Lotus Care (Finch Manor) Limited

Finch Manor Nursing Home

Inspection report

Finch Lea Drive
Liverpool
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Finch Manor is a care home providing personal care for up to 89 older people. The home is purpose built and the accommodation is in five units over one floor. One of the units within the home is designed to support people living with dementia and one unit is designed to support people with nursing needs. At the time of the inspection there were 69 people living at the home.

People's experience of using this service: People living in the home told us they felt safe. Most people felt there were enough staff to meet their needs. However, two people and some relatives told us there was not always enough staff and during these times response to call bells was slow. During the inspection we observed staffing levels to be adequate, with staff able to support people in a timely way.

People were not always receiving their medicines safely. Staff were not following the service medication policy when administering medicines. Staff had not been appropriately checked for competence with administering medication.

The service was not compliant with the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS). People had not always had an appropriate assessment when they were deemed to lack capacity for a specific decision. People were being restricted without the lawful process being followed.

Care plans were inconsistent and lacked detail.

The service failed to ensure staff were suitably trained and supervised in their roles.

Risk assessments were not fully completed or adequate for the management of people's risks. Environments risks were also not well managed. We found medicine rooms, maintenance rooms and other areas that posed a danger to people, unsecured. We also found concerns with hot water temperatures. These issues were addressed during the inspection.

People told us they had enough to eat and drink. We saw snacks being offered throughout the day. However, we raised concerns with the lack of drinks offered throughout the day. We also raised concerns with the lack of monitoring for people's fluids. Although fluid consumption was recorded in people's notes, there was no oversight of this to ensure people were having adequate fluids. The provider has since put new governance systems in place to address this.

Safe recruitment practices were in place for staff. People were complimentary about the staff that supported them. We observed caring, familiar interactions between staff and people living in the home.

Standards of cleanliness were poor in some parts of the home. Some communal areas appeared dusty and dirty. The home was in need of a refurbishment as it was 'tired' looking in parts..

The service did not have robust and effective systems in place to monitor, assess and improve the safety and quality of service being provided. Management oversight of the service was inadequate.

You can see more information in the Detailed Findings below.

Follow up: Following the inspection, we asked the provider to detail how they planned to deliver the required improvements. We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme.

Rating at last inspection: This is the first inspection for this provider.

Why we inspected: This was a planned comprehensive inspection.

Enforcement: Please see the 'action we have told the provider to take' section towards the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always Effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Inadequate**

Finch Manor Nursing Home

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: This inspection took place on 5 and 7 March 2019 and was unannounced on the first day. The team consisted of two inspectors, one specialist adviser for medicines and two experts by experience (ExE) on the first day. An ExE is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day, the inspection was carried out by one inspector.

Service and service type: Finch Manor 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 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.

Notice of inspection: Day one of the inspection was unannounced. The provider knew we were returning for the second day of the inspection.

What we did: Before the inspection, we reviewed information we had received about the service. This included details about incidents the provider must let us know about, such as safeguarding events and statutory notifications sent by the provider. A notification is information about important events which the provider is required to tell us by law, like a death or a serious injury. We sought feedback about the service from the local authority and other professionals involved with the service. The provider had completed a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help inform our inspection.

During our inspection we observed the support provided throughout the service. We completed the short

observational framework tool (SOFI) to help us to assess if people's needs were appropriately met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five people living in the home, nine relatives and four care staff. We also spoke with the registered manager, deputy manager, regional director, the chef and activities co-ordinator. We looked at records in relation to people who used the service including five care plans and fifteen medication records. We observed the administration of medicines. We looked at records relating to recruitment, training and systems for monitoring the quality of the service provided.

Details are in the Key Questions below.

The report includes evidence and information gathered by the inspectors, the specialist advisor and Experts by Experience.

Requires Improvement

Is the service safe?

Our findings

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

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

Using medicines safely
• People did not always receive their medicines as intended. Remaining stock balances did not always tally with the number recorded as administered. There were signatures on the medicines administration record (MAR) when the medicine was still in the trolley.
• Records were not sufficient to keep people safe. Some people did not have a photograph or details to identify them in their MAR, which meant there was a risk they would receive the wrong medicine. Staff did not record the time that medicines were given, so there was no assurance that these were given safely.
• There were insufficient plans when people were given their medicines covertly, hidden in food or drink. When documentation was present, it was incomplete or out of date.
• Medicines were not stored safely. Staff had recorded when temperatures on medicines fridges went out of range but no action had been taken. Waste medicines were also not securely stored.
• Staff did not always record the date when opening medicines. We found out of date medicine that was still in use.
• People's prescribed thickener was not managed well. Information how to thicken drinks was not always available to staff. Staff did not record the amount used when added to drinks so there was no evidence that this was done correctly.

