Moorshield Limited

Finch Manor Nursing Home

Inspection report

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Date of inspection visit:
30 October 2017
31 October 2017
08 November 2017

Date of publication:
22 January 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an inspection of Finch Manor Nursing Home on 30, 31 October and 6 November 2017. The first day of the inspection was unannounced.

Finch Manor Nursing Home 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. The home is registered to provide accommodation with support for personal or nursing care for up to 89 adults. At the time of the inspection 65 people lived at the home.

The home had a registered manager in post. 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.

We last inspected the service in May 2017. During this visit we identified significant breaches of the Health and Social Care Act Regulations with regards Regulations 9,10,11,12,14,16,17, 18 and 19. These breaches were assessed by CQC as serious as they placed people who lived at the home at risk of significant harm. The home was rated inadequate and placed in special measures.

Following the last inspection, we met with the provider and the manager to discuss our concerns. We asked the provider to complete an urgent action plan to show what they would do and by when to improve the service and make it compliant with the Health and Social Care Act regulations. During this visit we found insufficient improvements had been made and that the provider had failed to adhere to the urgent action plans that they had submitted to The Commission. This meant that they failed to take appropriate and timely action to mitigate the risks to people's health, safety and welfare identified at the May 2017 inspection.

We looked at the care files belonging to 14 people. We found their needs and risks were not properly assessed or managed. Some people had new risk management and care plans in place but they still failed to provide sufficient information on how to meet people's needs and keep them safe. Records relating to people's day to day care did not show they received the care and support they needed for example, some people had not received sufficient nutrition and hydration and little action had been taken to address this. Some people had not been repositioned in accordance with risk management advice and some people's health monitoring had not been undertaken to identify and respond to changes in their physical well-being. Some pressure mattress settings remained unsafe and posed a risk to people's skin integrity.

New capacity assessments were in place for some people but not others and we found that some people's

capacity was still not properly assessed in accordance with Mental Capacity Act 2005. Some people did not have capacity assessments in place for covert medication or bed rails and some capacity assessments had already been filled in before an assessment had taken place, There were best interest information in people's care files where decisions on people's behalf had been taken but sometimes these lacked detail of the discussions that had taken place. One person had conditions attached to their deprivation of liberty safeguard authorisation but despite this we found that the manager and staff had not ensured these conditions were compiled with. This meant that there was a risk that the DoLS was unlawful.

Some improvements had been made with regards to the management of medication for example, stock levels of people's medications were correct and records indicated that most people had received the medication they needed. The improvements made however were insufficient. Concerns were still identified with regards to the use of thickening agents in the drinks of people who had swallowing difficulties, some medication records were not completed properly and 'as and when' required medication plans lacked adequate detail. Some people had their medication administered covertly and we saw that some people had adequate guidance from the pharmacist on how to administer this medication safely, whereas other people did not. This placed people at risk of avoidable harm.

People's nutritional needs were not always clearly identified or properly managed. Kitchen staff lacked up to date and accurate information on people's special dietary requirements and some people did not receive the diet they need to keep them well.

Staff were recruited safely but some recruitment decisions made were not properly documented. Staffing levels were not always safe and some of the people and relatives we spoke with raised concerns about this during our visit. Some improvements in staff training had been made and the nursing staff had undertaken the provider's mandatory training programme. Records showed the supervision of staff was still inconsistent and insufficient. The manager also failed to produce any records to show that staff had received an appraisal of their skills and abilities. This meant they could not be assured that staff had the competency or the support they needed to provide good care.

Parts of the premises were in need of repair or were not suitable for use. The environment in which people lived was not dementia friendly and did not support people who lived with dementia to remain as independent as possible for as long as possible. The provider's fire safety arrangements were not safe and after our inspection we referred the home to Merseyside Fire Authority. This resulted in the provider being issued a enforcement notice.

Care staff were observed to be kind and patient in their interactions with people but tended to focus more on the completion of tasks. Some care staff demonstrated that they had a good knowledge of the different ways people used to communicate their needs but we saw that this information had not always been used to design or plan people's care so that all staff were aware of them. The language used in one person's care plan was also disrespectful. Nursing staff, the registered manager and the nominated individual were not a visible presence in the home and we found that the manager and nursing staff failed to have oversight of people's care.

People's privacy and dignity was compromised by the fact that some communal bathroom doors did not fit their door frames. This meant it was possible to see people using the bathroom from the outside. In addition records showed that people's access to regular baths or showers was limited. This placed their personal hygiene, dignity and skin integrity at risk.

People's previous complaints about the food on offer at the home had still not been adequately addressed

as some people continued to voice similar concerns at this inspection. People's feedback as to how the manager responded to complaints was mixed.

There were no effective systems or processes in place to ensure that the service provided was safe, effective, caring, responsive or well led. Audits were undertaken but they were ineffective in identifying the issues found during the inspection, most of which were of a serious nature. The manager and provider had failed to take proactive and timely action to the concerns identified at the last inspection. The overall rating for this provider remains 'Inadequate'. This means that it will remain in 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.

After our visit, we referred our continued concerns to the Local Authority and Clinical Commissioning Group. An urgent meeting was held to discuss the service and the action that needed to be taken to mitigate risks to people's health, safety and welfare.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medication arrangements had improved but issues with its administration, record keeping, the use of thickeners and covert medication were identified.

People's risks in the planning and delivery of care were still not properly assessed or managed.

Parts of the premises were in need of repair and some of the fire safety arrangements were unsafe.

New staff employed since our last inspection were recruited safely by way of appropriate pre-employment checks but some recruitment decisions did not appear robust. Staffing levels were at times insufficient to meet people needs. The feedback from people who lived at the home and their relatives with regard to whether the home was safe, were mixed.

Is the service effective?

Inadequate

The service was not effective.

Some improvements had been made in the way people's capacity was assessed but these improvements were not consistently applied. This meant some people's care failed to adhere to the mental capacity act and deprivation of liberty safeguard legislations.

The majority of staff had completed the provider's mandatory training programme but had not received adequate supervision or appraisal in their job role.

Systems in place to monitor and manage people's nutrition and hydration were not robust and did not ensure people received enough to eat and drink.

