London and Manchester Healthcare (Deepdale) Limited

Finney House

Inspection report

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Date of inspection visit:
27 August 2021
15 September 2021

Date of publication:
27 October 2021

Ratings

Overall rating for this service	Inadequate ●

Is the service safe?	**Inadequate** ●
Is the service effective?	**Requires Improvement** ●
Is the service caring?	**Requires Improvement** ●
Is the service responsive?	**Inadequate** ●
Is the service well-led?	**Inadequate** ●

Summary of findings

Overall summary

About the service
Finney House is a nursing home providing accommodation and personal care for up to 96 adults. Finney House accommodates people across four separate units, each of which has separate adapted facilities. Two of the units specialise in providing care for people living with dementia. There were 72 people living at the service at the time of the inspection.

People's experience of using this service and what we found
People and their relatives gave us mixed responses in relation to their safety and care approaches at the home. Some relatives felt their relatives were not safe and some felt they received safe care. Our observations and findings showed that people did not always receive safe care and treatment. Safeguarding concerns had not always been shared with relevant authorities. People did not always receive their medicines safely to manage their conditions which led to poor outcomes. Clinical risks to people were not always adequately monitored and records of care and did not accurately guide staff on what actions they were to take. Some people had been exposed to poor experiences and outcomes due to poor risk monitoring. Risks associated to weight loss, pressure care, self-neglect and infections needed to be improved.

The governance systems at the home had not been adequately implemented to protect people from risks and to promote a person-centred approach and the delivery of safe and high-quality care. Audits identified shortfalls but these were not always addressed in a timely manner and repeatedly carried over in some instances. Staff gave mixed responses regarding the culture and management style in the home and there was low morale. There was a lack of robust clinical oversight to ensure the clinical risks were continually monitored to prevent deterioration. There had been a high turnover of managers, however there was a new leadership team which had established community links with local health and social care services.

People were not supported by adequate numbers of suitably qualified staff to reduce risks of harm. People were not always supported by staff who had the right skills and knowledge. Staff did not receive suitable induction and training to meet the specialist needs of people they supported. In some instances, people were not consistently supported to have maximum choice and control of their lives. Staff supported people to have access to health professionals and specialist support however guidance was not always followed to reduce risks to people.

People and their relatives gave mixed feedback regarding their experiences and the caring nature of staff and people's personal hygiene. Relatives told us staff were caring and patient. A significant number of relatives shared concerns that their family members' personal care needs were not met. While we observed caring approaches from staff during the inspection, we received concerns about some of the staff's attitude towards people, we also observed this in some of the records written about people. This did not demonstrate people were always treated with dignity and respect.

People's care records were not always accurate to support the delivery of safe and person- centred care. A significant of records we reviewed did not accurately reflect people's current needs. People were not assured their end of life care needs would be adequately met. We received overwhelming concerns from visiting relatives about the difficulties in accessing the home either by phone or visiting in person especially on weekends.

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

Rating at last inspection
The last rating for this service was requires improvement (published 16 March 2021). The service has deteriorated to inadequate.

Why we inspected
The inspection was prompted in part by notification of a specific incident where a person using the service sustained a serious injury. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of people's clinical needs, medicines management, moving and handling, staff responses to people's needs and the leadership in the home. A decision was made for us to inspect and examine those risks. This inspection examined those risks.

We have found evidence that the registered provider needs to make improvements. Please see the safe, effective, responsive and well led sections of this report. The registered provider took immediate action to address some of the concerns and improve people's experiences.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

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 register providers to account where it is necessary for us to do so.

We have identified breaches in relation to keeping people safe from preventable harm such as medicines management and clinical risks, safeguarding and responding to changes in people's needs. We also found concerns with records keeping, person- centred and dignity, deploying suitably qualified staff, failure to report incidents and poor governance at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the registered provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the registered provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led Details are in our well-led findings below.	**Inadequate**

Finney House

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 registered 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Five inspectors, a pharmacy specialist and two Expert by Experience carried out the inspection. Two inspectors and a pharmacy specialist visited the home on day one and two inspectors visited on day two. Two of the inspectors and the two Expert by Experience supported the inspection remotely by making phone calls to staff and relatives. 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
Finney House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with CQC. However, they were not present at the inspection. This means that they and the registered provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service, including information from the registered provider about important events that had taken place at the service, which they are required to send us. We sought feedback from the local authority. The registered provider was not asked to complete a registered 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.