Medicines were not administered safely, or in line with best practice guidelines. This put people at risk of harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• Checks were in place to monitor health and safety concerns in the home. However, there was a lack of oversight of these. We found hot water temperature checks had been completed monthly, but had not been checked by the registered manager since September 2018. There were three peoples rooms whose hot water temperature had exceeded safety recommendations for at least three months. This placed these people at risk of avoidable harm. This issue was addressed immediately during the inspection
• People's risk assessments had not been completed effectively or fully. Some people had no risk assessments completed.
• Risks to the environment had been assessed to ensure people were kept safe from avoidable harm. However, during a tour of the home, we found two rooms unsecured. These rooms contained potentially dangerous equipment. We raised this with the registered manager. On the second day of the inspection, locks had been fitted to these doors to ensure they were secure.

The lack of appropriate risk assessments and plans in place for people and the environment, meant people

were placed at risk of avoidable harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had systems in place to ensure equipment was safe and fit for purpose.
• Personal emergency evacuation plans (PEEPs) were in place for people. One person's PEEP was not reflective of their needs. We spoke to the registered manager about this who told us this would be addressed immediately.

Staffing and recruitment
• Most people living in the home that we spoke with told us staffing levels were "good". Comments included, "I feel safe here because staff are always about" and "There is always enough staff about, when I use my call bell they always come quickly." Relatives we spoke with agreed, saying, "When I visit there are plenty of staff about and always a member of staff in the lounge"
• However, two people living in the home felt there were times that staffing levels were too low and they sometimes waited a long time for a response to their call bell. During the inspection we observed staffing levels to be adequate.
• Safe recruitment processes were not always followed. Checks to ensure staff were fit and safe to carry out their role had been completed. However, one person's checks highlighted that a further risk assessment should have been carried out. This had not been completed. We raised this with the registered manager who told us they would address this immediately.

Preventing and controlling infection
• Standards of cleanliness were poor in some parts of the home. Some communal areas appeared dusty and dirty.
• Some of the baths in the home had worn down to the enamel, preventing effective cleaning of that area.
• People we spoke with felt the home was clean. Comments included, "The home is lovely and clean and my bedding is always fresh and clean" and "The home is clean but I don't leave my room. My bedding is changed weekly and my room is cleaned every day."
• Staff told us they understood and followed infection control procedures. One staff member told us, "We always wear gloves and aprons."

Systems and processes to safeguard people from the risk of abuse
• People and their relatives told us they felt the home was safe with comments including "I feel safe here because staff are always about," "I feel safe; the staff are all good staff, not one I can say isn't," "I do feel safe. I was put at ease from the moment I arrived" and "I feel my relative is 100% safe and [the person] has not had any falls since coming into the home."
• Staff understood what was meant by abuse and were confident about how to report safeguarding concerns. However, training records showed not all staff had completed necessary training.
• The registered manager kept a record of safeguarding incidents that had occurred. Incidents were dealt with appropriately and action was taken to minimise future incidents occurring.
• A whistleblowing policy was in place and staff were aware of the procedures to follow with regards to this.

Learning lessons when things go wrong
• A system was in place to monitor any incidents or accidents which occurred. However, the information regarding these incidents was not fully effective for monitoring trends and using information for learning. The provider showed us new audit documents that would be used after the inspection to ensure learning from incidents was used to improve the quality of the service.
• Appropriate actions were taken following incidents, such as seeking medical advice, and referring to other services for further support, such as the falls team. However, care plans were not always updated with the

information.
• The home did not demonstrate effective learning from incidents.

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

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• Mental capacity assessments had not always been completed for people when needed.
• There was no evidence best interest's decision meetings had taken place for some people who had been assessed as not having capacity.
• Consent from people had not been appropriately sought, in line with MCA (2005). The registered manager told us they would book MCA training for staff, and review all care files and consent forms.
• Some people in the home were restricted of their liberty. The appropriate Deprivation of Liberty Safeguards (DoLS) had not always been applied for. One person had a DoLS in place but this had expired and not been reapplied for.

