London and Manchester Healthcare (Deepdale) Limited

Finney House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Finney House is a residential care home providing accommodation for up to 96 adults, who require assistance with personal or nursing care needs. 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. At the time of the inspection, there were 77 people living in the home.

People's experience of using this service and what we found
Since the last inspection, there had been changes to both the management and staff team and an outbreak of Covid-19 had impacted on staff absence; this resulted in the use of high numbers of agency staff which had created further instability in the home. Permanent staff were being recruited with further recruitment ongoing. We found, sufficient numbers of staff deployed to meet people's needs and ensure their safety.

The provider's quality assurance systems, audits and action plans had improved but were still not sufficiently robust or embedded into the service as we found continued shortfalls around medicines management, care planning, incident reporting and record keeping that could place people at risk of not receiving proper and safe care. The senior management team were aware of the shortfalls and was taking appropriate action to improve. An updated action plan for improvement was in place. This reflected the shortfalls found, action being taken and timescales for action.

Some people's care records were well written and provided staff with clear guidance about people's needs whilst others were not sufficiently detailed. This could result in people not receiving the care they needed or wanted. Record keeping was inconsistent and records such as care charts for nutritional/fluid intake and pressure care were lacking in detail.

Risk assessments were carried out to enable people to retain their independence and receive care with minimum risk to themselves or others. However, records did not always provide clear guidance for staff about peoples care and support needs. There were shortfalls in the management of behaviours that challenge; care records were not sufficiently detailed and guidance for staff was not always consistent. This placed people at risk of avoidable harm because records of care did not provide clear guidance about peoples care and support needs and these were not consistently recorded. Records of accidents and incidents were not always fully completed or analysed to avoid reoccurrence. Some aspects of the management of people's medicines had improved. However, further improvements were necessary to ensure people received their medicines safely and when prescribed.

The management team were aware of where improvements were needed and needed time to embed systems to ensure they were effective. They provided us with an updated action plan dated 29 January 2021 to support actions being taken. The management team and staff had a clear understanding of their roles and contributions to service delivery. Staff told us there had been recent positive changes to the management team and more permanent staff had been employed, which had made a difference to staff morale. Staff told us they were being listened to and confirmed training was up to date and said they felt

supported.

People told us they felt safe living in the home and staff were kind and respectful to them. People looked comfortable and settled and we observed caring interactions. Relatives were confident their family members were safe and made positive comments about the care and support provided by staff. Staff understood how to safeguard people from abuse and report any concerns. Appropriate recruitment procedures ensured prospective staff were suitable to work in the home. People were protected from the risks associated with the spread of infection. The home was clean and odour free. We discussed some areas for improvement which had already been noted.

Communication with relatives had improved. Relatives were happy with the contact they received and said staff on the units were knowledgeable about their family members. They felt they were kept up to date and involved in decisions. Relatives were complimentary about how staff had helped them to maintain contact with their family members during the pandemic and more recently during the outbreak in the home. Relatives praised staff for the support they provided.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 15 December 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for two consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about care, management of medicines, staffing and infection prevention control. A decision was made for us to carry out a focused inspection to examine those risks.

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.

We found evidence the provider needs to make further improvements and embed them into practice. The provider is aware of where improvements are needed and has updated their action plan accordingly. Action was being taken to mitigate any risks. Please see the Safe and Well-Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Finney House on our website at www.cqc.org.uk.

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 monitor the service and continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified three continued breaches of the Health and Social Care Act (Regulated Activities) Regulations 2008 in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, and good governance.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

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 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
Two inspectors carried out the inspection visit. Two other inspectors worked remotely and carried out calls to staff. This was to be mindful of reducing potential risks linked to the number of people entering the service during the pandemic.

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 Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with CQC. An interim manager supported by the senior management team were providing oversight at this service. A manager, to be registered with CQC, is due to commence working from March 2021. There was a nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We considered feedback from the local

authority and professionals who work with and visit the service. We also spoke with the nominated individual.

The provider was not asked to complete a 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.

We used all this information to plan our inspection.

During the inspection
We spent two days on site and other time was used to collate and analyse evidence.

We spoke with 16 members of staff including registered nurses, agency nursing staff, unit managers, care staff and housekeeping and maintenance staff. We also spoke with the interim manager and members of the senior management team including the quality support manager and the head of business and customer relations.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection, the provider had failed to ensure service users received care and treatment in a safe way and there was a failure in assessing risks to the health and safety of those who lived at the home; including doing all that was reasonably practicable to mitigate any such risks. 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.

● Risk management plans were in place to guide staff on the action to take to mitigate the identified risks. These included; bathing, falls, personal care, skin integrity, mobility, moving and handling, nutrition, hydration and medicines. Records of the care provided were not always fully completed and could place people at risk of not receiving the right care. The provider was taking action to address this.
● Records were kept of accidents and incidents that occurred to people who used the service and to staff. However, these were not always fully completed or analysed to identify what happened, action taken or patterns or themes that could prevent future risk. This included responses to behaviours that might challenge the service. Records showed daily oversight of incidents had been introduced on each unit.

Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This is a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had carried out environmental risk assessments and equipment was safe and regularly serviced.

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.

● Care records, relating to supporting people who exhibit behaviours that challenged the service, were not sufficiently detailed and did not always reflect the persons current needs. There was no specific system in place to provide staff with a debrief or formal support after serious incidents occurred. This is important as it helps staff to discuss their feelings and assess if any learning from the incident could help improve the support provided.
● We were told physical intervention was not currently being used within the home. However, we saw care records that guided staff on the use physical intervention with some individuals and records of daily care from January that indicated its use. Systems in place for the oversight and response to these interventions were not sufficiently robust. The management team were aware of the shortfalls and new monitoring systems were being introduced; a recent audit showed there had been improvement in this area but actions needed to be further embedded.
● Prior to the inspection, we received concerns that people were not receiving the care they needed. Records relating to care provided such as positional change, fluid and food monitoring and weights were not always completed in enough detail. This could result in people not receiving the care and treatment they needed. We noted there was more oversight of this as care needs were highlighted at the daily meetings.
● There was a system to enable managers to have oversight of safeguarding incidents. This included whether the incident had been reported to the appropriate authorities. However, this system had not been fully effective as we found two incidents that did not clearly demonstrate the decision-making process. The local authority safeguarding team were currently making further enquiries into safeguarding concerns raised about individuals care and support.

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

● People told us they felt safe and were content with the care they received. People said, "It's alright; I am safe here" and "They are a good lot of staff, always someone around to help me when I need it." Relatives had no concerns about the safety of their family members. They said, "[Family member] is well looked after and safe and the staff know her well", "They are very kind and know how to look after her; they give her kindness, love and attention" and "I have a good rapport with staff. I find them to be very efficient and I feel [family member] is safe and looked after." We observed good interactions between staff and people; people were settled and looked comfortable.
● Records showed 46% of staff had received training in the Management of Actual or Potential Aggression (MAPA). This had improved since the last inspection; further training had been delayed due to the pandemic. This meant more suitably trained staff were available to support and guide staff.
● Management and staff understood safeguarding and protection matters and were clear about when to report incidents and safeguarding concerns to other agencies. Staff had access to appropriate training and to policies and procedures.

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.

● Prior to the inspection we were told people were not receiving their medicines and errors had been made. We found medicine administration records (MARs), in relation to the application of external creams and provision of supplement drinks, were not always completed by the person administering the medicine; this could result in duplication or omission. The management of medicines varied between units; we were told this was being addressed as part of the increased monitoring process.
● There were gaps in the recording of administered medicines, the recording of PRN medicines, and whether one or two tablets were given and ongoing tablet counts. Gaps in recording were being picked up but, in some cases, not until the monthly audit was completed. This meant there was a risk of people not receiving their medicines at the right time in line with their prescription. As part of the action plan, we noted weekly audits and peer checks were being introduced.
● We noted body maps had been introduced to support staff with the application of creams. They were not being used consistently but we saw this was being monitored. Records to support the safe use of medicine patches were in use.
● Disposal records had been completed by staff, but collections not signed by the pharmacist. We discussed the use of two signatures to improve safety when recording medicines for disposal.

People were placed at risk of potential harm, as medicines were not consistently managed in a safe way. This is a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Policies and procedures were available to all staff. Designated staff had received appropriate training to administer medicines and checks had been carried out on their competence.
● Regular and detailed auditing provided staff with clear feedback about the actions they needed to take to improve the management of people's medicines.

Preventing and controlling infection

At the last inspection, the provider failed to ensure people were protected from the risk of infection, including the transmission of Covid-19. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this aspect of regulation 12.

● Prior to this inspection, we were told staff were not using appropriate personal protective equipment (PPE). During our visit, we were assured the provider was preventing visitors from catching and spreading infections. All staff were observed to be wearing appropriate PPE during our visit.
● The provider was accessing testing and vaccination for people using the service and staff. The provider was promoting safety through the layout and hygiene practices of the premises and was making sure any infection outbreaks could be effectively prevented or managed. The infection prevention and control policy was up to date.
● Areas of the home were clean and odour free. We discussed stains to walls and carpets and were advised this had been noted and would be part of the redecoration programme.

Staffing and recruitment

At the last inspection, we recommended the provider sought advice and guidance from a reputable source about safe recruitment practices. We also recommended the provider developed a more accurate means for recording staffing rotas and shifts so that safe levels of staff could be determined and checked.

