Lotus Home Care Limited

Lotus Homecare Sheffield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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:
Lotus Homecare Sheffield is a domiciliary care agency. It provides personal care to people living in their own home. It provides a service to adults with a range of health and social care needs. At the time of our inspection the service was providing personal care for approximately 69 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
At our last inspection people raised concerns about the consistency of care staff supporting them. At this inspection people and relatives raised this concern with us again. People also told us they wanted their calls delivered on time and not to experience late calls. Some people were experiencing short calls and not receiving their planned care. People and relatives told us there were not enough staff to deliver calls on time. This showed the provider had not ensured there was enough staff deployed to ensure people received continuity of care.

People and relatives told us they had contacted the service to complain about their calls being late. However, these concerns about people's late calls were not always being captured by the complaints process. This showed these informal concerns were not being monitored and used for learning and improvement. We shared this feedback with the regional manager.

The provider had not ensured there was proper and safe management of medicines. We found the systems in place to ensure people received their prescribed medicines at the right time required improvement. Safeguarding procedures were robust and staff understood how to safeguard people. The provider had completed pre-employment checks for new staff, to check they were suitable to work at the service.

People told us they had a written care plan in place. We received mixed views about the quality of care provided by care staff. People told us experiencing late calls and staff being rushed reduced the quality of care they received. People also worried they would not receive a call and did not always feel well supported. This was reflected in the feedback received from relatives.

At our last inspection we found the systems in place where the manager's monitored and reviewed the quality of the service required improvement. At this inspection, the feedback from people and relatives showed this area still required improvement. The registered manager did not have a sufficient knowledge about quality performance and risks. For example, the real time monitoring of people's calls required improvement.

People and relatives made positive comments about the staff and told us they were caring. Relatives told us most of the care staff treated their family member with dignity and respect.

Staff received a range of training and support relevant to their role. Our findings during the inspection showed some staff required further medication training and their competency re-checked. Staff told us they felt fully supported and listened to.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff understood the importance of respecting people's diverse needs and promoting independence.

Rating at last inspection
The last rating for this service was requires improvement (published 6 February 2019). The service remains rated requires improvement. The service has been rated requires improvement for the last two consecutive inspections.

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

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Lotus Homecare Sheffield

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one 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
Lotus Homecare Sheffield 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
This inspection to the main office was announced. We gave a short period notice of the inspection because the location provides a domiciliary care service and we needed to be sure that someone would be available to support us with our inspection.

Inspection activity started on the 6 February 2020 and ended on 20 February 2020. We visited the office location on the 20 February 2020.

What we did before inspection
We reviewed the information we held about the service, which included correspondence we had received and any notifications submitted to us by the service. Statutory notifications are information the registered provider is legally required to send us about significant events that happen within the service. We used the information the provider sent us in the provider information return. This is information providers are

required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We contacted social care commissioners who help arrange and monitor the care of people using the Lotus Homecare - Sheffield. We also contacted Healthwatch Sheffield. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During this inspection
We spoke with 10 people who used the service and eight relatives about their experience of the care provided. We spoke with six members of staff including the regional manager, registered manager, deputy manager and a care coordinator and two care workers. We also contacted care staff by email to gather their views.

We looked at three people's care records. We checked a sample of medication administration records, care rotas and three staff files, which included recruitment checks, supervisions and appraisals. We also looked at other records relating to the management of the service, such as quality assurance documents.

After the inspection
We looked at people's care rotas, staff training data and quality assurance records.

Requires Improvement

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 this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was increased risk that people could be harmed.

