Lotus Care Home Limited

# Lotus Care Home Limited

## Inspection report

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17 August 2018
20 August 2018

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## Ratings

| Overall rating for this service | Inadequate |
|---|---|

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

# Summary of findings

## Overall summary

We carried out an unannounced comprehensive inspection of this service on 27 February 2018. We rated the service as "Requires Improvement". After that inspection we received information of concern in relation to a safeguarding incident. As a result, we undertook a focused unannounced inspection on 17 and 20 August 2018. This report only covers our findings in relation to those topics and requirements we made in the last inspection report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lotus Care Home Limited on our website at www.cqc.org.uk"

Lotus Care Home Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission [CQC] regulates both the premises and the care provided, and both were looked at during this inspection. Lotus Care Home Limited is registered to provide personal care and accommodation for a maximum of two people. At this inspection there were two people living in the home with learning disabilities.

At the last inspection in February 2017 we found two breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The first breach was in respect Regulation16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to receiving and acting on complaints. The registered provider did not keep a record of several complaints made by a relative together with action taken in response. During this inspection, we found that the provider had still not kept records of several complaints made by a relative together with action taken in response.

Our last inspection also found a breach in respect of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to good governance. The registered provider did not have effective quality assurance systems for assessing, monitoring and improving the quality of the service. During this inspection in August 2018, the provider had still not established effective quality assurance systems.

During this inspection in August 2018, some areas were not well maintained and kept clean. There were some gaps in the laminate flooring and an emergency lamp was not in working order. We found that the sides of the cooker and the tops of the fridge freezer had not been fully cleaned.

The recruitment records of a care worker were not available for inspection. We could therefore not verify that this care worker was fit to work with people who used the service. Two care workers had worked excessive hours. There was no documented evidence that they had taken days off during a ten-day period. There were insufficient care workers deployed to meet people's needs.

People who used the service appeared happy and interacted well with care workers. The arrangements for the recording, storage, administration and disposal of medicines were satisfactory.

People's care needs and potential risks to them were assessed and documented. The regular care worker

we spoke with were aware of these risks and people's care needs. People's healthcare needs were monitored and arrangements had been made with healthcare professionals when required. The service had arrangements for assisting people with their dietary needs. Activities had been provided for people to ensure that they received social and therapeutic stimulation.

Some checks and audits had been carried out. We however, noted several deficiencies which the service had failed to identify and rectify. These included the lack of cleanliness in some areas of the home, care workers working excessive hours, a defective emergency lamp and complaints not recorded in the complaints book. The staff rota preceding the current staff rota been thrown away when they should have been kept to evidence that there was adequate staff deployed to meet the needs of people.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions 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?

**Inadequate**

Some aspects of the service were not safe. There were insufficient suitable care workers deployed to meet the needs of people. Employment records of care workers were not available. The premises had not been well maintained. There were suitable arrangements for the management of medicines.

### Is the service responsive?

**Requires Improvement**

One aspect of the service was not responsive. The provider had not kept a record of several complaints made by a relative together with action taken in response.
The needs of people had been carefully assessed and appropriate care plans were in place. Appropriate activities had been provided for people.

### Is the service well-led?

**Inadequate**

Audits and checks of the service had been carried out by the registered manager. These were not sufficiently comprehensive as these checks failed to identify and rectify certain deficiencies we noted. The organisation did not demonstrate a culture of transparency. Some information given to us was not always accurate.

Some of the required records were not available for inspection.

# Lotus Care Home Limited

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 17 August 2018 and it was unannounced. The inspection on 20 August 2018 was announced. The inspection team consisted of a total of three inspectors. Before our inspection, we reviewed information we held about the home. This included notifications and reports provided by the home and the local authority.

There were two people living in the home. We spoke with both of them. However, one of them communicated with us via nods and expressions. We also spoke with the deputy manager, a director of the service who also worked as a care worker and a temporary care worker. The deputy manager informed us that the registered manager had gone abroad at the beginning of the month to visit a sick relative. We observed care and support in communal areas and looked at the medicines cabinet.

We reviewed a range of records about people's care and how the home was managed. These included the care records for the two people living there, the accident book, complaints book, staff training records. We checked the record of meals provided and the medicines records.

Inadequate

# Is the service safe?

## Our findings

We found the home was not well maintained. The emergency light in the lounge was not in working order. This was also noted by other professionals who visited the home recently. The lamp was not fixed when we visited on 17 August 2018. It was fixed when we visited by the time of our visit on 20 August 2018. Failure to ensure that the lamp was promptly repaired places people at risk in the event of an emergency during the night.

We also noted three small gaps in the laminate flooring. The deputy manager stated that there was leakage from the washing machine and once dry, they would glue the laminate together. Information we received from other professionals who visited the home indicated that the gaps had been there longer than a few weeks. Failure to ensure that the gaps are fixed may compromise health and safety as dirt could get trapped in the gaps and they may also become a trip hazard.

We further noted there was a broken window pane on the outside of the double glazed window of the kitchen. The deputy manager said it would be repaired once the insurance company approved it.

The premises were mostly tidy when we visited the home. However, we found that some areas had not been fully cleaned. There was dirt on top of the fridge by the cooker and on top of the freezer. The sides of the cooker were sticky and had not been fully cleaned. Failure to keep all areas fully cleaned may compromise health and safety.

The registered provider had not ensured that all areas of the home were clean and well maintained. The deficiencies identified posed a safety risk to people. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to Premises and equipment.

We discussed the staffing arrangements with the deputy manager. We were informed that one care worker had worked continuous night shifts over a ten-day period or longer. The deputy manager and one of the directors informed us that this was due to a shortage of care workers. We also confirmed with the deputy manager that he had also worked continuously over a ten day period prior to our inspection. Care workers who either worked excessive hours and who have worked continuously without appropriate breaks place people at risk of receiving inadequate care.