The service failed to act in accordance with legislation regarding the Mental Capacity Act 2005. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• Training records we saw showed not all staff had completed training necessary to support them in their role.
• Twelve staff were permitted to administer medicines to people in the home, however records demonstrated that only one had undertaken medicines administration competency in the last 12 months. This was not in line with the home's medication policy or national guidance.

There were ineffective processes in place to ensure training for staff was completed in line with national guidance. This is a breach of Regulation 18 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff received support through one to one sessions. However, these were inconsistent. Staff told us they did feel supported and could speak to the registered manager anytime.
• New staff completed an induction when they started working at the service. This included the completion of 'shadow shifts'. Staff told us they felt the induction was good and prepared them adequately for working at the home.

Supporting people to eat and drink enough to maintain a balanced diet
• Information regarding people's nutrition and hydration needs was inconsistent. Some care plans recorded this information, others did not.
• Some people had health conditions that meant they needed to drink 'adequate' amounts of fluid. These care plans did not record what was adequate for the person. The registered manager told us the care plans would be reviewed and updated with more specific information. There was also a lack of evidence that fluid consumption was monitored to ensure people were receiving adequate amounts.
• We raised concerns regarding a lack of drinks offered to people. During two observations of different dining rooms, we observed people not being offered drinks. Some people had drinks they had been given earlier in the day, but others had no drink. We raised this with the registered manager who agreed to address this immediately.
• People told us they were happy with the food. Comments from people and their relatives included, "The food is fine, I choose in the morning what I want for lunch and dinner. I can always say if I don't like something and the chef would give me something else," "Plenty of choice with food and it's ok and adequate" and "There's a good variety of food. I can ask for alternatives to the options on the menu."
• We observed snacks being offered in the day. People told us they could eat something when they chose to.
• We could see a menu was available each day so people were able to choose what they wanted to eat in advance.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support
• People's needs were assessed before admission to service. Care plans had been developed from these assessments. However, some care plans lacked detail.
• Some people had not had their choices and preferences regarding care recorded.
• The service worked with other health and social care professionals to help ensure people's healthcare needs were met. We saw evidence that appropriate referrals had been made.

Adapting service, design, decoration to meet people's needs
• Parts of the home were tired looking and in need of re-decoration.
• There were signs around the home to support people to locate different rooms, such as the lounge and bathrooms.
• We could see some areas of the home had been decorated to meet the needs of people living with dementia. We spoke with the registered manager about changing colours of the doors to support people finding their rooms. We were told there were plans to paint people's doors the same colour their front doors on their houses were painted.
• Some rooms had the person's name and photos of themselves on the door, other people had chosen to personalise their room with photographs.
• Equipment was in use to support people to move around the house independently.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Supporting people to express their views and be involved in making decisions about their care
• Resident meetings were held, although these meetings had been 'sporadic'. The registered manager told us more regular meetings were being planned. Records showed that people were asked their opinions during the meetings and whether anything could be improved. We saw that action was taken based on this feedback.
• A service user guide was available to people. This provided information regarding what the service provided and what people could expect, to help them make decisions regarding their care. This guide could be printed in different formats to support people's communication needs.

Respecting and promoting people's privacy, dignity and independence
• Relatives told us they felt staff protected people's dignity and privacy. One comment was "They are always respectful and knock before they enter my room."
• Staff clearly described how they protected people's dignity and privacy, including closing doors and curtains when providing personal support and helping people to remain covered with towels.
• Records regarding people's care and treatment were mostly stored securely. However, on one occasion we found people's care files not securely stored in an unlocked filing cupboard within an unlocked office. We spoke with the registered manager about this who assured us the cupboard was usually locked.