The environment of the home was not dementia friendly and did not support people who lived with dementia to remain as independent as possible.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always have regular baths or showers to maintain their dignity or personal care needs.

Some people's personal information was pinned up in their bedrooms and the language used in one person's care plan was disrespectful.

Records relating to people's care had been completed retrospectively, were not always accurate or properly completed.

Staff were kind, patient and caring in all interactions and were observed to know 'the person' they were caring for.

Is the service responsive?

Inadequate

The service was not responsive.

Some people's care files now contained person centred information. This was an improvement from our last inspection.

Dementia care planning was poor. Information about how people communicated their needs and the support they required when they became distressed or agitated required improvement.

Some people's care plans were contradictory and confusing .This placed people at risk of receiving care that did not meet their needs.

Daily records in relation to people's care did not demonstrate that people always received the care they need to keep them safe and well.

Few activities were provided to occupy and interest people. People and relatives voiced concerns about this.

There was a complaint system in place but concerns about the

quality of the food were raised again at this inspection. People's feedback on how well the manager responded to complaints or, concerns was variable.

Is the service well-led?

Inadequate

The service was not well led.

There were no effective systems or processes in place to ensure that the service was safe, effective, caring, responsive or well led.

The manager and provider failed to adhere to the urgent action plan provided to The Commission after the last inspection. This meant people continued to experience poor and unsafe care.

The manager failed to demonstrate they had the skills and competencies to manage the service. Prior to our inspection concerns had also been reported to the Commission about the negative culture of management at the home.

Finch Manor Nursing Home

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 was planned to check the provider was now meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to relook at the overall quality of the service and to provide a rating for the service under the Care Act 2017.

At the last inspection of the service in May 2017, the service was rated inadequate. This was due to multiple and significant breaches of the Health and Social Care Act 2008 regulations. The service was placed in special measures. When a service is placed in special measures, we re-inspect the service within 6 months. This is to check that the provider has taken appropriate and sufficient action to address the failings of the service and mitigate risks to people's health, safety and welfare.

Since our last inspection in May 2017, The Commission continued to receive significant concerns about the service and the quality and safety of people's care. Due to this, we changed our timescale for returning to the service and brought forward the date of the inspection to the 30 October 2017.

Prior to our return to the service, we reviewed the concerns we had received, looked at any information sent to us by the registered manager, nominated individual and provider. We liaised with the Local Authority and the NHS Clinical Commissioning Group for their feedback. Both the local authority and the clinical commissioning group have been involved with the service since the last inspection due to the serious concerns identified.

The inspection was conducted over three days on 30, 31 October and 6 November 2017. The first day of the inspection was unannounced. This inspection was carried out by three adult social care (ASC) inspectors, a specialist medicines inspector and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of service.

Since our last visit to the home, the nominated individual for the service had changed from the provider to a person contracted by the provider to act in this role. A nominated individual is a person who represents the

provider and carries out the provider's role on their behalf. A nominated individual is responsible for supervising the management of the regulated activity. The registered manager remained the same.

During our visit, we spoke with ten people who lived at the home, nine relatives and six visiting health and social care professionals. We spoke with the registered manager, the nominated individual, four nurses, a care co-ordinator, seven care assistants and three members of the housekeeping team.

We looked at fourteen people's care records, six staff recruitment files, records relating to staff training and supervision, medication administration records and other records relating to the management of the service.

We observed people and staff throughout the inspection and saw how people were being cared for.

After our inspection, we spoke with a medical professional involved who had contacted us to give us specific feedback about the home.

Inadequate

Is the service safe?

Our findings

At the last inspection in May 2017 we identified serious and significant concerns with regards to Regulations 12, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These concerns related to unsafe medication management, inadequate risk management, poor infection control and poor staffing levels. After this inspection the provider submitted an action plan to The Commission outlining the immediate action they intended to take to make the service safe. At this inspection we found that little effective action in respect of the provider's action plan had been taken.

At our last inspection, we found that the way medicines were managed and administered was dangerous. For example, there were problems with the electronic medication system, staff training, the use of thickening agents to thicken people's drinks and the storage and disposal of waste medication. People had also not received the medicines the needed to maintain their well-being. At this inspection some improvements had been made but overall the improvements were not sufficient.

We looked at 17 medicines administration records (MAR) and checked the balance of people's medication against what had been recorded administered. We found that the balance of most people's medication was correct and that most people had received the medication they needed. This was an improvement from the last inspection. We found however that some medicines were still not stored or administered correctly and records were not always completed properly. There was also no improvement in the way people's drinks were thickened to minimise the risk of aspiration or choking.

For example, one person required a pain- relieving patch to be applied at the same time of day each week. The administration of this medication was late on one occasion which meant the person may have experienced unnecessary pain or discomfort. The manufacturer's guidance for this medication advised that the pain relief patch should not be placed in the same position for longer than 3-4 weeks as this had the potential to cause side effects. We found that there was no record kept by the home to show where the person's pain relief patches had been applied. This meant that there was no way of knowing if the patch had been administered correctly.

Four people were prescribed a powder to thicken their drinks to reduce their risk of aspiration or choking. Information relating to the use of this thickener was conflicting for three of these people. One person was given a different brand of thickener than the one prescribed and there was no stock of thickener in the home for the other two people for whom it was prescribed. This meant it was likely they were being given drinks that were not safe for them to consume. People with swallowing difficulties are at risk of aspiration or choking if drinks are not made to the correct requirements.

At the home care staff were responsible for making people's drinks and adding the prescribed thickener. Care staff however completed no records in relation to this and when we asked the care staff about the use of thickening agents, they were unable to tell us the correct amount of powder to put in people's drinks.

When we checked people's medication administration records, we saw that nursing staff had signed to indicate that they had added the thickeners to people's drinks. When we asked the nurses if they added this medication to people's drinks, they told us that they signed the MAR chart but that they did not make or give the thickened drinks. This meant that nursing staff had signed to confirm that they had added the thickener to people's drinks and observed them consume it. This was not the case, meaning these records were false.