During the inspection
We spoke with five people who lived at the home about their experiences of the care provided. We spoke with nine members of staff including the deputy manager, a quality director, the regional manager, maintenance person and two unit managers on the inspection. We spoke with 15 care staff and 22 relatives over the phone. We also spoke to the nominated individual for the service. The nominated individual is responsible for supervising the management of the service on behalf of the registered provider. We reviewed a range of records. This included 13 people's care records, multiple medication records, accident and incident records, two staff recruitment records and we looked at a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the manager and the nominated individual to validate evidence found. We looked at training data and quality assurance records and sought feedback from health and social care 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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At the last inspection, the provider failed to ensure people's medicines were consistently managed in a safe way. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

● Medicines were not always administered safely or as prescribed. People were exposed to risks of harm and poor outcomes because staff did not always follow safe and best practices in medicine management, storage and administration. Before the inspection, we had received allegations of neglect in respect of medicines management in the home. This included an incident of a person receiving double doses of medicines, not giving medicines as prescribed, people running out and going for periods of time without their medicines and/or missed medicines. We could not be sure that all people were protected from the risk of overdosing from medicines.
● We saw an error of a double dose of medicines being given to a person which then led to a hospital admission. We asked for action taken by the provider and the manager assured us the staff member received further training before resuming the administration of medicines. Staff did not always record when time specific medicines were administered, where a record was made, we saw that the required four-hour gap between paracetamol doses had not been observed.
● Medicines stock management was not robust which led to people missing their medicines and resulting in a deterioration of their conditions. Records we reviewed showed four instances where people had not been given their medicines for up to five days because medicines were either not in stock, misplaced or not identified as not supplied when people were admitted into the home or when new medicines were delivered. These were reported to the local safeguarding authority and we asked the provider to review their processes for checking medicines and asked for assurances that people had adequate stocks of medicines throughout the inspection.
● The provider had failed to ensure that staff responsible for administering medicines were competent to do so. One staff member had not been adequately trained to administer medicines safely in line with best practice and the providers own policy. This staff member was also responsible for supervising non-qualified staff who administered medicines. We could not be assured they would adequately support other staff and asked the provider to take immediate action to ensure a trained member of staff was responsible for medicines going forward.

● Records for medicines were not always accurate or sufficiently detailed enough for staff to administer medicines safely. This included missing details of people's allergy status and photographs and handwritten records with no evidence who had written them and whether they had been checked for accuracy of prescriptions directions.
● As and when required medicines were poorly managed. Guides for staff to administer medicines when required was not always available. One person had an emergency rescue medicine and all staff responsible for medicines administration told us they were not confident what to do if needed. We asked for urgent action and staff were provided guidance on the use of this medicine.
● Records for covert medicines were incomplete and inaccurate with some stating people were on covert medicines when they were not and where required not all covert medicines were listed on covert authorisations.
● People who consistently refused medicines or had a known history of not accepting their medicines as prescribed were not always supported in an adequate or timely way.

We found evidence that people's welfare had been affected by unsafe medicines administration and management practices, systems were either not in place or robust enough to support safe medicines management. This placed people at risk of harm. This was a continued 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.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People were not adequately protected from the risk of harm because arrangements for monitoring and reviewing risks were not robust.
● Risks to people were not well managed. Actions required to reduce risk to people had not always been carried out despite risk assessments being in place for areas such as falls, nutrition risk and wound care.
● Clinical monitoring was not always in place to check actions were being taken and to monitor if further intervention was needed. For example, a person was admitted from hospital requiring clinical monitoring on their skin condition and escalation to specialists in the event of deterioration. This was not followed when the person's condition deteriorated resulting in harm.
● Risk management plans were not followed. For example, two people who had been assessed as requiring weekly weight monitoring to monitor deterioration did not always get weighed as planned and care records linked to nutrition and skin care were inaccurate. In addition, we found one person had been exposed to risk because of staff had failed to ensure there was a catheter in stock when required, this resulted in the person experiencing pain and urinary retention, subsequently requiring to be admitted in hospital.
● Incidents were not always analysed, and reports were not always completed to show what actions had been taken to reduce the incident from happening again.
● The provider had not ensured that staff had completed training on the use of fire equipment and training in relation to fire marshals. People had personal emergency evacuation plans which ensured, in case of a fire, staff had guidance on how to support people out of the building. However, not all staff were aware of these plans. The provider responded during and after the inspection and informed us they were aware of some of the shortfalls and were working to resolve them.

We found evidence that people had been exposed to harm and systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The premises and equipment had been maintained to protect people from risks.

