Lotus Care Management Services Limited

Lotus Care Marmaduke Street

Inspection report

13 Marmaduke Street
Liverpool
Merseyside
L7 1PA

Tel: 01512610005

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27 April 2018

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 10 and 27 April 2018. This inspection was unannounced, and it was the providers first inspection since they took over ownership of the care home.

Marmaduke street is situated in Liverpool and provides personal care, nursing care and accommodation for up to 48 people. The home is situated over two floors. All bedrooms are single occupancy, and there are communal areas on each floor with a shared garden.

Marmaduke Street is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Marmaduke Street accommodates 48 people in one adapted building. There is a downstairs section of the home, which offers residential support, and an upstairs section, which is designed for people with nursing needs. Both sections of the home specialise in providing care to people living with dementia.

At the time of our inspection there were 20 people receiving support in the upstairs section of the home and 16 in the downstairs section.

There was a manager in post, however they had not yet registered with the Care Quality Commission.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, 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.

It was not always clear that the Mental Capacity Act 2005 (MCA) was applied correctly and decisions were being made in people's best interests. Most records we viewed in relation to the MCA did not have specific decisions recorded on them and best interest processes for people were not always considered.

Care plans, paperwork and records were not organised or set out in a format which was clear and concise. Some people's records were missing pieces of information or not completed accurately or in full. There was a lot of information in people's care plans which was out of date and still had the logo from the old provider on the front. We saw on day two of our inspection that the provider had already begun to amend this information and they showed us a completed care plan, in a new and more organised format.

Governance arrangements were in place and regular checks on service provision were being completed, however these checks were not always effective. They had failed to highlight some of the issues we saw during our inspection.

Staffing was a concern on day one of our inspection, particularly on the residential section of the home. We observed staff to be exceptionally busy, and people had to ask for things repeatedly. Staff did not raise any concerns however some people we spoke with did confirm this could sometimes be an issue. There were no issues with regards to staffing in the nursing section of the home.
We have made a recommendation regarding this.

People told us they felt safe living at the home.

Medication was safely managed, stored and administered. People received their medications on time.

Staff were recruited and selected to work at the home following a robust recruitment procedure. The manager retained comprehensive records of each staff member, and had undertaken checks on their character and suitability to work at the home.

The home was clean and tidy. There was provision for personal protective equipment stationed around the home, and staff were trained in infection control procedures. We did raise on day one of inspection that the outside smoking areas were untidy, due to the disposal of cigarette butts. We saw on day two of our inspection this had been actioned and the outside areas had been tidied to a high standard.

Staff were able to describe the process they would follow to ensure people were protected from harm and abuse. All staff had completed safeguarding training. There was information around the home which described what people should do if they felt they needed to report a concern.

The training matrix showed that staff were trained in all subjects which the provider considered mandatory to their role, and as stated in the provider's training policy. New staff with no experience in health and social care were enrolled on an induction process which was aligned to the principles of the Care Certificate.

Staff received regular supervision and appraisal. We did see some gaps in the recording of this however, the manger was able to explain the reasons for this.

People were supported to eat and drink in accordance with their needs. People, who were assessed as at risk of weight loss had appropriate documentation in place to monitor their food and fluid intake. We did raise at the time that some of these documents were not completed accurately or in full. Where specialist diets were needed for some people, the chef had knowledge of this.

The service worked in conjunction with all medical professionals to ensure people had effective care and treatment.

Everyone had records in their files relating to external appointments with healthcare professionals such as GP's, opticians, dentists or chiropodists. The outcome of these appointments was recorded in people's records.

We observed kind and caring interactions between staff and people who lived at the home. Staff spoke kindly and fondly about people, and demonstrated a good knowledge about them, their likes and their needs. People told us they liked the staff and felt that they were kind to them.

There was information recorded in people's care plans with regards to their likes dislikes and how their care should be delivered.

People confirmed they knew who the manager was. Team meetings and resident meetings took place. Feedback was gathered from people who used the service and their families.

We saw all notifications had been sent to CQC.

You can see what action we told the provider to take at the back of this 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?

Requires Improvement

The service was not consistently Safe.

Staffing levels were mixed within the two sections of the home, our observations and conversations determined that staffing levels requires some further improvement. We have made a recommendation about this.

Risk assessments were mostly in place for people and contained a good level of detail. However some risk assessments lacked clear instruction and were not always stored in the correct place in the persons care plan. The manager took action to address this issues which we checked on day two of our inspection.

Medication was managed safely.

Staff were recruited safely after checks had been completed on their character and employment.