Some people received their medication covertly. This meant their medication was hidden in their food or drink without their knowledge. Some people's care files contained guidance from the pharmacist on how to administer this medication safely but we found that recently prescribed medicines were not included in this guidance. In addition, one person's care file contained no information on how to administer the covert medication even though they received their medication in this way. This meant staff did not always have sufficient guidance on how to administer people's medication in a safe way.

Some people were prescribed 'as and when' required' (PRN) medications. We saw that when the dosage of medication was variable for instance one or two paracetamol tablets, there was not enough personalised detail to ensure the right dose was given. This meant people may not have received the right level of pain relief to ease their discomfort. We saw that charts to record the application of prescribed creams and ointments failed to give clear guidance on where to apply them and were not always completed properly. This meant there was a risk that they had not been applied.

We saw that one person's injectable medication had been opened and placed in the fridge. Once opened the medication needed to be used within three weeks otherwise it expired. The date it had been opened had not been recorded. This meant it was impossible for staff to know if the medicine was safe to use.

These issues meant there was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because some medicines were not managed safely. This placed people at significant risk of harm.

People had mixed opinions about the safety of the service and the quality of care they received. Comments included "They certainly look after you"; "The place is secure and staff are sound"; "I do and I don't. Sometimes residents wander around but its more or less ok in my own room" and another person said they had "Too many (concerns) to mention" with regards to the home.

A relative we spoke with voiced concerns about a recent incident that they felt had not been managed appropriately. They said "(Name of person) had a bruise on their head when I came in. Staff had not informed me and said (name of person) had knocked themselves on a bedside cabinet and lamp. They had two black eyes after a few days and they found bruised knees a few days later. I think they may have fallen. I didn't get an explanation. They didn't get the doctor. I was not approached by management (name of manager). I took photos on my phone".

At the last inspection in May 2017, we found that people's care files contained inaccurate, contradictory and insufficient information about their needs and risks. This placed them at risk of inappropriate and unsafe care. People's daily records did not show they received the care they needed and professional advice in relation to people's care had not always been followed. After the last inspection, we asked the provider and the registered manager to ensure all of the people who lived at the home had their needs reassessed as a matter of urgency so that suitable risk management plans were put into place to keep them safe. The provider and registered manager assured us this work would commence immediately and be completed by the end of the month.

When we returned to the service to conduct this inspection, some five months later we found that these timescales had not been adhered to. The provider and registered manager had failed to re-assess and plan appropriate care for 69% of the people who lived at the home. The manager told us only 20 out of the 65 people who currently lived at the home had been re-assessed and although we could see some improvements with the way people's care had been assessed and planned people's new care plans and risk management plans were still poor and lacked sufficient detail.

For instance the Maelor risk assessment had been used to assess the risk of people developing pressure sores. The risk assessments failed to provide information on what people's risk assessment scores meant for example, high, medium or low risk so these were meaningless to staff. Some people's new risk assessments were also inaccurate. For example, one person's skin risk assessment stated that they were alert yet their care plan indicated confusion, agitation and disorientation. It also stated that the person was occasionally incontinent yet their continence risk assessment and care plan indicated they were totally incontinent. This lack of accurate risk management information meant staff did not have adequate information on people's skin integrity risks in order to mitigate them.

Two people whose care had been reviewed since our last inspection had not had their risk of malnutrition assessed. Another person's new nutritional risk assessment had been totalled but provided no further information as to how the total score had been decided. This meant that staff had no information on how the person's level of risk had been determined in order to be able to identify any changes that may occur.

One person had two falls risk assessments in place. One had been totalled but gave no indication as to the level of risk. The other had been scored but not totalled or dated which meant it was unclear whether the risk identified were still current. We saw that the person also had three moving and handling risk assessments that contained contradictory information. One risk assessment stated that the person was mobile with one care assistant, the other stated they needed two care assistants to keep them safe and the third stated they were independent and at low risk of a fall. Records showed that this person had fallen five times since their admission to the home in March 2017. This lack of clear information placed the person at risk of receiving unsafe and inappropriate care. We saw that this person had bed rails on their bed. When we checked the person's care file we saw that their care plan indicated that the person was at greater risk of harm with bed rails in place than without. This meant that safety advice in relation to the person's safety had not been followed.

Two people had medical conditions that pre-disposed them to seizures or involuntary movements. Despite this, no assessment of the risks these conditions posed to the person's well-being had been undertaken. One person's care had been reviewed and all of the health conditions that had been identified as risks to the person's health, safety and well-being at the last inspection, had been crossed out in their care file, with no further explanation.

We spoke with three health and social care professionals. All three professionals indicated that significant improvements were needed to the way people's care was provided and their risks managed. One health care professional told us they "Couldn't make head nor tail' of people's care records and that information on people's needs and care was "Very scanty".

At our last inspection, people who had pressure sores in place did not always have adequate information about their wounds and the care they required. This was a basic nursing requirement. At this inspection we saw that improvements to this aspect of clinical care had been made and that the majority of people who had pressure sores had a wound assessment and care plan in place. Further improvements were required to ensure that all of the people who had skin wounds or sores had this important documentation and

guidance in place for staff to follow.

Prior to the last inspection in May 2017, the local authority had raised concerns with the manager about an unsecured fire door at the rear of the home that staff, visitors and people who lived at the home were using to come in and out of the building. This was a safety risk as it meant that there was no check of who was entering or exiting the home and no accurate record of who was in the home at any given time for fire safety purposes. The local authority asked the manager to address this and prior to our visit in May 2017, the manager had given firm assurances to the Local Authority that they had done so. When we visited in May 2017 we found their assurances had not been acted upon and the door still remained unsecure.

In May 2017 we again asked the manager to ensure that the unsecure fire door was addressed with immediate effect. They assured us they would. When we returned to conduct this inspection, the fire door was still unsecure and remained a significant safety risk. During our visit, we observed one person exit the home and stand outside of this door smoking a cigarette. We did not observe any staff member check with the person that they were safe to do so or even check that they had returned into the home.

