regarding their support needs. People told us they received care from a variety of staff with sometimes no consistency as to which staff would arrive to support them. Staff told us their rotas were sometimes unmanageable with little planned scheduled breaks. People told us they felt safe, however, a relative spoke less positively regarding safety after staff visited. Staff were recruited safely.

People and their relatives felt their concerns were not always addressed satisfactorily by the senior management team. Some care staff told us they felt the office staff did not listen to them or act on information they provided regarding people's changing needs. Care staff spoke positively about the care they provided to people and their job role. One member of staff told us, "Every single client is telling us we're doing a really good job." People and their relatives spoke positively about the care staff. One relative told us, "If [Person] is happy, then I'm happy."

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

We have made a recommendation about the Mental Capacity Act.

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 26 October 2018).

Why we inspected
We received complaints and whistleblowing concerns in relation to peoples care needs and late call times. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to assessing risk, safety monitoring and management, staffing and good governance at this inspection.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Lotus Home Care Wakefield

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 Care Act 2014.

Inspection team
This inspection was carried out by an 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.

The service had a manager 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 24 hours' notice of the inspection. This was because we needed to be sure the provider would be in the office to support the inspection.

Inspection activity started on 16 March 2021 and ended on 24 May 2021. We visited the office location on 16 March 2021. We spoke with people and relatives on 18 and 22 March 2021 and staff on 19, 21 and 26 April 2021.

What we did before the inspection
We reviewed information we received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return prior to this inspection. This is information we require

providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager, regional manager and a care co-ordinator.

We reviewed a range of documents relating to how the service was managed including; two care plans in detail and two care plans in a specific area, three staff personnel files, staff training records, staff rotas, policies and procedures.

After the inspection
We looked at records related to protecting people from harm as well as systems used to monitor quality of care. We continued to seek clarification from the provider to validate evidence found. We spoke with seven people who received this service, ten relatives, a care co-ordinator and ten members of care staff. We received feedback from three healthcare professionals.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Risks to people's safety were not adequately identified, mitigated or monitored. One person's care plan stated they could use their walking mobility aid when being escorted around the house, however, there was no associated risk assessment in place.

● People were not always moved safely. One person's care plan contained contradictory information. The care plan stated the person was unable to walk or weight bear but also instructed staff to prompt the person to use equipment when walking. Another person's moving and handling assessment had been completed appropriately but was not dated to record when the assessment was undertaken.

● Changes to people's care requirements were not always actioned. Staff were aware they needed to report any changes in peoples care needs to the office staff. However, they were unaware what actions were taken, if any, by the management team. One member of staff told us, "I phone the office on numerous occasions when things have happened at a client's house. The office say they will sort it. We have been telling the office for weeks. When my colleague rang [Registered manager] they had no clue. They had not been told."

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate risks to people were assessment and effectively managed. This placed people at risk of harm. This was a breach of regulation 12(1) (2)(a)(b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

● People's care needs recorded information required improvement. Some care plans had not been scanned correctly onto the electronic system and sentences recorded on the top and bottom of pages were missing. The registered manager told us they were aware of the problem and action was being taken to rectify these.

Staffing and recruitment

● People did not always receive consistency of care by a regular staff team. One relative told us their relative had 27 different care staff within a 13-day period. A member of staff said, "Clients have no consistency of care. I do not feel the [staff] rota took the clients into consideration."

● Staff were not always deployed safely and effectively. People and their relatives told us staff did not always arrive on time and some calls were completely missed. Comments included, "The carers should have been on site at 9am but hadn't turned up until 11.30am" and "The staff I cannot fault. It's the times that are the problem." We saw one person's scheduled morning call time had been formally changed by two hours in July 2020. However, we found staff rotas had not been updated to reflect this change and the registered manager was unaware of the request until we raised this as a concern.

● Daily care calls were split into four specific time periods. We saw one staff member's rota started before 7am with client calls booked into until 10.30pm with the next two consecutive days being similar. This

meant staff were working very long days with consecutive early starting times and late finishes. We raised our concerns with the registered manager who told us they signed off the weekly rotas and care staff had the choice if they wished to work all four shifts before accepting the shift.
● Staff told us additional care calls were often added to their rotas at last minute due to staff sickness. Comments included, "The rota is ridiculous. You don't get a break" and "The rota is unmanageable; 11pm would be your last call and then you'd start back at 6.30am the next morning. I have raised this and said I need a break, but nothing gets done."

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate safe staffing levels. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

● Staff were recruited safely. Staff files evidenced a safe recruitment programme.

Using medicines safely
● Medicines were not always safely managed. Records showed staff responsible for administering medication had received training and had their medicine competency checked to ensure their practices were safe. However, we found these were not always consistent or effective at supporting safe medicines practice. A staff member said, "We make sure the medication is taken while we watch." However, a second member of staff told us, "There was no training with Lotus. Just training on dosette boxes and how to check it."

Systems and processes to safeguard people from the risk of abuse
● People and their relatives gave us a mixed response when we asked if they felt the service was safe. One person said, "Absolutely. They're doing great for me." A relative told us, "I have found [Person's] key safe unlocked or the dials not scrambled."
● Records showed staff had received safeguarding training. Staff told us they knew how to recognise potential abuse however, we received a mixed response when asked if they knew how to raise safeguarding concerns. A staff member told us, "We've just referred [Person] who we felt wasn't eating. [Person] was in pain." However, another member of staff said, "We have to go to the office normally to raise one. I didn't know we can just raise them ourselves; it's office staff who do that."

