London and Manchester Healthcare (Deepdale) Limited

Finney House

Inspection report

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Date of inspection visit:
07 September 2020
08 September 2020

Date of publication:
15 December 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
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 specialises in providing care for people living with dementia.

People's experience of using this service and what we found
People were at risk of avoidable harm because they were not always supported by staff with the skills or experience to keep them safe. Staff had not received appropriate training and plans of care did not provide clear guidance about the management of one person's challenging needs. This exposed the individual to potential risks of abuse and improper treatment. This had not been adequately managed or escalated in line with safeguarding and duty of candour processes. We shared this with the local authority safeguarding team.

People's needs and choices were not always assessed to ensure their care, treatment and support was delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes. There were significant shortfalls in the management of behaviours that challenge. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests.

People and their relatives were not involved in planning their care and support, and therefore they did not always receive personalised care that was responsive to their needs. Care and support provided was not always accurately recorded.

Systems were either not in place or effective enough to support safe medicines management. Medicine Administration Records were not always completed by the person administering the medicine.

The premises were clean and well maintained throughout. However, people were not always protected from the risk of transmitting Covid-19 and other infectious disease. This was because we found a number of staff failed to comply with best practice guidance around the use of Personal Protective Equipment (PPE) and the processes to manage infection control were not robust.

We could not determine if there were always enough staff deployed on each shift, as the staff rotas were not clear or accurate. Recruitment process were in place, however there were some gaps in employment histories, which had not been explored further. We made a recommendation about recruitment practices and staff rotas.

Most staff members of the 16 we spoke with told us they could approach the managers of the home. However, others said they did not feel able to raise their concerns with the management team.

Systems were not fully in place to monitor and assess the quality of care provided. Action plans were not updated.

People were being treated with kindness and compassion. We saw some good interactions with those people who lived at the home and people were assisted in a gentle and respectful manner.

Some relatives spoke positively about the care provided. One family member told us, "They (the staff) are always smiling and seem happy". However, some relatives told us communication could be better. The provider had identified ways to improve communication with relatives moving forward.

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

Rating at last inspection
The last rating for this service was good (published 25 September 2019).

Why we inspected
We received concerns in relation to people's care needs, the management of medicines and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. 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.

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 infectious outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified three breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, and good governance. We also identified one breach of the Care Quality Commission (Registration) Regulations 2009, namely Regulation 18 Notifications of other incidents.

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?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement

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
The inspection team comprised of six inspectors, one medicines specialist inspector and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Only three members of the inspection team visited the service during the inspection. The other members of the inspection team reviewed evidence remotely that the provider had sent us during and following the inspection. 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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. 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 sought feedback from the local authority and professionals who work with the service. The provider had previously completed a provider information return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spent two days on site and the rest of our time was dedicated to collating and analysing evidence.

We spoke with 19 members of staff including the nominated individual, operations manager, registered manager, deputy manager, senior care workers and care workers. We reviewed a range of records. These included nine people's care records and multiple medication records. We looked at 11 staff files in relation to recruitment, training and supervision. A variety of records relating to the management of the service, including quality assurance audits were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- People were at risk of avoidable harm because they were not always supported by staff with the skills or experience to keep them safe.
- Care planning and risk assessments did not guide staff on how to effectively manage people's behaviours which could challenge the service.
- Robust systems had not been embedded for staff to review and learn from incidents in order to reduce re-occurrences. This led to repeated themes of people experiencing poor care and inappropriate treatment.
- Risk assessments did not always accurately reflect the care and support being delivered on a day to day basis, by staff. This included risks of falls, nutrition and hydration and skin care.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We observed staff responding well to an emergency situation and call bells were answered promptly.
- The premises were well maintained and provided a safe environment. Relatives felt their loved ones were safe living at the home.

Preventing and controlling infection

- People were not being safeguarded from the risk of transmission of Covid-19 and other infectious disease because the provider did not have robust control measures in place to highlight staff who were not following their infection prevention and control processes.
- Some family members told us they had seen staff members not wearing face masks during window visits. We saw the Facebook page for Finney House which showed staff members wearing masks inappropriately or not wearing them at all, despite being in close contact with people who lived at the home.
- On the first day of our site visit we also saw a number of staff who demonstrated non-compliance with use of essential (PPE). Some staff were not wearing facemasks whilst others were wearing them inappropriately and not in line with best practice standards. We raised our concerns with the management team. On the second day of our site visit we found this area of concern had improved.

We found no evidence to demonstrate people had been harmed by unsafe infection control practices. However, people were placed at risk of harm because systems and practices were ineffective. Some staff were failing to follow best practice guidance and infection control training around using PPE appropriately, at a time when lives are at serious risk during a national pandemic. This increased the risk of infectious

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

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured that the provider was accessing testing for people using the service and staff.

Using medicines safely
● People were exposed to risk of harm, as systems were either not in place or effective enough to support safe medicines management.
● Medicine Administration Records were not always completed by the person administering the medicine.
● Body maps were not always used by staff to record where a medicine patch had been previously applied.
● Fluid thickening regimes in order to aid swallowing were not being recorded and care plans did not provide staff with clear guidance about how to administer some medicines.