Is the service effective?

Requires Improvement

The service was not consistently Effective.

There was gaps within the recording of the MCA which highlighted a lack of understanding of the act and its principles.

Staff confirmed they received supervisions and appraisals, although some records had not been updated to reflect this.

Overall, we received positive comments concerning the food.

Is the service caring?

Good

The service was caring.

We observed kind and familiar interactions between people who lived at the home and the staff who supported them.

Staff were able to demonstrate a good knowledge of the people they supported.

There was advocacy information available for people who wished to access this service.

People's privacy was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's information was not well organised. It was difficult to find some people's information within their care plans.

Information about people's backgrounds, likes and dislikes was recorded at some level in their care plans.

Complaints were well managed and responded to in accordance with the providers complaints policy. People said they knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were audits (checks) taking place on service provision such as health and safety checks. Some audits, such as medication audits and care plans audits were not robust enough.

People spoke positively about the provider and the manager and said they were approachable.

Lotus Care Marmaduke Street

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 10 and 27 April 2018 and was unannounced. At the time of our inspection there were 36 people living at the home.

The inspection team consisted of two adult social care 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. In this instance, the expert had expertise in care of older people. The expert by experience joined us for day one of our inspection.

Before our inspection we reviewed the information we held about the home. This included information the Care Quality Commission had received about the home. We also accessed the Provider Information Record (PIR) we received prior to our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This provided us with information and numerical data about the operation of the service. Before our inspection we received some information from an anonymous source which we used during our inspection to help plan and conduct the visit. Some of these concerns were in relation to staffing levels, food and cleanliness. All were checked as part of this inspection.

We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication impairments.

During the inspection we spoke with six people who were living at the home and they shared their views of the home with us. We also sought feedback from three relatives who were visiting the home at the time of our inspection. We spoke with five staff, the manager, the chef, the provider and the area manager.

We looked at the care records for four people living at the home, four staff personnel files and records relevant to the quality monitoring of the service. We looked around the home, including people's bedrooms, the kitchen, bathrooms, garden and the lounge areas.

Requires Improvement

Is the service safe?

Our findings

Some people had limited verbal communication abilities. However, those whom we could speak with told us they felt safe living at the home.

We spent some time on day one of our inspection observing people being supported in the residential section of the home. We observed that although clearly staff were trying their best to support people, there were some shortfalls in relation to staffing. For example, at lunchtime, one person had to wait over twenty minutes for their meal to be served, someone else requested support with another issue, and staff were trying to support other people to eat their meals. One relative we spoke with later on during our inspection told us that staffing had been 'cut' in the residential section of the home. One person we spoke with on the residential section told us they sometimes had to wait as staff 'were busy'. Additionally, there were telephones in the communal areas of the home that were ringing often throughout the day which added to the busy environment.

The nursing section of the home was calm and relaxed. We did not observe anyone waiting long periods of time for support, and staff did not look rushed or pressured. No staff raised any concerns with us during our inspection about feeling pressured or rushed. We did see however, that an audit completed by one of the night staff had document that they felt more staff presence was sometimes needed. There were dependency tools in place which were completed accurately and reflected the staffing levels. On day two of our inspection the provider had diverted the phone lines so they were not ringing in the residential section of the home. We noticed this change seemed to have a more calming influence on the environment. Additionally, we saw there was another member of staff on shift.

We recommend the provider reviews their approach for staffing numbers in the residential section of the home and takes action accordingly.

Medicines were administered individually from the trollies to people living at the home. Medication requiring cold storage was kept in a dedicated medication fridge. The fridge temperatures were monitored and recorded daily to ensure the temperatures were within the correct range. We saw there was a thermometer on the wall where the trolleys were stored. Checking medications are stored within the correct temperature range is important because their ability to work correctly may be compromised.

Some people were prescribed medicines only to be taken when they needed it (often referred to as PRN medicine) and had a plan in place to guide staff about when this medication should be given. PRN medicine was mostly prescribed for pain or if people became upset or anxious.

We spoke to the Nurse in charge who told us how they had contacted the GP and the pharmacist because they noticed a person's medication was making them drowsy during the day. They got this changed to be given with the night time medication so it would not have this effect on the person. This means that staff are looking out for side effects of medication and taking action accordingly.

The medication administration records (MAR) included a picture that was sufficiently large enough to identify the person. We noted that the MAR charts had been completed correctly and in full.