● There were safe systems for staff recruitment in place. Staff files contained the necessary checks to ensure fit and proper people were employed. There was a system for checking nurses were up to date and validated with the Nursing and Midwifery Council (NMC.)
● Staff told us there were enough staff to meet people's needs. Management and staff told us staffing levels were reviewed in accordance with the changes in people's dependency needs. Staff told us staffing levels were improving and the workforce was more stable. We observed sufficient staff on each unit to meet people's needs.
● Relatives told us they were happy with the staff. They told us staff were knowledgeable about their family member's care. Relatives made positive comments about the care and support provided by staff.
● Prior to the inspection, people raised concerns about the high use of agency staff and turnover of staff. Relatives commented, "They do use agency staff, but I see the same familiar faces" and "The use of agency is problematic; they are aware of this." Records, the management team and staff confirmed agency use remained high. However, we saw evidence action was being taken to address this issue and permanent staff were being recruited.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection, this key question was rated as requires improvement. At this inspection, this key question has remained the same. This meant the service management and leadership had not been embedded into the service and did not always support the delivery of high-quality, person-centred care.

Since the last inspection, there had been changes to both the management and staff team. Staff morale and permanent staff numbers had been low due to a recent outbreak of Covid-19 and the home had relied on high numbers of agency staff. This had created instability in the home, continued shortfalls in a number of important areas and an increased number of complaints. The management team and staff confirmed permanent staff had been recruited including unit managers and senior care staff; further recruitment was underway. A manager, to be registered with CQC, and a regional support manager were due to commence in March; this was key to improvement.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At the 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. This was a 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 remained in breach of regulation 17.

● The provider had governance policies and procedures in place to ensure people received safe quality care which achieved good outcomes for people. We found the provider's quality assurance systems, audits and action plans had improved but were still not sufficiently robust or embedded into the service. There was a wide range of daily, weekly and monthly quality assurance checks and audits in place. There was some evidence of analysis, follow up or lessons learned, however we found continued shortfalls around medicines management, care planning and record keeping that could place people at risk of not receiving proper and safe care. Accidents and incidents were not consistently analysed to identify action, patterns or themes that could prevent future risk. We saw evidence care and medicine issues were being discussed and actioned as part of daily walkarounds.
● Care plans were not sufficiently detailed or person centred. Some were well written and provided staff

with clear guidance about people's needs. However, others failed to accurately reflect the care and support people were receiving or that they required. This could result in people not receiving the care they needed or wanted. The management team told us additional care planning training had commenced for unit managers and this would be shared with unit staff.

● Record keeping was inconsistent, care charts for fluid intake and pressure care were lacking in detail. The management of incidents and behavior which challenged the service was not always properly recorded and records remained unclear. There was a system which prompted senior staff to check these records regularly. However, it was clear this was not used effectively as shortfalls were still evident. The management team assured us additional training was underway and records were being monitored more frequently as part of the auditing system.

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.

● The management team and staff had a clear understanding of their roles and contributions to service delivery and of the improvements needed. The action plan was kept under review. Staff told us there had been recent positive changes to the management team and more permanent staff had been employed; they said this had made a difference to staff morale. They felt supported and they enjoyed working in the home. Staff told us, "Staff seem happier and things are improving", "There has been low morale but changes to management team have improved this" and "The management team are trying hard to improve things but this takes time; we need a manager and permanent staff on the units."

● The management team would remain until the permanent manager was in place. They told us they would continue to have oversight of the service, provide support for staff and to carry out detailed checks and audits to ensure people received safe care and treatment.

● A recent staff meeting had been held and areas for improvement were discussed; further meetings were planned. Staff told us they were being listened to and their wellbeing had been checked regularly during the pandemic. They confirmed training was up to date and told us they felt supported.

● The provider understood the duty of candour and their responsibility to be open and honest when something went wrong. The management team and staff were open and honest with us during the inspection; they were aware of the shortfalls in service delivery and were happy to discuss improvements going forward.

● Staff said they were able to approach the management team and were confident appropriate action would be taken to respond to any concerns. They were confident about raising their concerns with outside agencies.

● Care records included information about people's equality needs and preferences. Most staff had received training in equality and diversity.

● People told us they were settled and happy living in the home and they were treated with respect. People looked comfortable and settled and we observed some caring interactions. Staff understood people's needs and preferences and said any care updates were made available to them on the handsets and during handover sessions.

● Communication with relatives had improved. Relatives said staff were knowledgeable about their family members and they were kept up to date and involved in decisions. Due to the Covid-19 outbreak, visiting restrictions were in place; relatives were complimentary about how staff had arranged regular phone calls and video/facetime with their family members. Resident meetings were suspended during the outbreak but would recommence each month.

At the last inspection, the provider had failed to notify us of an incident that had occurred in the service. This was a breach of regulation 18 (Notification of other incidents) of Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

- We found the provider had submitted notifications to CQC.

Working in partnership with others

- Records showed advice was sought from community health and social care professionals, when needed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people received care and treatment in a safe way and there was a failure in assessing risks to the health and safety of those who lived at the home. This is a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure people's medicines were consistently managed in a safe way. This is a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure service users were consistently protected from potential abuse, harm and improper treatment. This is a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 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. This is a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.