Systems and processes to safeguard people from the risk of abuse

At the last inspection, the provider had failed to ensure service users were consistently protected from potential abuse, harm and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 13

● Systems and processes for safeguarding people from risks of abuse had not been effectively implemented to ensure regulations and local safeguarding protocols were followed. While some safeguarding incidents had been reported, we found a significant number of repeated falls, and missed medications that had not been reported to the local safeguarding authority in line with local protocols.
● People did not always receive care in a timely way. Our review of call bell waiting times showed on occasions waiting times for a few people on one floor and in particular one person more than others was more than an hour. One person informed us this had resulted in them not having their toileting needs met in time. Eight out of 15 staff told us they were times when staff deployment in parts of the home did not ensure they could provide care in a timely manner to meet people's needs. Records in the home confirmed unwitnessed incidents had occurred. Comments included; "A lot of incidents have happened because we are not able to respond to people in time" and, "It is such a busy day and people are at risk of harm because we don't have time to support people."
● There was a lack of awareness by staff and management on what actions to take where a person was at risk of self-neglecting. We found an instance where a person had been refusing care leading to self-neglect of their health needs. The provider had sought the intervention of a GP, however this had not been identified as a safeguarding concern and shared with relevant authorities in order to follow national and local guidance. We raised a safeguarding with the local authority and asked for an immediate review of the person's care by the GP and other professionals.

There was a failure to report safeguarding concerns to authorities and protect people from inappropriate treatment. This was a continued breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● We received mixed responses from relatives regarding the staffing levels in the home. 11 out of 20 relatives and one person who used the service told us staffing levels were not always enough to keep people safe. However, five relatives informed us they felt there were adequate numbers of staff. Comments from relatives included; "I have only been able to visit twice and there seem to be quite a few around", "It is impossible to get through on the telephone and it is distressing. There are never enough staff about and you don't see the same faces, massive staff turnover. Weekends you cannot speak to anyone as no one is on reception."
● Similarly, we received mixed responses from staff regarding the staffing levels. Seven staff told us the

home had adequate numbers of staff. Eight out of 15 staff told us they were times when staff deployment in parts of the home did not ensure they could provide care in a timely manner to meet people's needs. Records in the home confirmed unwitnessed incidents had occurred. Comments included, "Staffing levels on the nursing unit feels alright, and do not generally present a problem.", "A lot of incidents have happened because we are not able to respond to people in time." And, "The main challenge is that we do not have the staff or the regular staff to ensure we can support each other and people when there are new changes." We shared the concerns, feedback from people and staff with the nominated individual and the registered provider's representatives.
●The provider had a system for determining people's needs and staff numbers including duty rotas however we found the dependency assessments were not always accurate to support the correct deployment of staff.

We found evidence that people's experiences had been affected as a result of deployment of staff in parts of the home. This placed people at risk of harm. There was a failure to deploy adequate numbers of suitably qualified staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider and the registered manager followed safe staff recruitment procedures. All the necessary background checks were carried out. This ensured only suitable staff were employed to support people.
●The provider used positive incentives to recruit and retain staff and reduce the use of agency staff. On the second day of our inspection we found there were adequate numbers of staff deployed where required agency staff had been brought in to cover absence and sickness. The home felt calm and pleasant.

Preventing and controlling infection
● The registered provider had systems to protect people, staff and visitors against the risk of infection. However, improvements were required to ensure that the systems were robust and adequately followed by staff to protect people.
● We received mixed comments from visiting relatives on cleanliness at the service, some told us the premises were unclean. We observed parts of the home to be unclean on our first visit.
● We observed staff not wearing their face masks as recommended and the home was unclean on the first day of our visit. This had improved on our return. There was adequate signage to inform people about the risks of infection, social distancing and hand hygiene.
● Arrangements were in place for testing visitors and staff and new admission into the home.

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 in February 2021 we did not inspect this question, this key question was last rated as good in August 2019. 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.

Staff support: induction, training, skills and experience
● The provider had not adequately supported staff with training and supervision to ensure they had the relevant knowledge and skills to care for people .
● Staff had not always completed training that was essential for the role and relevant to the needs of people in the home. This included areas such as, person centred care, oral hygiene, pressure care, falls awareness, dignity in care, swallowing/choking awareness and nutritional awareness. We identified a significant number of people in the home were at risk of malnutrition and 15 lived with diabetes. While some of the training was impacted by COVID-19, we expected the provider to have provided or facilitated training in other areas using alternative methods such as e-learning in line with national guidance.
● The registered provider's system for inducting staff at the beginning of their employment had not been effectively implemented.
● Staff did not always receive supervision in-line with the provider's policy. Comments from staff included, "I have not had supervision in the last year." And; "I have had supervision but only when you have done something wrong or when something else needs doing, the managers are very good at doing that."