Arrangements were in place for the safe storage and management of controlled drugs. These are prescription medicines that have controls in place under the Misuse of Drugs Legislation. Some people were prescribed topical medicines (creams). These were stored safely and body maps were routinely used to show where topical creams should be applied.

We looked at how incidents and accidents were managed at the home. We saw that there was a process in place to analyse the number of incidents which occurred over the month. There was also consideration given to time of day of incidents and staff on duty.

We asked the staff about safeguarding, and how they would ensure actual or potential abuse was reported. There was information around the service with regards to safeguarding and whistleblowing, and staff described the action they would take to ensure concerns were escalated.
A safeguarding policy was displayed in the premises and staff understood the reporting procedures if they felt someone was at risk of harm or abuse. Staff received safeguarding training as part of their induction and also received annual refresher training.

Staff records we saw demonstrated the manager had robust systems in place to ensure staff recruited were suitable for working with vulnerable people. The manager retained comprehensive records relating to each staff member. Full pre-employment checks were carried out prior to a member of staff commencing work. This included keeping a record of the interview process for each person and ensuring each person had two references on file prior to an individual commencing work. The manager also requested a Disclosure and Barring Service (DBS) certificate for each member of staff prior to them commencing work. A valid DBS check is a check for all staff employed to care and support people within health and social care settings. This enables the manager to assess their suitability for working with vulnerable adults. This shows there were safe procedures in place to recruit new members of staff.

Clinical risk assessments for people living at the home were concise and clearly written. We saw that where people were identified as being at risk of skin breakdown or falls they had documentation in place to ensure staff were supporting them to manage their condition. Some of the risk assessments we viewed contained detailed information with regards to how to mitigate risk. For example, one person's risk assessment stated, 'when transferring (person) you must be sure to fully explain what you are doing, and always check the sling for tears and rips.' This means that staff had clear instructions with regards to how to support that person.

Not all risk assessments were recorded as thoroughly. Despite the documentation being in place, the description of the risk was not always as instructive. For example, one person's risk assessment stated they had behaviours that may challenge and intervention was needed to 'calm' this person. However, the risk assessment then did not expand into more detail to say what type of intervention was needed. Our discussions with staff highlighted they knew this person very well, and they were able to explain how they supported them, it was not recorded accurately in the care plan for us to view. We highlighted this to the manager and area manager at the time of inspection on day one, and we saw by day two they had taken action.

We saw that all firefighting equipment had been checked, and new equipment was in place in various parts of the home to help people evacuate safely. Personal Emergency Evacuation Plans (PEEP's) explained each person's level of dependency and what support they would require to ensure they were evacuated safely. We spot checked some of the other certificates for portable appliance testing (PAT), electric, gas, and

legionella. These were all in date. We did raise on day one of our inspection that the outside areas of the home required some attention due to a large presence of cigarette butts. We saw on day two of our inspection these had been picked up and there were new disposal stations in place. Procedures were in place to ensure the safe removal of hazardous waste, and bins and toilets were regularly cleaned and checked. Personal protective equipment PPE was available for all staff, such as gloves and aprons. There were hand sanitizers fitted to the walls in various areas of the home, and these were full.

Requires Improvement

Is the service effective?

Our findings

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The DoLS provide a legal framework to protect people who need to be deprived of their liberty in their own best interests.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that applications had been made to the local authority to deprive people of their liberty in their best interests and these were being monitored by the manager and further applications had been made when needed.

However, there was some inconsistent information in people's care plans relating to the MCA and best interest decisions, which needed further clarification and did not always demonstrate a good understanding of MCA processes. For example, we viewed mental capacity assessments for three people and saw that they were assessed as not having capacity. However, the form used to assess the person's capacity did not document what the decision was they did not have capacity to make. This meant that the mental capacity assessments were not decision specific and people's ability to make some decisions was not explored further using other means of communication. For example, one person was assessed as not having capacity, however the rest of the form was not completed and just stated that the person 'could not weigh up information'. However, further on in their DoLs assessment, it stated that the person could weigh up information. Additionally, they had been involved in the completion of their care plan. There was also information in the care plan such as 'ask (person) what they want' which shows that the person has some understanding and could weigh up risk. This was not captured in the mental capacity assessment.

Also, we saw that one person was using bedrails. There was no best interest process in place to show how the decision to use bedrails had been made for this person. When we checked the rest of this person's care plan we saw that there was a risk assessment in place for them as they bruised easily, and had recently had an accident where their arm had become trapped in the bedrail and caused some bruising. This information would have needed to be taken into consideration during a best interest meeting however there was no evidence this had taken place.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 Regulated Activities (Regulations) 2014.