We reviewed the provider's fire risk assessment and saw that it had been reviewed in June 2016 by the manager. The fire risk assessment stated that the laundry was to have a second exit so that there was an alternative means of escape in the event of a fire. The manager had handwritten on the fire risk assessment "To open up door asap". When we visited the laundry however, no action had been taken. We saw that the laundry had a space were a previous door had been in place, but that this had been plaster boarded over. Staff working in the laundry told us that when they had asked the manager about the second exit, they had been told to "Push the laundry trolley" through the wall were the previous doorway had been if a fire occurred. This was completely unreasonable and highly dangerous.

During our tour of the home we also identified other areas of concern relating to fire safety. Some of the home's fire doors did not fit their frames so would not prevent the spread of a fire and the automatic door guards on three fire doors were constantly bleeping over the three days we inspected, indicating that they required new batteries to work.

After our inspection, we referred the home to Merseyside Fire Authority for a fire safety visit. Merseyside Fire Authority visited the home on 8 November 2017 and issued the provider with an urgent enforcement notice. The enforcement notice stated "Merseyside Fire and Rescue Authority is of the opinion that you have failed to comply with a provision of the Regulatory Reform (Fire Safety) Order 2005 because people were unsafe in case of fire".

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

We saw that the home's gas, electric, fire alarm and moving and handling equipment had been inspected and were safe to use. During our visit however, we found that parts of the home were in need of repair. Paintwork on some doors and handrails was heavily scuffed. Some of the paint work on the walls had peeled off. Skirting boards in parts of the home were heavily marked. Some of the home's walls and flooring were stained from where spillages had occurred, some of the bathroom doors did not fit their frames and some of the radiators in the home were damaged.

Due to the damage in some areas of the home, effective cleaning was difficult. For instance in one bathroom, the paint and woodwork at the back of the toilet unit was damaged, one of the communal bath

hoists was rusty and enamel around one of the communal baths was chipped. There was mouldy sealant around some of the communal baths, multiple cigarette butts and debris around the grounds of the home, and one person's bed rail was stained with what looked like dried faeces. The person was asleep in their bed at this time. Similar issues with the maintenance and cleanliness of the home were identified at the previous inspection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have systems and procedures in place to ensure the premises were clean and properly maintained.

Staffing levels were not safe at all times. Rotas for the first week of October 2017 showed that two nurses were on duty to care for 65 people during the day with 16 to 17 care staff split across five units. There were two nurses planned to be on duty at night with eight care staff supporting people's needs. We saw that there as a dependency tool in place. A dependency analysis is a tool used to determine safe staffing levels based on people's needs and risks The nominated individual told us they used the dependency tool to work out safe staffing levels. We looked at the dependency tool in use. We found it to be confusing and we could not understand how it worked. It failed to show how information on people's needs and risks had been used to determine safe staffing levels. We asked the manager and nominated individual about this. Neither were able to explain how they had used the dependency tool to work out safe staffing levels. The nominated individual acknowledged they had "No formula" to do this.

When we looked at staff rotas in more depth, we found that some aspects of staffing did not make sense. For example, 19 people lived in one of the five units of the home. More people lived on this unit than any of the other four units. It was difficult to understand what people's dependency needs were on this unit, as the dependency tool in place was unclear. The staff rota's we looked at showed that during the day this unit had the greatest number of staff on duty in support of people's needs. Yet, at night it had the least number with only one care assistant on duty to meet the night time needs of 19 people. This did not make sense and without an accurate and reliable dependency tool it was unclear how the manager, provider and nominated individual could be assured that people were safe.

Feedback we received from people who lived at the home about whether there were enough staff on duty was mixed. People's comments included "I think there are enough but I don't really need to bother them"; "No there aren't enough, they are overworked and underpaid"; " Yes there seems to be enough"; "They could do with a few more – it's difficult in summer"; " For my needs there are enough. Staff would come if I need them"; "Not many (staff). There should be more" and "It is shocking, there is not enough, especially nurses".

The majority of relatives we spoke with thought there were not enough staff on duty at all times. Their comments included "There are mostly enough. It used to be the weekend when there were not enough but it has improved"; "No, because even if there are four staff on duty, the care co-ordinator is taken off to do paperwork. There is a constant flow of agency staff and the agency staff don't know the residents. Others are overworked with the agency workers just sitting around"; "There aren't enough. Sometimes only two staff and the agency staff don't know them" and "No I think the numbers have gone down".

Records of people's care showed limited evidence that they had received the care they needed. We saw that the number of baths and showers people received was sparse and records showed that people did not always receive the care they need to maintain their health and wellbeing.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not enough staff on duty at all times and there were no adequate systems in place to

determine what staffing levels were safe.

We looked at how staff were employed. Staff recruitment was in the majority safe in terms of the pre-employment checks made but we found that recruitment decisions were not properly documented when further investigation in to the staff member's suitability were required. For example, one staff member had been employed without a satisfactory reference from their previous employer. The manager reported that since they started employment they had issues with their conduct and competency. The manager also told us another member of staff had also been recruited and later found to be unsuitable. This raised concerns over the quality of the provider's recruitment and selection process.

We looked at the people's personal emergency evacuation plans (PEEPs). These plans advise staff and emergency service how best to support people during an emergency and we found the PEEPs in place to provided sufficient information about this.

We looked at how the provider monitored the risk of Legionella in the home's water system and found there were some systems in place to monitor this risk. This was an improvement since our last inspection. Further improvements were needed to ensure that the home's shower heads were cleaned effectively to prevent the build-up of bacteria. There were no records available to evidence this aspect of Legionella management.

Inadequate

Is the service effective?

Our findings

At the last inspection in May 2017 we identified serious and significant concerns with regards to Regulations 11, 14 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These concerns related to how the provider obtained people's lawful consent, provision of sufficient nutrition and hydration and the training and support of staff. At this inspection we found little action had been taken to address these concerns.

During our visit we observed the serving of lunch and saw that people's meals were of an adequate size. Some people were given support to eat their meals. This was done in a patient, sensitive way but we found some staff did not have sufficient knowledge of what was on the menu in order to help people decide what they would like to have.