Staffing and recruitment
• At our last inspection people raised concerns about not having regular care workers and experiencing late calls. At this inspection people and relatives spoken with raised these concerns with us again. People told us they wanted their calls delivered on time and to experience continuity of care.
• People told us the service did not have enough staff to deliver their calls on time and this was having negative impact on their care. Comments included, "Not enough staff no, because they're [staff] rushed, the different times they come and for how long, leaving early," "I expect the carer at between 9am to 11am, they are late" and "They need more staff, the supervisors have had to come out and work this week. Not enough staff for the amount of people they have to look after."
• Relatives told us the lack of staff to deliver calls had a negative impact on their family member. One relative said, "8am was agreed for the first call and sometimes its 11am. Medication is too late when the carer comes at lunchtime for the 8am call, it puts everything out."
• The delivery of late and inconsistent calls was reflected in people's care rotas. For example, time critical calls being delivered over 30 minutes late.
• Some relatives and people told us care staff rang them to tell them they were running late so they refused the call. This resulted in one person living with dementia refusing their call and not receiving their required care or medication. The regional manager told us this was being addressed with individual members of staff.

This showed the service did not have a sufficient number of staff deployed to ensure people experienced continuity of care and received their planned care. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had completed pre-employment checks for new staff, to check they were suitable to work at the service. We noted the provider's recruitment policy needed updating so it fully reflected the requirements of regulation 19. The regional manager told us immediate action would be taken to update the policy.

Using medicines safely
•The provider had not ensured there was proper and safe management of medicines.
• Some people required time critical calls to ensure they received their medicines at the right time. We found people did not always receive their calls at the right time. For example, one person's rota showed their morning call was delivered late at 10:39 and their lunch call was delivered at 11:53 on the 10 February 2020.
• People who were prescribed paracetamol four times a day required four hourly intervals between doses.

Two people's care rotas showed some of their calls were being delivered too close together so they were being put at risk. Staff were coming late or too early to their calls.
• Some people shared concerns about the administration of medicines. One person said, "Medication I can do myself. My patch and creams are on the MAR (medication administration record) sheet. If my regular carer is off my patch gets forgotten." The person's administration records for January 2020 showed a relative had administered their patch.
• Relatives comments included, "I [relative] get phone calls asking me about the medication and the taking of pills because it hasn't been recorded. A patch should be applied and that's not done either." These concerns were reflected in the person's medication records for January 2020.
• Some people were prescribed a medication that should be given a minimum of 30 minutes before food for best effect. There were no arrangements in place to ensure people waited 30 minutes before eating.
• Staff told us there were no guidelines in place to help staff decide when to administer medicines prescribed 'when required'. A patch chart was not always used to record the removal and replacement of a patch. There were no arrangements in place to check a patch was still in place between administration.
• Staff who administered medication had received training and their competency had been checked. However, our findings showed some staff required further training and their competency re checked.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• There were systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. However, some people were not being protected from the risk of not receiving their medicines at the right time or their calls at the right time.
• People's risk assessments were reviewed regularly or more frequently if a person's needs changed. This supported staff to take appropriate action to reduce risks as risk levels changed.
• Care plans contained appropriate guidance for staff about how to support people to reduce the risk of avoidable harm
• An environmental risk assessment was undertaken of people's homes before staff started supporting the person.

Preventing and controlling infection
• Staff had access to personal protective equipment (PPE) such as gloves and aprons.
• Most people told us staff used gloves and aprons appropriately whilst supporting them. One person told us staff did not always use gloves when they applied their cream. We shared this information with the deputy manager so appropriate action could be taken.
• Relatives spoken with did not raise any concerns about infection control.

Systems and processes to safeguard people from the risk of abuse
• People did not express any concerns about their safety. However, people told us being supported by regular care workers made them feel safer. People described how the delivery of late calls caused anxiety.
• Systems were in place to safeguard people from abuse. The registered manager understood their responsibilities and worked with other agencies to ensure any safeguarding concerns were dealt with properly
• Staff had undertaken safeguarding training and were knowledgeable about their roles and responsibilities in keeping people safe from harm. Staff told us they would always report any concerns to the registered manager.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• We found the delivery of people's care in line with standards required improvement. Our findings during the inspection showed the scheduling, the delivery and the monitoring of people's calls required improvement so people always achieved good outcomes and consistent care.
• People's and relatives feedback showed people's care and support was inconsistent and they were not always receiving good quality of care. Some people told us their calls were rushed, staff did not always stay the full allotted time. One person said, "I haven't been forgotten completely just very very late. They're [staff] rushed when here, the carers tell me. Harassed they are." People also worried they would not receive a call. One person said, "I have spent fifteen hours in bed waiting for the carer. That happens about once a month."