The service could not provide us with a recent and appropriate Disclosure and Barring Service disclosure (DBS) for the care worker who worked the night shifts prior to this inspection. They stated that the registered manager had locked the documents away. This care worker was reported to have given inaccurate and conflicting information to professionals when they visited. The disclosure which was later provided was not appropriate for her current post as it related to another service. In the absence of documents confirming her status she could not be regarded as fit to work in the home.

Two care workers were reported to us by the deputy manager as having medical ill health. This could affect their ability to carry out certain care duties. There was no risk assessment regarding this. On the second day

of inspection, these risk assessments were provided and they stated that they could work safely. However, there was no medical confirmation of this. In the absence of confirmation from their doctor they could not be assessed as being fit for work.

Our findings indicated that the registered provider did not have adequate numbers of staff deployed who were fit and capable to support people to stay safe. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

A recent fall experienced by a person who used the service had been recorded although no mention of guidance to prevent a reoccurrence. Such guidance is needed to ensure the safety of people. The deputy manager stated that this would be done in the future.

Risk assessments had been prepared and these contained guidance for minimising potential risks such as risks associated with mental health issues, behaviour which challenged the service and self-neglect. We noted that risk assessments had last been carried out and documented in January 2018. The care records indicated that they should be done six monthly. They had not yet been updated. The deputy manager stated that they would be updated.

The medicines cupboard was locked. The two medicines administration charts (MARs) had been signed to indicate that medicines were administered. We noted that there were no gaps. The deputy manager informed us that a person had bruised their lips. We were provided with documented evidence that this person had seen their doctor and prescribed a cream for it.

Requires Improvement

# Is the service responsive?

## Our findings

At our last comprehensive inspection on 27 February 2018 we found a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to receiving and acting on complaints. The complaints book did not contain a record of several complaints made by a relative. This relative also stated that they had made a number of queries which were not responded to. These complaints were relayed to the registered manager following the last inspection. The registered manager stated that this would be rectified and they would improve communication with this relative. At this inspection we noted that the complaints book contained only one complaint. We noted that recent complaints had not been recorded and there was no documented evidence that they had been responded to. One relative had also informed us that the service had repeatedly failed to respond to concerns raised by them.

Appropriate records of complaints and action taken in response to them are needed to evidence that the concerns of people have been adequately and promptly responded to. The registered provider failed to record and establish an effective system for handling complaints. This is a repeated breach of Regulation16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to receiving and acting on complaints.

We spoke with one of the directors who spoke on the phone about this. He admitted that their complaints documentation was deficient and he said that they were taking it seriously and in future would document all complaints.

The care records of people contained assessments and care plans. There was appropriate guidance on meeting the specific needs of the two people who used the service. Appointments had been made for people to see healthcare professionals. A social care professional informed us that the doctor responsible for the two people's healthcare had seen them at intervals and expressed no concern regarding their care.

Reviews of care had been arranged for people who used the service. One care professional stated that there were some concerns expressed by a relative of their client. This related to communication with the home and the poor relationship they had with care workers.

The care records contained individual programmes of weekly activities to ensure that people received adequate social and therapeutic stimulation. Activities that people had chosen to engage in included shopping, walks, eating out, outings to places of interest and attendance at a day centre.

Inadequate

# Is the service well-led?

## Our findings

At our last comprehensive inspection on 27 February 2018 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to good governance. We noted that the registered provider did not have effective quality assurance systems for assessing, monitoring and improving the quality of the service. At this inspection we noted some checks had been carried out. However, these were not sufficiently comprehensive or effective. We found numerous deficiencies related to failure to ensure that the premises were clean and properly maintained. Complaints had not been documented and fully responded to and the staffing arrangements were inadequate.

We also found that certain records had not been well maintained or made available for inspection. We further noted that the deputy manager said he threw away the old rota. He was unaware he had to keep this to evidence that the staffing arrangements were adequate. The staff records were locked away by the registered manager and no one else had access to it. This is unsatisfactory as there should have been alternative arrangements made to ensure that records are available for inspection when needed.

Some professionals reported that the deputy manager had provided information which appeared confusing regarding the staffing arrangements and the running of the service. This included issues related to the commissioning of agency support staff for the home which was organised by them but later cancelled by the deputy manager. We noted that some senior staff from the service had not always provided accurate information to us and have not always done what was agreed with us. This included giving information that there was always a female care worker on night duty when there was no female care worker available on some nights. The registered manager had previously stated that all complaints would be recorded but this had not been done.

We noted that the registered provider did not have effective quality assurance systems for assessing, monitoring and improving the quality of the service. A record which needed to be kept in relation to the running of the regulated activity had not been kept. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to good governance.

The service did not have a culture of openness and providing accurate information. We received a report from some professionals that there were several instances where care workers and senior staff had provided inaccurate information regarding their status and the staffing arrangements. We also noted that there had been instances when inaccurate information was provided to us.

Information requested was not always provided promptly. We had requested information regarding the financial arrangements but this has still not been provided. A relative also informed us that they had repeatedly requested certain information which they were entitled to but this was not provided. The request concerned had also been relayed to registered manager following the last inspection. The deputy manager stated that the information was available but the relative concerned had not asked them for it.

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 |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The registered provider had not ensured that all areas of the home were clean and well maintained. The deficiencies identified posed a safety risk to people. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The registered provider failed to record and establish an effective system for handling complaints. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered provider did not have effective quality assurance systems for assessing, monitoring and improving the quality of the service. A record which needed to be kept in relation to the running of the regulated activity had not been kept. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered provider did not have adequate numbers of staff deployed who were fit and capable to support people to stay safe. |