We visited the kitchen. There was a whiteboard in the kitchen which provided information to kitchen staff on people's special dietary requirements. This information was not up to date. For instance, two people were diabetic but their requirement for a diabetic diet was not listed and we found that some people were not always given meals in accordance with their requirements. In addition, when we asked the cook whether people who were at risk of malnutrition had their diets fortified, they did not know what the word 'Fortified' meant. We spoke with the manager about this. The manager told us all the meals provided were "Fortified".

One person's care plan indicated they needed a low fat, diabetic diet to prevent further weight gain and associated health complications. The person's low fat diet requirement was not listed on the kitchen whiteboard and we were concerned about this as the manager had told us that all meals were fortified. This meant that extra calories were added to the meals by the use of extra cream, butter or milk powder. A fortified diet is usually given to people at risk of malnutrition. It is not suitable for people who need a low fat diet to prevent further weight gain. The manager confirmed they did not receive a low fat diet.

One person's care plan stated that they preferred 'finger food' yet at lunch they were given a bowl of soup which they immediately put their fingers in. This was quickly changed to a cup of soup and we saw that the person was able to hold and consume the soup when it was served in this way. One person's care plan indicated that they did not like salad, yet at lunch time this is what they were given to eat. One person asked if they could have a biscuit with their cup of tea. This request was declined and the person was told "Maybe a bit later".

Prior to our visit, we were informed of two safeguarding incidents by the Local Authority relating to two people who were allegedly admitted to hospital dehydrated. During our visit, similar concerns were expressed by a visiting healthcare professional and a relative. The relative told us their loved one had "Ended up in hospital because they were dehydrated". They told us "There is no-one here to take time to feed them (the person) or give them drinks. They are blind and can't cope".

Some of the people who lived at the home were on food and drink charts to monitor their weight due to the risk of malnutrition. People's food and drink charts however showed that some people had not received sufficient nutrition to prevent weight loss and ill-health. For example, one person's food and drink charts showed that for a period of ten days they had declined all of their meals and simply had a couple of spoonfuls of porridge or dessert each day. They had also not received the right amount of dietary supplements.

Another person records showed they had lost 16% of their own bodyweight in the last 6 months. Despite this neither, the manager or clinical staff had picked this up so that action to prevent malnutrition was taken. When we checked the person's nutritional care plan we found that it not been updated since May 2017. This meant it did not accurately reflect the person's needs or the nutritional care they needed. We checked the special dietary requirement board in the kitchen to see if any changes to the person's diet had been made to mitigate risk of further weight loss. The person was not listed on the board as requiring any extra nutrition to support their needs. We saw that some notes had been made in the person's care file about a dietician's referral, but none of the staff including the manager could produce any evidence to show a referral had been made or that they had followed it up. At the time of our visit the person had still not been seen by a dietician despite some of the notes being made in July 2017.

The Social Care Institute for Excellence states "The consequences of malnutrition and dehydration can be very costly both for the individual, in terms of their health and wellbeing, and for services as people may become ill and require more intervention for longer". We found no effective action was been taken to avoid the consequences of malnutrition and dehydration at Finch Manor.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's nutritional needs were not properly assessed or provided for in the delivery of care.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that 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.

At our last inspection, we found some people had their capacity assessed but the assessments undertaken were generic and lacked sufficient detail. There was also little evidence that a best interest decision making process had been followed when making decisions on people's behalf. During this inspection, some improvements had been made. The format of the mental capacity assessment had been improved and it was evident that the manager had re-assessed some people's capacity since our last inspection. We found however the action taken to improve this aspect of service delivery was insufficient.

For example, we saw that some people had capacity assessments in their care file with regards to their ability to keep themselves safe outside of the home; to consent to their care plan, for the use of bed rails and for the administration of covert medication. But others did not. Where a best interest decisions had made,

the records relating to the best interest process did not always contain sufficient detail of how the decision had been made and the least restrictive options explored.

We found that some of the capacity assessments located in people's medication administration were photocopied and pre-populated. This documentation did not identify the person to whom the assessment belonged and the answers and outcome of the assessment had already been filled in before the capacity assessment had taken place. This did not show that the assessment process was an open and transparent one.

We saw that one person's deprivation of liberty safeguard had conditions assigned to it in order for the deprivation of the person's liberty to be lawful. We found little evidence that these conditions had been adhered to by the manager or staff at the home despite the DoLs authorisation stating these conditions "Must be complied with" .This meant the legal parameters in which the person's deprivation of liberty safeguard had been authorised had not been met.

These examples were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment.

At the last inspection we found that the induction, training, supervision and appraisal of staff was ad hoc and inconsistent. At this inspection, we found that some improvements had been made but they were minimal.

We asked the manager for records relating to the supervision, appraisal and training of staff. There were no appraisal matrix provided to inspectors to demonstrate that staff members had received an appraisal of their skills and abilities. During the inspection, the manager gave us three versions of the supervision matrix which recorded when staff had received supervision. The third and final version showed a more favourable view of the supervisions taken and to be proportionate we used this information on which to base our judgement of the provider's compliance with regulations. From our review of this information, we found that all staff members had still not received adequate supervision.

We saw that three nursing staff had access to one supervision session since our last inspection in May and three nursing staff had received no supervision since our previous inspection. The manager told us they had done them but was unable to provide any evidence. One of these nurses was subject to a performance plan to improve their competency and job performance yet the matrix showed they had received no one to one or clinical supervision in their job role.

The majority of care co-ordinators had received one supervision session since our last inspection in May 2017 but the supervision of care staff was sporadic. Some of the care staff had received two or three supervision sessions, whereas others had received just one or none. This did not demonstrate the arrangements in place were properly organised or managed to ensure that all staff had equal access to the support they required.

These incidences are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to ensure staff received appropriate support in their job role.

Staff training had improved and there was an ongoing programme of refresher training. We looked at a sample of the certificates and workbooks from these. At the last inspection the majority of nursing staff had

not completed the provider's training provided but we saw that this had now been addressed.

The provider's website indicates the home provides specialist care for people who live with dementia but we found aspects of care that were not dementia friendly. For example by the way of good signage around the building or the use of contrasting colours in different parts of the home to help people who live with dementia to find their way around the home so that they could remain as independent as possible, for as long as possible.