• Most people told us they did not have regular care workers, so they did not experience continuity of care. One person said, "I have at least a dozen different carers who come and not at the right time either." People who had regular care workers made positive comments about the quality of care provided. One person said, "My regular carer is marvellous and I can talk to her about what needs to be changed or whatever."
• The deputy manager explained how people's needs were assessed before they started using the service. The assessment considered all aspects of people's needs and the information was used to develop written care plans and risk assessments. Protected characteristics under the Equality Act were considered.
• Relatives told us they were involved in their family member's care planning. One relative said, "We set the care plan up together as a family."

Staff support: induction, training, skills and experience
• Staff received a range of training and support relevant to their role. People's MARs showed some staff required further medication training and their competency re-checked.
• An administrator had been given the task of checking people's MAR charts. We were unable to ascertain whether they had been given any additional training or were qualified to do this. We found concerns in the management of medicines at the service.
• Our findings during the inspection showed the care coordinators required further training in the scheduling, monitoring of calls and relevant software.
• We received mixed views about the quality of staff training. Some people and relatives told us the more experienced staff had better skills and delivered a better standard of care. Comments included, "Some of the carers are better than others" and "Some of the carers are okay some who are older are better and show better skills."
• Staff were supported to undertake the Care Certificate. The Care Certificate is an identified set of standards

health and care professionals adhere to in their working life. Staff told us they felt supported and received regular one-to-ones and appraisals.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported with their health and dietary needs, where this was part of their plan of care. Staff were aware of those people who required a specialised diet.
• People told us they were asked for their meal and drink choices. Comments included, "My meals get done by the carers, we discuss what is going to be made. I don't have a special diet" and "I get my breakfast done by the carers, it's agreed between us."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support:
• The service had processes for referring people to other services, where needed.
• People told us care staff contacted community health professionals when they were feeling unwell. Comments included, "A doctor has been called when I have been unwell" and "If I have a sore the carers will tell me and contact a doctor or district nurse, but I can do so myself and have done." One relative told us they were not always contacted when staff phoned for an ambulance or doctor. These instructions were in their relative's care plan.
• In people's records we found evidence staff sought advice from community health professionals such as the GP and district nurse. This process supported staff to achieve good outcomes for people and to help people maintain their health.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. 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.

• The service was working within good practice guidelines.
• At the time of the inspection none of the people supported by the service had a Court of Protection Order in place.
• People had signed to indicate their consent to their care plans where able. People we spoke with told us support workers consulted them and asked for their consent before providing care and support.
• Care staff had received training in the MCA. Staff described how they promoted people to be as independent as possible and to make decisions for themselves.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated 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

• People's and relatives feedback showed people's care and support was inconsistent and they were not always receiving good quality of care. The provider had failed to ensure people were always well treated and supported. People's comments included, "Most carers [staff] do the best they can in the time they have," "Sometimes they send someone who I have asked not to come and that not respectful," and "If I get left in bed too long when the carer comes she's upset for me." Relatives comments included, "More effort could be made regarding spending quality time with my relative and not rushing" and "Lots of different carers every week. It's inconsistent."

• People who had regular care workers made positive comments about them. One person said, "My regular carer shows me great kindness and understanding." People also shared details of the impact on them when they did not receive support from their regular care worker. Comments included, "Dignity well when I don't have my regular carer and youngster comes in I don't shower bearing all, it's the way I feel about how they do it."

• Relatives made positive comments about the care staff. Comments included, "I think they [staff] are caring, they make my relative feel better, laugh and joke. It's the way they treat them, very kind," and "There are some lovely ladies and gents [care staff]." However, some relatives told us some care staff did not always treat their family member with dignity and respect. Some staff did not always listen. Comments included, "Some carers get it right, but once or twice it's not been right (dignity and respect)" and "Great kindness is shown to my relative on the whole. Ninety percent of the staff listen to my relative."