Preventing and controlling infection
● People and relatives gave a mixed response when we asked whether staff routinely wore PPE. Comments included, "[Staff] are very careful; they cover up with gloves and masks" and "I am not happy with [staff]. They are not wearing masks properly; it doesn't cover their noses and they don't wear aprons."
● One relative told us they had specific concerns regarding staff poor hygiene practices in relation to the emptying of commodes and catheter bags. They raised concerns relating to these products being rinsed out in the handbasin after the contents were emptied down the toilet, with no attempt to clean the handbasin afterwards. We asked the registered manager to investigate these concerns.
● Personal protective equipment (PPE) for example, face masks, disposable gloves and aprons were available for staff. Staff confirm they were adequate supplies of PPE. A staff member told us, "We have to go and collect them from the office."

Learning lessons when things go wrong
● The provider had an up to date accidents and incidents policy. Accidents and incidents were recorded on the electronic system. Staff were aware they needed to report incidents or accidents to the office. However, staff felt communication from the office was not good and were unaware what, if anything, was done when

they reported concerns.

● The registered manager told us lessons learnt were shared with staff via staff meetings. However, the agendas and minutes of staff meetings we looked at did not record any of these conversations.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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; Continuous learning and improving care

- The registered manager did not have effective oversight and governance of the service, which meant regulatory requirements to keep people safe and provide high-quality care were not met all regulatory requirements were met. There was an absence of meaningful overarching analysis of the governance systems that were in place. Significant changes were required to ensure regulatory requirements were met. We found breaches of regulation relating to moving and handling, risk assessment, care plans and call times. These widespread failings demonstrated the registered manager did not fully understand regulatory requirements.
- The planning of people's care was not person-centred, up-to-date or reflective of their changing needs or concerns. The registered manager was unaware of the client concerns, despite staff informing us these had been raised over the telephone with office staff numerous times. We looked at the provider's summary document relating to concerns raised by staff in April 2021 in relation to a person's changing needs and saw nothing recorded.
- Records were not always accurately maintained. The registered manager provided us with a contact list for people and their relatives who had consented to speak with us to gain feedback regarding the service they received. We found four people's contact details were incorrect or had unidentified numbers and two people had a social services department telephone number recorded as their contact number. This meant we could not speak with some people and relatives as previously agreed.
- Staff were clear what was expected from them and understood their roles and responsibilities. However, care staff felt the office staff did not always listen to them. One staff member told us, "You give information regarding people's changing needs, it sometimes is not always actioned in a timely fashioned. Sometimes you have to go to management via an email so you know there is an audit trail and it's not just a telephone conversation."

We found no evidence that people had been harmed however, systems to assess, monitor and improve the service were not sufficiently robust and management oversight was not evident over key aspects of the service. This was a breach of regulation 17 (1) (2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

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

- 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We looked at three people's care records and saw each person had been assessed as having the capacity to consent to their care. However, we also saw a best interest's assessment had been completed for each person. We discussed this with the registered manager who told us it was the policy of provider to undertake a best interest decision for all clients. This is not in line with the requirements of the Act. After the inspection they told us the provider had changed their policy.

We recommend the provider consider current guidance on the principles of the Mental Capacity Act (2005) and take action to update their practice accordingly.

● The service did not operate safely. The concerns highlighted throughout this report demonstrate the culture and ethos within the service was not person-centred. The provider and registered manager had not ensured the fundamental standards of quality and safety in people's care.
● People and relatives provided positive feedback about the care they received. Comments included, "There are some lovely [staff]; they bend over backwards, they're outstanding" and "My [Person] thinks the world of them." However, they spoke less positively regarding the management of the service. One person told us, "The care staff I cannot fault, it's the times that are a problem." A relative said, "We've complained loads of times… don't hear anything."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were asked for feedback on the service provided by the provider. We saw 22 people had provided feedback to a questionnaire in December 2020 and no concerns had been noted. However, when we asked people and relatives about the quality of service provided, they gave us a mixed response. Comments included, It's like talking to a brick wall" and "They took a lot off my shoulders; they're marvellous."
● Staff spoke of the enjoyment they had in their job role; feedback on support they received from the registered manager and provider was mixed. One member of staff told us, "I don't feel supported. I can only get in touch with the office if I put my number as withheld. They won't answer if they know it's a carer ringing." However, a second member of staff said, "We can get in touch with management by telephone."
● Staff had been asked for their feedback via a survey in March 2021 and the registered manager was waiting for these to be returned.

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
● The registered manager was aware of their regulatory requirements to notify CQC and other agencies when incidents occurred which affected the welfare of the people who used the service.

Working in partnership with others
● The service worked with a range of professionals, commissioners and other organisations.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure safe staffing levels.

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 Systems were either not in place or robust enough to demonstrate risks to people were assessment and effectively managed.

The enforcement action we took:

Issued warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems to assess, monitor and improve the service were not sufficiently robust and management oversight was not evident over key aspects of the service.

The enforcement action we took:

Issue warning notice