There was minimal signage around the building to help people familiarise themselves with the home. Large sections of handrails that people use to aid their mobility in corridor areas were the same colour as the walls and did not easily stand out for people who lived with dementia to see.

In one unit there was different coloured and poorly contrasting flooring in the corridor and one of the bathrooms had heavily patterned flooring. People who live with dementia may find this confusing as they can sometimes interpret patterns in the carpet as holes or steps. One lounge did not have any curtains in place on the windows to enable staff to reduce the glare of the sun in the room if required. These elements of the environment posed a risk for people living with dementia who may have issues associated with visual misperception.

There were limited signage in place to support people to understand what a room, cupboard or space was used for. For instance, the use of food and drink pictures in dining areas to enable people to associate the pictures with the purpose of the room. We noted one kitchen area in the home used pictures that people may associate with bathing, as opposed to eating and mealtimes. This could have caused confusion.

The nominated individual told us that they had audited the environment using a template provided by Kings Fund. The Kings Fund are a charity who specialise in research into dementia friendly environments. The nominated individual told us they had a formal qualification in dementia care but did not produce any formal plans of how the dementia care provided at the home and its environment would be improved to more effectively support people's well-being.

Requires Improvement

Is the service caring?

Our findings

People's feedback about the staff was mixed. Comments included "They certainly look after you, especially (name of staff member) who is a most lovely lady"; "I can't go to the toilet by myself. Most of them help but a few are not that helpful"; "It's more like a dodgem. Some are nice but others no so"; "Yes they have always been nice to me" and "They have no idea" (how to be caring).

A relative we spoke with told us "Most of the staff seem caring but they need more"; Another said "They (the person) had a fall a while ago and the staff were marvellous and cared for him really well". All of the relatives we spoke with said they were made welcome by staff when they visited.

When we looked at people's care plans we found that the language used in one person's care plan to describe their needs was inappropriate and disrespectful. For example, the person was described as "nasty and aggressive". We also found that some of the language described people's mental health needs as a reason for their limitations as opposed to focusing on their abilities as an individual. This did not indicate that the service was promoting people's independence. One person's care plan also referred to another person and looked like it had been copied and pasted from one person's care plan to another. This did not show that the service ensured that people's care plans reflected their individual needs and preferences.

We checked a sample of people's personal care charts and saw people did not always have regular baths or showers. One person's records showed that they had only had one bath or shower in 31 days and two other people had only received two baths or showers in this period. This did not demonstrate that people received the care they needed to maintain their dignity or preserve their skin integrity.

During our visit, we found that some of the bathrooms doors in communal bathrooms and toilets did not fit their frame. This left a gap between the door frame and the door which meant that other people, visitors and staff could see through the gap into the bathroom. This meant if someone was using the bathroom, they could be seen from the outside. The meant people's right to privacy and dignity were compromised.

These examples demonstrate a breach of 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service did not always ensure people's privacy and dignity were respected.

Relationships between people who lived at the home and staff appeared calm and relaxed. We observed staff speaking with people in a compassionate and kind manner. Staff on some units demonstrated a good knowledge of people such as their likes and dislikes. Most people we spoke with felt staff knew them well. One person said "They know what I like, we get on great" and another person told us; "They are very good indeed and know what I like and don't like". A third person we asked said "I don't think they know me as there is no one to talk to".

We saw that the staff were patient and kind when they interacted with people but interactions tended to be

based on the tasks the staff needed to complete. For example, priorities for the day were making sure peoples care needs such as eating, drinking and personal care were tended to. We observed staff had little time to sit and meaningfully engage with the people they supported. We asked people if staff had the time to sit and chat with them. One person we spoke with told us "Yes we have a chat and a laugh sometimes". Two other people told us "They don't have much time to talk as the paperwork seems more important" and "No, they are too busy, but they do work hard".

We observed staff in one unit handle a potentially difficult situation with one person well and in a caring manner. The person had become distressed and verbally agitated and we saw that staff continued to talk to them throughout this time, no fuss or drama was made and the person appeared to calm down after about 10 minutes.

Some staff were also good at interpreting people's non- verbal communication cues. For example, one person stood up, tapped the pockets on their trousers and stated that "They were off to go there". A staff member immediately recognised that the person required support to use the bathroom. Another person was observed pointing and tapping on their tray table and a staff responded quickly by offering choices relating to food and drink. We found however that the various ways people used to communicate with staff were not documented in their care files, so that all staff were made aware of the methods used by the person to express their wishes or needs. This aspect of care planning required improvement.

During our last inspection we found that staff sometimes discussed people's needs in communal areas where they could be overheard. During this inspection, this had been addressed and we did not hear any staff member discuss people's personal needs in communal areas. This indicated that staff understood that people's personal information should be kept confidential.

At our last inspection, we saw that some people's care files were stored in an unlocked cupboard in the communal lounge area and a number of people's confidential care records were found in a skip outside of the home. At this inspection, we found people's care files and medication records were kept secure and confidential. We saw however that some people had personal information about their needs pinned up on their bedroom wall. This meant the information was visible to people who entered this person's room.

Inadequate

Is the service responsive?

Our findings

At our last inspection, we found that people's care plans were not person centred. At this inspection we saw that some improvements with regards to this had been made.

We viewed fourteen care files and found there was some evidence that people's wishes and preferences had been discussed with them and their families. Some people's care files contained evidence of people's life histories, preferences in day to day living and the things that were important to them. The manager told us that care staff had been involved in helping gather this information by talking to people and their families and also used the knowledge they knew about people in the day to day delivery of care. Further improvement was required however to ensure everyone's care plan contained this information.

For example, one staff member explained that one person liked to be warm and required a clear explanation of what care was going to be provided. They told us the person needed to be supported in a quick and effective way and so it was important to have everything ready to hand when helping them with their personal care. This information was not documented in the person's care plan.

We saw that this person had communication difficulties. We checked their communication care plan and found that it lacked sufficient detail. The care plan stated the person would use a phrase or word to describe 'something' but there was no further information about what words or phrases the person would use to communicate. This meant that the care plan was relatively meaningless. Another person's communication care plan was also vague. It stated that the person used non- verbal expressions to communicate but failed to identify what these where.