There was a failure to ensure that all staff had received appropriate support and training to enable them to carry out the duties. This was a breach of regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider started to take some action during the inspection to review the learning needs of their staff.

Supporting people to eat and drink enough to maintain a balanced diet
● The provider needed to improve the practices for supporting people with their eating and drinking. This was because people's nutritional records did not always reflect the care and support they were receiving with their diet.
● We observed people receiving support with their eating and drinking and being offered choice and alternatives. The atmosphere was pleasant, and meals were appetising.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's needs and choices were assessed and reviewed and requests had been made for external

specialist professionals such as dieticians and mental health services to support where required. Improvements were required to ensure the actions set out to meet the assessed needs were followed and reviews arranged in a timely way. This included where people were refusing their medicines or care interventions.

● Practices in the service did not always follow best practice guidance. This included guidance on medicines management, nutrition, diabetes and staff training and supervision.

● Arrangements for supporting people with their oral hygiene were not effective. We found two people who were receiving end of life care did not have oral hygiene care plans and staff had not received training in this area. The registered provider took action and started to address this during the inspection.

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection all people living at the home were subject restriction under DoLS.

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 had the appropriate legal authority and were being met.

● Staff were working within the principles of the MCA. Some staff had received MCA training and understood they could not deprive a person of their liberty unless it was legally authorised.

● The registered manager had made appropriate applications to the local authority for DoLS assessments. We discussed with the management and staff the need to ensure restrictions such as wheelchair lapbelts were included in authorisations.

● Staff sought people's consent and gave them choice.

Adapting service, design, decoration to meet people's needs

● People's individual needs were met by the adaptation, design and decoration of premises. Access to the building was suitable for people with reduced mobility and wheelchairs.

● There were adequate spaces for people to spend their time on their own or to share with others.

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 in February 2021 we did not inspect this question, this key question was rated as good in August 2019. This key question has deteriorated to requires improvement.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence
● People's relatives gave mixed responses in relation to the caring nature of staff and whether staff treated people with dignity and respect. While some gave positive feedback and were complimentary about the caring nature of the staff team, some raised concerns about staff attitude and felt some staff were not caring. Comments from people included; "They try to maintain dignity, with closed doors and towels", "Sometimes when I visit [relative] looks as if they haven't been cared for, he needs the barber, sometimes not shaved, this takes away a man's dignity."
● We received a significant number of comments from relatives regarding poor personal hygiene. Eight of the 22 relatives stated they found family member with long and dirty nails with faeces. Comments included; "My [relative] is no longer cared for as well as we would like, sleepy dust in her eyes, unwashed hair, poo under her fingernails, inappropriate clothing for certain days."

We found evidence that people had been exposed to poor care experiences and systems were either not in place or robust enough to promote dignity and choice. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- (Dignity and respect).

● Care records did not always refer to people in respectful ways or demonstrate patience and empathy. Some records showed staff questioning a person's care preferences and for directing their care. Staff had not completed training such as person-centred care and dignity and respect. These practices did not demonstrate people's human rights and diverse needs were always upheld.

We found evidence that people had experienced poor care outcomes and systems were either not in place or robust enough to promote person centred care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- (Person-centred Care).

● We shared the concerns above with the management at the home and they took immediate action to identify and remove some of the care staff involved in the alleged poor practices and would review their staff training.
● People told us they were consulted about care and decisions for their wellbeing and support they required. However, two relatives told us information regarding hospital admissions was not always shared with them at the time of the event.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs.

At the last inspection in February 2021 we did not inspect this question, this key question was last rated as good in August 2019. This key question has deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care; 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

- People's care records did not always reflect their current needs, risks and the actions required to address them. A significant number of records were inaccurate, and the information contained in them could not be relied on to give safe, effective and person-centred care. Feedback from one person and relatives showed some of the staff's practices did not reflect a person-centred approach to care.
- Care records and feedback from people showed on three occasions staff had expressed a dissatisfaction to a person for summoning for help with their personal needs. The person was accused of taking too much of staff time when they attempted to do things for themselves to enhance their own independence. These practices did not demonstrate people's preferences, choice and control were promoted.
- People were not adequately supported to share their end of life wishes. Care records for people assessed as requiring end of life care did not include care plans specific to their end of life needs and wishes to support staff in providing dignified, pain free care.
- While the provider and staff had established alternative ways of supporting people to maintain contact with their families, they did not effectively support people to maintain relationships and to avoid social isolation.
- 16 out of 22 relatives informed us that communication with the home via the telephone and physically visiting the home was difficult. Comments included; "Visiting rules such as not after 3.30pm and not at weekends is poor and communication is very difficult." We received similar comments from a visiting professional.
- The registered provider and staff had arrangements and plans for people to take part in activities of their choice in the home and in the community. However, our feedback from relatives and from our observations showed there were limited activities. The manager and the activities staff informed us they were in the process of reviewing how they can improve the provision of activities.