• Staff received training on equality and diversity. The service ensured people were not treated unfairly because of any characteristics that are protected under the legislation, such as gender and race.

• People's care records had information about their preferences which included their preferred name, race, religion and sexual orientation. Care plans contained information about how the person would like their care and support to be delivered.

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

• People told us they had been involved in making decisions about their care and support needs. People's comments and wishes had been recorded in their care plans. Relatives told us they could ask for changes to their family member's care and support.

• Care plans contained information for staff on how people expressed their views and how to support them to be involved in making decisions about 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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns
• People and relatives told us they had contacted the service to complain about their calls being late. Comments included, "I ring up and say my carers not here and get told its sickness, traffic, but I don't believe it always is. Sometimes I have to ring up with a very stern voice to get something done" and "I know how to ring the office and do, lots of times, but it doesn't get sorted they just can't get the staff, or enough staff anyway." However, the informal concerns about people's late calls were not always being captured by the complaints process operated at the service. These concerns were not being monitored and used for learning and improvement. We shared this feedback with the regional manager.
• Most people and relatives felt confident they could raise concerns with staff. Some people and relatives told us they had made complaints, improvements had been made, but not sustained. One person said, "I have rung up and complained about the time of my calls being late, it gets sorted for a while then it slides back to being late again."

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support
• There was no one receiving end of life care at the time of our inspection. People's wishes and preferences were not explored during their assessment. The deputy manager told us they would add this to the assessment. They were experienced in providing end of life care and had completed relevant training. They were a qualified train the trainer and would provide end of life training to staff who carried out the initial assessment.
• People we spoke with told us they could ask for changes for their plan of care.
• People had a written care plan. There was a record of the relatives and representatives who had been involved in the planning of people's care. We saw people's care plans would benefit from containing more information about people's life stories. We shared this information with the registered manager and regional manager.
• People's care plans and risk assessments were reviewed regularly and in response to any change in needs.
• The service provided an on-call service for staff to contact if they needed assistance and advice. Care staff described to us how they would respond if someone became on unwell.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• The service could support people to attend activities within the community, where this was part of their plan of care.

The provision of accessible information

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's communication needs were identified, recorded and highlighted in care plans.
• The regional manager told us the service could provide information in an easy read format for people with a learning disability.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

• At our last inspection we found the systems in place where the manager's monitored and reviewed the quality of the service required improvement. At this inspection, the feedback from people and relatives showed the checks to identify any areas for improvements and to ensure it provided high-quality care and support required improvement. During the inspection we found breaches relating to the management of medicines and staffing.
• The registered manager did not have sufficient knowledge about quality performance and risks. For example, people's concerns about late calls and inconsistent care workers were not being sufficiently monitored by the registered manager and sustainable action taken to address them. Our findings showed the systems in place to check people were receiving their medication as prescribed required improvement.
• The systems in place for scheduling and monitoring of people's calls required improvement to ensure people received continuity of care and their medicines at the right time.
• The regional manager regularly visited to the service. However, the times of people's calls and the informal concerns being raised by people and relatives which defines quality were not being sufficiently monitored. The managers weekly key performance indicator did not give sufficient oversight of the delivery of calls and concerns being raised.
• People and relatives told us action was taken in response to formal complaints to make improvements, but these improvements were not sustained. This showed they were not sufficiently reviewed by the registered manager or the provider.

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

• There was a welcoming atmosphere at the main office. We received positive feedback from care staff about the deputy manager and two care coordinators. They told us they were approachable, supportive and always responded to their calls for help.
• Care staff told us there was a good team of people working at the service. Senior staff meetings took place to review the quality of the service.

• The registered manager was aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
• People and relatives told us they could not remember when they had been asked for their views about the service. The majority of the telephone questionnaires had been completed in July 2019. This showed the registered manager had not ensured people's and their representatives views were regularly sought.

Working in partnership with others:
• The service worked with other agencies such as the local authority and clinical commissioning groups who commissioned care for some people living in the home.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We could not be assured the provider had effective systems or process in place to assess, monitor and improve the quality and safety of the service provided.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured enough staff were deployed to ensure people experienced continuity of care.