Ensuring people are well treated and supported
• People told us staff were kind and caring and treated them with respect. Comments included, "I love the staff who look after me, they are marvellous. They are kind and patient with me and nothing is too much trouble," "Yes, the staff are great, we get on really well. The staff are caring and kind" and "The staff are all kind and listen to me."
• Relatives we spoke with agreed and their comments included, "They [staff] are very kind and respectful to people" and "The staff are very caring."
• We observed positive, familiar interactions between staff and people living in the home throughout the inspection and staff spoke warmly of the people they supported.
• Relatives told us they felt welcomed and could visit anytime they wanted.
• Relatives told us communication between them and the home was good. We were told relatives were kept well informed of any incidents with people. This was a source of comfort for people we spoke with.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Care plans we saw were not detailed enough to provide effective care to people. However, as staff knew people well, they could meet their needs without the detail in the care plan. We spoke with the registered manager about this who told us care plans would be reviewed and updated immediately.
• There were no care plans for people with specific physical health conditions, such as epilepsy. Although we could see appropriate care was being provided, this was not documented appropriately.
• Care plans did not always reflect people's current needs. Care plan reviews were recorded, but every review we saw stated 'no changes'. We saw some care plans were needs had changed, but this was not reflected accurately.
• Some care plans detailed people's preferences, likes and dislikes. This meant they were supported in line with their wishes and needs. Other care plans we saw did not include information about people's likes and dislikes. However, it was clear from our observations that staff knew people well, and could personalise their care. We saw staff asking people their preferences whilst supporting them.
• People told us they enjoyed some of the activities, but would like to go out more.
• People we spoke with told us staff knew them well.

Improving care quality in response to complaints or concerns
• A complaints system was in place and displayed in the service. The complaints log contained both complaints from people using the service and relatives. However, we found some complaints had not been responded to promptly.
• People and their family members told us they felt confident to be able to raise any concerns they had with the management.

End of life care and support
• There were no end of life care plans in people's files. We were told the home were not supporting anyone with end of life care at the time of the inspection.
• Staff training was not fully complete for end of life care. Staff did tell us they would feel comfortable supporting people at the end of their life.

Inadequate

Is the service well-led?

Our findings

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• There were systems in place to assess and monitor the quality and safety of the service. However, the oversight from the provider and manager had not been effective at identifying concerns found at this inspection.
• Incidents had not been fully analysed to provide effective learning.
• Staff had not completed necessary training and medicines competencies were out of date. There was no effective system in place to monitor this.
• There was no effective oversight of aspects of people's care. A DoLS had expired and not been re-applied for. Mental capacity assessments were either missing, or completed inappropriately. Consent to care and treatment was not appropriately recorded.
• When people's needs had changed this had not been reflected in the care plan, and the care plan review stated 'no changes'. This had not been picked up in care plan audits.
• The provider had failed to act on recommendations from two care plan audits. Issues identified at these audits completed in July 2018 and January 2019, were still evident at this inspection.
• We saw medicines audits were not completed in line with the service policy. These audits failed to identify concerns found at this inspection.
• There was a lack of appropriate planning for the home. Concerns identified had not been appropriately addressed because of this.
• The registered manager and staff told us they understood their roles and responsibilities within the service. However, these roles were not always being completed in line with their responsibilities.

Systems were either not in place or fully embedded to demonstrate safety and quality was effectively managed. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

• CQC had been notified of all incidents that had occurred within the home as required.
• Policies and procedures were in place, including disciplinary processes. This helped to ensure staff were aware of the expectations of their role and were held accountable for their actions.
• Most people living in the home told us they knew who the manager was and would tell them if they had any concerns.
• Staff told us they felt supported in their roles. Comments included, "[The manager] is approachable, can talk to them anytime," and "It's a very open culture. Can get any support needed any time."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

• Systems were in place to gather feedback from people. These included surveys and meetings as well as complaints and compliments processes. However, we found complaints had not always been responded to promptly. We also found relatives meetings were irregular. Relatives had asked for more regular meetings, but this had not been actioned. We were told there was a schedule of meetings in place for 2019, with meetings taking place every two months.

• Records showed staff had not received regular supervision. However, staff told us they felt they could speak to the manager any time and they felt supported in their roles.

• When referrals to other services were needed, we saw that these referrals were made.

Planning and promoting person-centred, high-quality care and support

• People provided positive feedback regarding the quality of the care they received. People told us staff were caring and looked after them well.

• Staff told us they felt listened to and that the registered manager was approachable.

• Most staff we spoke with told us they worked well together as a team to deliver high standards of care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not acting in accordance with the Mental Capacity Act (2005) and the associated Deprivation of Liberty safeguards (DoLS).

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 Medicines were not administered safely or in line with best practice guidance. Risks to people and the environment were not well managed.

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 Systems and processes to monitor the quality and safety of the service were inadequate. Lessons from incidents were not shared, or used to improve practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The service had not ensured staff were appropriately trained and supervised in their role.