We found evidence that people had experienced poor outcomes, systems were either not in place or robust enough to ensure people's records were complete, accurate and up to date. There was a failure to ensure care and treatment was person centred to meet people's needs, choice and reflected their preferences. This placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed they had been aware of the state of care records and work was underway to correct these. They started to put end of life care

plans in place.

Meeting people's communication needs
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.

● The registered manager had assessed people's communication needs as required by the AIS. People could be provided information and reading materials in a format that suited their communications needs.

Improving care quality in response to complaints or concerns
● The provider had a complaints procedure that was shared with people's relatives when they started using the service. Relatives we spoke with knew how to raise concerns.
● We saw complaints had been dealt with and others were being investigated. However, comments were mixed, Comments included ;"Yes, all my concerns have been dealt with" And; "I raised concerns and was promised changes will be made however nothing has changed for my [relative], the care and response is poor." We shared this with the provider who informed us they would investigating.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread shortfalls in the governance systems. 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; Planning and promoting person-centred, high-quality care and support with openness;

At our last inspection the provider had failed to assess, monitor and improve the quality of service provided for those who lived at the home, which could potentially impact on their safety and wellbeing. Systems needed time to embed. This is a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider has been in breach of regulations 12, 13 and 17 for three consecutive inspections. Their systems had failed to achieve and maintain compliance with regulations.
● The provider had established a new management team including a new registered manager. However, the registered manager left during the inspection and an interim manager was appointed. Two-unit managers had also recently left. We noted a continued high turnover of managers in the service.
● The provider had introduced new governance and quality monitoring systems to monitor and improve the service. We found these had not been fully imbedded and were not effectively monitoring and responding to ongoing risk to people.
● There was a lack of robust systems for ensuring staff received essential training and that the training met the needs of people at the home to promote high quality and person-centred care.
● There was not sufficient clinical oversight which meant some clinical risks to people, including end of life care and deteriorations in their health had not been adequately monitored and responded to.
● The provider's system for promoting continuous learning improvements was not adequately supported by the practices in place. For example, a newly employed staff member had been allowed to administer medicines and supervise untrained staff which was against the provider's own policy and best practice guidance. Systems for recording people's care were not effectively managed. We were not assured that staff were competent to use the information systems in the home.
● Systems for learning from incidents and near misses were in place but not consistently followed. For example, some incident reports were blank or had not been reviewed by managers. This would include checking whether there were pattern or adequate numbers of suitably qualified staff to support people or the right equipment. In addition staff raised concerns regarding the sharing of information via handovers,

we saw evidence of how this had impacted on the delivery of safe care.

There had been a failure to assess, monitor and improve the quality, safety and welfare of service users and others who may be at risk. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- We received mixed responses from staff regarding the culture and management's ability to respond to staff suggestions and clinical concerns about people. Staff and visiting professionals shared overwhelmingly positive feedback regarding the deputy manager who had been appointed as the interim manager.
- Staff told us morale was low and we observed a high turnover of staff in the service.
- People's relatives told us they were involved in the planning of their family member's care. However; they informed us it was not always easy to communicate with the home due to the phone system or visit arrangements at the home. We shared our concerns with the nominated individual during the inspection.
- There were close links and working relationships with a variety of professionals within the local area.

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;

- While the registered manager had submitted notifications to the CQC in majority of the cases, we found incidents that had not been reported to CQC, the safeguarding adults authority and to the local clinical commissioning group in line with local reporting arrangements and regulations. This included an allegation of abuse and/or an incident involving the police and an incident of physical restraint. The failure to report incidents meant that we could not undertake our regulatory function effectively.

This was a potential breach of regulation 18 (Notification of other incidents) of Care Quality Commission (Registration) Regulations 2009.

- The Clinical Commissioning Group informed us they would start working with the provider to improve this area to promote scrutiny and independent oversight on the clinical care provided.