Where people experienced behaviour that challenged. Staff had little guidance on how to support the person in a person centred way. There was little information on what triggered people's episodes of distress or challenging behaviours or the strategies staff should use to support the person to reduce their agitation. This placed people at risk of receiving care that was inappropriate and did not meet their needs.

Dementia care planning overall was poor. For instance some people's care plans failed to identify the type of dementia people lived with and the impact it had on their day to day life. This meant staff lacked key information on how the person's dementia affected them. Some people who lived with dementia had no dementia care plan in place at all. Staff had little guidance on what people's day to day abilities were in order to promote their independence.

At the last inspection, information in people's care files about their needs and care was contradictory and confusing. Although some improvements had been made they were insufficient. Gaps and contradictory information about people's needs and care were still evident in people's care records even with regard to the new care plans put into place for some people. This made it difficult in some cases to understand what people's needs were and the day to day support they required to keep them safe and well.

For example, one person's falls risk assessment stated they were able to mobilise with a walking aid. Their mobility care plan stated that they were able to stand with two staff and a stand aid. The person's hospital passport stated that the person was unable to mobilise and required a hoist for transfers. This conflicting information placed them at risk of receiving care that was not responsive to their needs.

One person had two nutritional care plans in place. One care plan stated the person's weight was to be monitored weekly due to weight loss, the other said monthly. There was a letter in one person's care file from a speech and language therapist. This letter indicated that staff had cancelled the person's appointment as staff had no concerns about the person's ability to swallow. This did not correspond with the person's nutritional care plan that stated they had a poor swallowing reflex which placed them at risk of choking or correspond with the type of diet the person was receiving.

Some people's care records showed that they lived with a number of health conditions. The majority of these health conditions were not adequately identified or described in people's care plans and staff had little guidance on how to respond to their needs and identify changes in their well-being.

People's care was not always regularly reviewed to ensure their care continued to meet their needs. For instance, one person had lost a significant amount of weight but despite this their nutritional risk assessment had not been reviewed for over 5 months. One person's skin integrity risk assessment stated that there were no changes to the person's skin but other care records showed that during the same time period they had a skin infection for which medical treatment was obtained. Furthermore there was little evidence that people and their representatives were involved in any care reviews to ensure that the care provided continued to meet their needs and wishes.

These examples did not demonstrate that people's needs and preferences were appropriately assessed and reviewed so that person centred care could be provided. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people's needs and care had not been properly assessed, designed or reviewed to ensure it was appropriate and met all of their needs.

People's care records showed that they did not always receive the care they needed to keep them safe and well. This was a serious concern identified at our last inspection. For example, we found that people who required clinical observations to be taken in respect of their physical health had little evidence in their care files to demonstrate that these observations were taken. One person had a medical condition that required staff to monitor their blood pressure on a monthly basis but when we asked the nurse on duty for the records in relation to this, none were available. This did not demonstrate that this person's care was responsive to their needs. There was little evidence that people who needed to be repositioned at regular intervals to prevent skin breakdown were supported consistently or in accordance with their plan of care.

At our last inspection, we found that some people's pressure mattresses were set at an incorrect setting for their weight. At this inspection, this was still the case. We found that two people's mattresses were set at too high a setting for their weight. Too high or too low a pressure setting for a person's weight can increase their risk of developing a pressure sore as opposed to preventing it. This did not show that people's care was responsive to their needs.

Records showed that staff were required to check people's pressure relief equipment and bed rails at regular intervals each day. Despite this the records showed these checks were not always undertaken. The records completed were meaningless. Different staff used different codes to record what checks had been completed and none of the staff at the home including the manager seemed to understand what all of the

codes meant.

We saw that some people did not always have the equipment they needed. For example, one person was identified as requiring specific pressure relief and safety equipment but we found that this was not in place. Staff told us that the person had moved into their unit two weeks ago but the equipment had not transferred with him. There was no evidence that the manager or the unit staff had followed this up or organised for the transfer of this equipment. This did not show that the service was responsive to this person's needs.

People's care remained inconsistent and poorly managed. We found that staff and the manager still lacked adequate knowledge of people's needs in order to be able to respond to them. For instance we saw that one person's GP has ordered a series of blood tests, when we asked the nurse on duty what these were for, they told us they did not know. We asked one of the care staff why one person was on food and drink charts, they told us they did not know.

One person care plan indicated they lived with diabetes. We checked their care records to see if they had received their annual diabetic review and diabetic eye screening. There was no evidence that either had been undertaken. When we asked the manager about this, they were unsure. This person's care plan stated that they needed to have their blood sugars monitored on a monthly basis to ensure they remained at a safe level. We asked to see the clinical records in relation to this but none where available. A nurse told us "I don't think (name of person) has diabetes. It was concerning that neither the manager or the nurse had clinical oversight or understanding of this person's needs and care.

A visiting healthcare professional confirmed our observations. They told us that when they had visited people at the home "Nobody could tell us anything about the patients" as two agency nurses were on duty. They also told us they did not think the manager knew about people's needs and care. Subsequent to our inspections further concerns were raised by two medical professionals about people's care.

At our last inspection some of the units in which people lived did not provide a calm, stimulating or therapeutic environment for people to live in. At this visit, fewer people now lived at the home and we noticed the atmosphere was much calmer. There were still no activities available for people to participate in and for the most of the day people sat around watching television or were in their rooms.

People we spoke with told us "I go in the day room but I don't like it when people scream"; "There used to be two activity people but they left"; "Sometimes two singers come in but we never go out anywhere"; "We used to go out for a pub lunch but that stopped"; "No I just sit and watch TV. I'd love a change of scenery" and "There is no entertainment. I wish they would take us to the pictures or go on a coach trip to Southport".

A relative we spoke with said "No (activities). (Name of person) just sits in their chair when in the lounge at the table. Activities are few and far between, there is only the TV". Another relative said "They used to have people coming in, but not now. The TV is on but no music and they don't use the garden much" We saw that a residents and relatives meeting had taken place in November 2017, where relatives were "Very concerned about the lack of activity provision".

These examples were a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people who lived at the home did not receive person centred care that was appropriate, met their needs or reflected their preferences.