We found no evidence to demonstrate people were affected by unsafe medicine practices. However, people were placed at risk of potential harm, as suitable arrangements were not in place for the safe management of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The provider and registered manager failed to ensure people were protected from abuse. There was no system in place or oversight to ensure incidents of potential abuse were reported.
● Incidents which exposed people to risk of potential harm and improper treatment had not always been reported under safeguarding procedures. One person was being unlawfully restrained by staff without the essential skills to do so in a safe and ethical way.
● Care plans did not provide staff with clear guidance about how best to support people when they were receiving support, distressed or anxious, to ensure the least restrictive options of support were provided. Best interest decisions had not been made in relation to the management of actual and potential aggression.
● The registered manager told us there was always someone on shift who is trained in the Management of Actual or Potential Aggression (MAPA). However, records showed only seven staff members, including two part time staff had completed this training out of a team of 95 care staff. Therefore, it was difficult to determine if appropriately trained staff were deployed on each shift to always support people with safe holding techniques. Staff were concerned about hurting people while carrying out these holds as they had not received sufficient training.

People had been exposed to potential 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.

Following our inspection, the management team organised the relevant training modules for the staff team and confirmed the plan of care had been appropriately updated.

Staffing and recruitment

● We looked at the personal records of eleven staff members and found eight to contain all relevant information. However, there were some gaps in three of these records in relation to recruitment practices.

We recommend the provider seeks advice and guidance from a reputable source about safe recruitment practices.

● We observed sufficient staff to meet people's needs. The management team told us that staffing levels were reviewed in accordance with the changes in people's dependency needs.
● It was not possible to determine whether there was always enough staff on duty to meet people's needs as records were not clear or accurate. Staff rota's and records of who had completed shifts were not well maintained and failed to provide assurance that staffing levels were safe.
● Comments from relatives and staff varied in relation to staffing levels and the use of agency staff. Some felt enough staff were deployed, but others thought the staffing levels could be increased.

We recommend the provider develops more accurate means for recording staffing rotas and shifts so that safe levels of staff could be determined and checked.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider's quality assurance systems, audits and action plans were not always effective, as shortfalls around medicines management, staff training, care planning, recruitment and infection prevention and control practices were identified.
- The management of incidents and behaviour which challenged the service was not always properly recorded. The management team assured us this would be dealt with and staff would receive additional training.
- Record keeping was poor with examples of records not being accurate, with omissions or not being updated. For example, care charts for fluid intake and pressure care were lacking in detail and some large gaps were evident. The management team told us they were aware of these failings and a system had been implemented, which prompted senior staff to check these records regularly. However, this was not effective, as shortfalls were still evident. The management team agreed to review the system in order to make improvements in this area.
- Staff did not have access to enough devices to input care information into the computerised care system. This was raised with the management team, who assured us additional devices had been sourced. However, more than two weeks later, when asked, the registered manager told us these devices had still not been obtained.
- Systems for supporting staff including training, inductions, supervision and appraisals were not always implemented to support the delivery of safe and effective care.
- The training matrix provided during the inspection was not up to date with accurate training information.

There had been a failure 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.

- The registered manager had submitted notifications to the Care Quality Commission. However, we found a recent safeguarding referral, had not been notified to CQC.

This was a breach of regulation 18 (Notification of other incidents) of Care Quality Commission (Registration) Regulations 2009. This matter is being dealt with outside of the inspection process.

● The registered manager told us they had contacted staff regularly during the pandemic, particularly those self-isolating or shielding to check they were alright. One staff member told us the manager had offered to do some shopping for them during self-isolation. The registered manager said they had contacted staff by video calls, group huddles, telephone and zoom, but had not recorded these conversations. However, they did supply us with evidence of text support for some staff members.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People did not always receive person centre care and support. The plans of care we saw varied in quality. Some were well written, person-centred documents, which provided the staff team with clear guidance about people's needs and how these were to be best met. However, others failed to accurately reflect the care and support people were receiving or that they required.

● Some poor care practices were being carried out, of which the registered manager told us they had not been made aware.

● Feedback from the 16 staff members we spoke with outside of the management team was mixed when referencing the management of the service. Whilst most staff we spoke with said they enjoyed working at the home and were supported well. Others told us they didn't feel supported by the management team or did not consistently feel able to raise their concerns both internally and externally to other organisations.

● Communication with relatives could have been improved during the covid-19 pandemic. Some relatives said they felt they were not getting regular updates about their loved ones, unless something had gone wrong. One relative told us communication was 'appalling and feels excluded' and they were not involved in decision-making. The provider told us that a survey had been sent to all relatives and a good response was received with many positive comments. However, they agreed improvements could have been made in communication with relatives during the pandemic and had identified how this could be achieved moving forward.

● The provider had failed to create a culture to actively seek and act on feedback from people using the service, those acting on their behalf and from staff. Robust quality assurance systems had not been properly embedded into the overarching structure of the service, so the provider could continually evaluate the service and drive improvement. People were at risk from a closed culture.

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

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 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. The provider failed to ensure people's medicines were consistently managed in a safe way. The provider failed to ensure people were protected from the risk of infection, including the transmission of Covid-19.

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.

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 ensure robust quality assurance systems had been properly embedded into the overarching structure of the service.