We saw that all training had been completed in accordance with the provider's training policy, and there

was a system in place which tracked when refreshers or updates were due. Staff were booked on these when required. We checked a sample of certificates in staffs' files and saw training in relation to moving and handling, first aid, infection control and fire safety; training for moving and handling and medication was both e- learning and classroom based. We saw that other training such as dementia and end of life were also available for the staff team and this had been completed.

Our conversations with staff indicated they had the correct training to support people with their assessed needs, and we observed staff helping people to mobilise and give medications throughout the day.

We checked records and saw that new staff were trained and inducted in accordance with the principles of the care certificate. The care certificate requires new staff to undertake a programme of learning before being observed and assessed as competent by a senior colleague. All of the staff that we spoke with confirmed that they had been given regular supervision and appraisal. We saw that this was recorded in staff records and there was a supervision schedule displayed in the office on the staff notice board. We saw there were some gaps in supervision records which indicated some staff were due a supervision, however some of these staff were on long term sick. This had just not been recorded accurately.

Most people we spoke with told is they enjoyed the food. One person we spoke with said "The food is ok. If I don't like anything they will do something else." We observed this at lunch time as one person did not want what was offered on the menu. People said they could have a snack if they wanted to.

People were supported to access medical care when they needed it. Each person's care plan contained a log of professional's visits. These were completed by staff following each appointment people attended, including the reason for the appointment and the outcome.

We saw that people were assessed prior to them being admitted to the home. The initial assessment process focused on people's needs and choices while taking into account the type of treatment and support they required. The initial assessments were stored at the front of people's care plans and focused on what outcomes the person needed from their support at Marmaduke. We saw in most cases, most of this information had been used as a basis for the risk assessments, care plans, and background information to be formulated. We did see some missing information around capacity and consent in this document which we fed back to the manager at the time of our inspection. This prompted them to change the MCA form which we saw on day two of our inspection.

The home was decorated to a pleasant standard with further plans on-going. There was directional signage and different coloured areas to help support people living with dementia to orientate their way around.

Good

Is the service caring?

Our findings

We received the following comments with regards to the caring nature of the staff. "The staff are great." "They are lovely". Someone else said, "Very nice. They do their best for me, they are just really busy." Another person said, "Staff always knock on my door to come in. If I can do anything for myself staff let me." Additionally we were told "Lovely girls (staff). Nothing too much trouble." Also, "When my family visit I can go into my room." Someone else said "Staff ask me first, they don't do anything without saying." Visiting family members told us, "Yes (Family member) is treated well, cared for. Also "When I have been in to visit, I see staff talking to everyone not just my husband." Additionally, "I would speak up if I did see anything. I'm very happy with the home. They treat me well as well." Someone else said, "When I come in I'm made to feel very welcome. That's good as it's difficult enough."

Most care plans reviewed were written in way which took the person's choices and diversity into consideration. For example, how people liked to be dressed each morning, when they liked to get up, and how they wanted their personal care needs to be met. One care plan stated, '[person] must be offered a choice of food." We also saw consideration was given to people's culture and spiritual needs.

Staff we spoke with described how they protected people's privacy during personal care. This included closing doors and windows and covering people up with towels and blankets. One staff member discussed the importance of not discussing people's personal information in communal areas, as it would be breaking their confidentiality.

We also observed staff talking to people discreetly respectfully and offering help and reassurance. This was well received by people.

All of the staff we spoke with told us they enjoyed working at Marmaduke and liked spending time with the people who lived there.

Care plans were signed by people who were able to do so. For people who were not able to sign their own care plans we saw this had been done via a best interest processes. We did see one occurrence where consent was not signed, and we were unsure if this was because the person was unable to or if a best interest process had not been followed. We highlighted this to the manager at the time of our inspection. People who were able to had also signed consent forms within their plan of care to say they agreed with the plan, and have given permission for their records to be shared with appropriate professionals.

There was information provided for people with regards to the local advocacy agency. At the time of our inspection there was no one making use of this service.

Requires Improvement

Is the service responsive?

Our findings

Documents viewed showed that consideration was given with regards to people's likes, dislikes and how they wanted their care to be delivered. There was some specific information which was meaningful for people, such as, 'Please make sure I am offered a choice of clothes' and 'If the room is too noisy, please help me to move to another room'. However, we saw in some documentation this level of detail was not always recorded. For example, we saw that one person needed support with exercising their hand. There was no specific information recorded in the care plan to show how the staff offered this support. We visited this person in their room and spoke to the staff and from our conversations it clearly evidenced they knew this person well, and this person was supported with this need. The records however, did not reflect this.