At our last inspection, we saw that several complaints had been received from relatives and staff about the quality and quantity of the food provided. We asked the manager if any further complaints had been received. They told us no complaints had been received since we last inspected. This suggested that improvements had been made. When we asked people and relatives at this inspection however about the food provided, some of those we spoke with remained unhappy with the food.

Some people also raised concerns about aspects of their care during our visit. One person said they were concerned with other people coming into his room. They also told us that they would like to use their laptop computer but that they were unable to get onto the Internet as the manager won't give them the code. One person told us "I worry about my clothes in a hot wash. Everything seems to shrink and you don't always get it back".

People's opinions about how complaints were responded to, were mixed. One person told us "If I had any concerns, the staff would sort it". A relative we spoke with said "If I have concerns I go to (name of the manager) but nothing ever happens". A medical professional told us that when they have raised concerns about people's care with the manager, they have said that they will sort it but there have been "No changes".

This is a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was no effective complaints system in place to ensure that necessary, proportionate and timely action was taken in response to people's complaints and concerns about the service.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found that the management of the service was inadequate. We had serious concerns about the quality and safety of the service. This meant that a significant breach of Regulation 17 of the Health and Social Care Act 2008 was identified as the service was not well-led.

At our last inspection in May 2017, there were no effective systems in place to monitor the quality and safety of the service. At this inspection we found that some of the systems in place to monitor the service had changed. We found these new systems to be ineffective in driving up improvements. Some of the newer audits had not been introduced until September 2017, despite our last inspection being in May 2017. This did not demonstrate that the manager and provider had taken a proactive and timely approach to addressing the serious concerns previously identified. This lack of accountability and responsiveness meant that people continued to be placed at risk of unsafe and inappropriate care.

For example, at our last inspection we identified serious concerns with the management of medication. During this visit, although some improvements were noted, similar issues with medication administration records, use of thickeners and the administration of some medicines were found again. Medication audits had been conducted but they had failed to identify these ongoing concerns. This showed a lack of adequate clinical and managerial oversight.

Accident and incident audits were in place and looked at trends in how accidents and incident occurred. The audits were not specific to each unit and its staff team which meant it was impossible to tell if people fell more in one unit than any other unit in the home. This would have been useful information for the manager to have as it would have enabled them to investigate whether people's needs were accurately assessed on this unit and to re-assess whether staffing levels were sufficient. Both of which are current and ongoing concerns.

The health and safety audit in the manager's audit file was blank but we could see that some health and safety checks had been undertaken by the maintenance person for example, weekly fire alarm testing and water temperature checks. Repair and maintenance issues with the premises had however not been picked up and some of the fire safety arrangements were unsafe. This meant that the health and safety checks in place were ineffective in identifying risk.

We saw that some people's care records were in the process of being re-written. There was no formal evidence that prior to this taking place, people's needs, risks and care had been properly reassessed. We saw that the manager was involved in the re-writing of people's care plans. When we spoke with the manager at this inspection we found that they still lacked sufficient knowledge of people's needs and the care they required. We asked two visiting healthcare professionals if they thought the manager had a good knowledge of people's needs and care. Both said no. One healthcare professional said the manager "Talks a good talk but when you pin them down, no", they don't know about people's needs". This raised concerns

about the manager's ability to write accurate and up to date care plans for people who lived at the home.

The newly appointed nominated individual was also involved in writing new care plans for people who lived at the home. We found this concerning as they told us they had only been in post for approximately 5 weeks prior to our inspection. We found little evidence that they had any day to day involvement in or, knowledge of the day to day care of the people's whose care plans they were re-writing. This impacted on the quality and accuracy of people's care records. For example, one person had not eaten properly for several weeks and in the last ten days had not eaten a proper meal. Despite this, the care plan that had been rewritten by the nominated individual indicated that the person was eating and drinking normally. This was not accurate. It did not demonstrate that a proper review of the person's needs had been undertaken or that the person's day to day care records had been used to inform the person's new plan of care. This raised serious concerns about the reliability and validity of the process determined by the manager and nominated individual as the method by which care records would be improved.

Prior to our inspection, information of concern was reported to the Commission and the Local Authority that staff were being asked to complete care records including medication administration records in retrospect. In retrospect means that care records were completed 'after the fact' as opposed to at the time the person received their care. Information recorded about the people should be contemporaneous. This means that people's records should be written at the time of the event or as soon afterwards so that is possible to provide a chronological and accurate record of events.

During this inspection, we observed a staff member sitting with a pile of daily records at the end of their shift. We asked the staff member what they were doing. They told us that they were completing the full set of daily records for each person in the unit. We found this concerning. This was because the staff member completing the records was doing so in retrospect. This meant that people's care records were not completed at the time the care was provided. This meant they were not contemporaneous. It also raised concerns about the validity of these records as it was unlikely that the staff member completing these records had been involved in the provision of everyone's care. This meant there was a risk that the records were not accurately reflective of the care provided or the staff members who provided the care.

This was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014 as a contemporaneous record of each person and the care and treatment provided had not been made.

During our visit, we had concerns about the abilities of both the manager and the nominated individual to drive up improvements in the service. During our inspection, the manager was approachable but failed to demonstrate that they were aware of the seriousness of our concerns or the action they need to take to drive up improvements. Where concerns were raised, they failed to take accountability and gave various reasons for why concerns were not addressed and placed the blame on other staff members.

During our visit, the nominated individual presented inspectors with an updated action plan from the one previously agreed with the Commission. We saw that the nominated individual had changed all of the previously agreed deadlines for improvement from end of May to June 2017 to December 2017. This was because the original deadline for urgent improvements had not been achieved by the manager and provider. These changes had not been agreed with the Commission or the Local Authority. This raised concerns about their reliability and ability to commit to and achieve compliance with the regulations.

All of the examples above demonstrate that a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were no effective systems or processes place to ensure that

the service was safe, effective, caring, responsive or well led.

After the inspection we referred our concerns about people's care to the Local authority and the Clinical Commissioning Group. An urgent meeting was held after the inspection wherein actions were planned to mitigate the risks to people's health, safety and welfare going forward.