In addition to this, we saw that one person required thickener to be added to their drinks. Adding thickener makes the drink a consistency that is less likely to cause aspiration. Thicker liquids travel more slowly down the throat and that makes them easier to control. It was recorded in the care plan in various places, however, some documents had this information missed off, or the amount of thickener the person needed changed from one to one and a half scoops. We spoke to the staff and the chef who confirmed the correct amount of thickener. We raised this with the manager who agreed it was not recorded consistently throughout the care plan.

Recording of people's information and the layout of most of the care plans we viewed on day one of our inspection was quite disorganised. In some cases, risk assessments made references to numbered accompanying plans which were not in the correct place in the files, so it made it difficult to check that all documentation was in place as it should be. Also, there were some gaps in fluid charts on various days, despite the fact that people were getting the fluid they needed, it was not always recorded. Additionally, one of the providers own care plan assessment tools relating to assessment around someone's drinking need was not completed correctly. Some care plans still had paperwork in place which had the logo on from the previous owners of the home, and not all had transitioned to Lotus Care, which was confusing.

This is a breach of Regulation 17 of the Health and social care act 2008 (Regulated Activities) Regulations 2014.

We saw on day two of our inspection a new proposed care plan structure for people living at the home, one had been completed in full and it was to a good standard. The manager had a plan in place for when all of the care plans will be presented in this new format.

Activities were organised by the staff at the home, and consisted of painting, armchair exercises and other requested activities such as games, puzzles, cards, movement and music and ball activity. This was to ensure everyone was getting an opportunity to engage in something that they enjoyed. One person did tell us they felt it was sometimes 'boring' at the home as the activities coordinator had recently left. The manager was addressing this; staff were also working extra hours to coordinate activities as an interim measure.

People we spoke with told us they knew how to complain, and we saw the complaints procedure was displayed in the main hallway of the home, as well as in the Service User Guide. There had been eight complaints since July 2017. We tracked one of these complaints through to ensure the manager had followed the process, we saw that they had.

There was end of life program training for the staff to ensure that people were subject to a dignified and pain free death.

Requires Improvement

Is the service well-led?

Our findings

There were systems in place to monitor the quality of service provision. Audits for the environment and health and safety of the building regularly took place and actions were completed. We saw however, that some of the governance framework was not always effective and did not identify when further action was needed. For example, the care plan audits did not identify the concerns we found with regards to the MCA and some of the missing information and disorganisation in the care plans. We saw that the manager had devised an audit to enable them to look at all of these areas every month, however it was not yet as robust as needed. We also saw an audit which had been completed which highlighted the need to look at staffing numbers in the residential section of the home, we did not see that this had been actioned.

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

There were other audits in place, which took into account the environment, medication and falls. We saw that these were completed accurately and in full and appropriate actions were being assigned to the relevant staff members in the home to follow up, for example repairs and maintenance concerns were being assigned to the maintenance person. In addition, the area manager completed their own audit when they routinely visited the home, and the outcome of this was shared the with the manager.

People spoke fondly about the manager. Comments included, "Yes I see her." One staff member told us, "I know I can approach (manager)".

Our discussion with the manager and the area manager indicated that they accepted some improvement was needed in this area. We felt reassured when we retuned for day two of our inspection as the manager had clearly listened to our feedback and had begun to take action to address some of the issues we found during day one.

We asked the manger about lessons learned and if they had improved any practice since they had been in post. The manager had changed the approach to managing staff sickness, and as a result this had now improved.

The manager had a good working relationship with the Local Authority and hospitals.

Feedback forms had last been gathered from people who lived at the home in April, and the report had not yet been completed, however the manager will share this with us when they are able.

Team meeting and resident meetings take place often, and we saw a sample if minutes from these.

There was a manager in post who was in the process of registering with the Care Quality Commission.

The provider had policies and guidance for staff regarding safeguarding, whistle blowing, dignity,

independence, respect, equality and safety. Staff were aware of these policies and their roles and responsibilities within them. This ensured there were clear processes for staff to account for their decisions, actions, behaviours and performance.

We saw that the Care Quality Commission had been notified appropriately of incidents and events which occur at the service, as legally required by law.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Information relating to the Mental Capacity Act and associated principles was not always clear and consistent and some processes relating to best interest decisions were not always being followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Records relating to people's care needs were not always completed accurately or presented in an organised format. Systems in place for assessing, monitoring and improving the service were not always effective.