Lotus Care (Finch Manor) Limited

Finch Manor Nursing Home

Inspection report

Finch Lea Drive
Liverpool
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21 November 2023

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Finch Manor Nursing Home provides accommodation for up to 89 people who need help with nursing or personal care. At the time of the inspection 82 people lived in the home. The majority of the people living in the home lived with dementia or other complex health need.

People's experience of using this service and what we found
The last 5 CQC inspections of the home have continually identified serious concerns with the safety and quality of the service provided for people. There continued to be multiple breaches of the regulations which continued to place people at significant risk of avoidable harm.

People needs were still not adequately assessed or met, with significant gaps and failings in the care they received. Clinical care was ad hoc and poorly delivered which meant risks to people's health were not always picked up and addressed. Care was not person centred, did not meet their individual needs, or protect their dignity.

Accidents and incident of a similar nature kept repeating. This indicated that the system in place to learn from and prevent injuries, care failures and safeguarding events happening again was not robust. This meant people continued to be exposed to preventable harm.

Medicines were not managed safely. People did not receive the medicines they need to keep them and did not receive them in a safe way to prevent medicines related harm. Diabetes management was poor. Insulin designed to control blood sugars was administered without the relevant checks in place to ensure it was safe to do. This placed people at serious risk of harm.

There was no safety equipment in place to help people clear their airways in the event of a choking episode and not all staff had completed first aid training.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. People's consent was not sought in line with the principles of the Mental Capacity Act 2005.

Satisfactory pre-employment checks were not always completed when staff were recruited to work in the home. This meant the provider could not be assured they were suitable to work with vulnerable people.

Staffing levels were not safe and did not ensure people's needs were met. The provider relied heavily on agency staff to staff the service. People told us agency staff did not always know what their needs were or how to support them. One person told us, "My heart sinks if it's ad hoc agency staff. Some don't speak English well, so don't understand my needs and what I'm asking for". Everyone we spoke with said that there were not enough staff on duty. Some people said they waited a long time for staff to come when they

pressed their call bell for help.

Systems in place to monitor the quality and safety of the service were not effective and did not ensure risks to people's health, safety and welfare were identified and managed. Managerial and clinical oversight by the provider and registered persons was not thorough and risks to people remained.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 17 August 2023).

At this inspection, we found that the quality and safety of the service continued to be inadequate. Multiple breaches of the regulations were found, resulting in a continued rating of inadequate. At this inspection, breaches of regulations 9 (Person centred care); 11 (Need for Consent); 12 (Safe care and treatment); 17 (Good governance); 18 (Staffing) and 19 (Fit and proper persons) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were found.

The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

Why we inspected
This inspection was prompted by the inadequate rating given at the last inspection. We also had concerns about a number of safeguarding incidents reported to us by both the provider and the Local Authority which raised concerns about the safety of people's care and the management of the service. As a result, we undertook a comprehensive inspection of the service.

Enforcement
We have identified breaches in relation to the safety of people's care, assessment and risk management, accident and incidents, the management of medicines, the implementation of the Mental Capacity Act 2005, staffing levels, staff recruitment, staff training, staff supervision, the delivery of person centred, responsive care and the overall governance of the service.

Immediately after the inspection, we asked the provider to submit an urgent and immediate action plan for improvement. The local authority were also informed about our concerns to ensure people were safeguarded from potential harm.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work alongside the provider and Local Authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not caring.	**Inadequate**
Is the service responsive? The service was not responsive.	**Inadequate**
Is the service well-led? The service was not well led.	**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 (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 Health and Social Care Act 2008.

Inspection team
The inspection was undertaken by four inspectors, a Specialist Advisor and an Expert 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.

Service and service type
Finch Manor Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Finch Manor Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with CQC to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection, there was a manager in post, but they were not registered with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with the Chief Executive Officer/Nominated Individual, manager, area manager, clinical director, interim manager, 2 unit managers, 2 nurses, 2 senior care staff, 2 care assistants, the chef, and the maintenance officer. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with 4 people who lived in the home and 6 relatives, about their experience of the care provided.

We reviewed a range of records. This included 12 people's care records and multiple medication records. We looked at 4 staff files and a selection of agency profiles in relation to safe recruitment and a variety of records relating to the management of the service.

After the inspection visit.
We continued to seek clarification from the provider to validate evidence. We continued to review evidence in relation to people's care, and the management of the service. We also liaised with the local authority to share information about the service and our inspection.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection, the rating for this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

At our last inspection effective systems were not in place to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

At this inspection the provider had failed to assess, monitor, and mitigate; the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act

Assessing risk, safety monitoring and management
- People's needs and risks were not accurately identified or planned for. Staff lacked clear and up to date information on people's needs, risks and the care they required.
- People's medical needs were not clearly described, and people did not receive the nursing care they needed to maintain their physical well-being.
- Wound management was inadequate. People's wounds were not assessed or cared for appropriately to prevent further skin breakdown or infection. Catheter and continence care, nutritional support and other aspects of basic care were not provided consistently or monitored effectively to prevent harm.
- Some people had swallowing difficulties which placed them at risk of choking. There was no anti-choking equipment available for staff to use to clear people's airways in the event of a choking incident.

Learning lessons when things go wrong Systems and processes to safeguard people from the risk of abuse;
- Accident and incidents of a similar nature regularly reoccurred. The system in place to learn from and prevent accidents and incidents was ineffective. Staff had not acted on any safety recommendations made to mitigate further risk.
- Allegations of possible abuse were appropriately reported. However, incidents of neglect were not always reported to CQC as required. This meant we did not have true picture of the amount of serious and significant failings in people's care.
- Visitors to the home were given the security codes to freely access the building and all areas of the home including people's bedrooms. There was no-one monitoring this for fire safety purposes or, to ensure that people living in the home were protected from unwanted visitors and the risk of possible abuse. We spoke with the chief executive officer about this and on the second day of inspection, action had been taken to address this.

Using medicines safely
At the last inspection, medicines management was unsafe. This was a breach of Regulation 12 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 this regulation.

● Medicines were not always stored safely and there was no effective system in place to ensure medicines requiring cold storage were stored at the correct temperatures.
● Some people's medicines had changed following discharge from hospital or a medical appointment, but these changes were not adhered to. This meant people received too many medicines.
● There was no effective system in place to ensure medicines and creams prescribed 'when required' (PRN), were given safely. This placed people at unnecessary risk of avoidable pain, anxiety and discomfort.
● Some people were not given the medicines they need to keep them safe and well because the home had run out of their medicines and had not re-ordered them in a timely manner.
● Diabetes was not safely managed. People's Insulin was administered without the required blood sugar checks to ensure it was safe to do so.
● People prescribed time sensitive medicines did not always receive them at the correct times or with a safe time interval between doses. This can have a serious impact on people's health and quality of life.

Risks to people's health, safety and welfare were not adequately assessed or mitigated to prevent serious avoidable harm. No robust action had been taken to learn from and prevent accident and incidents reoccurring, including incidences of neglect. The management of medicines was also unsafe. This failings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At the last inspection, staff recruitment and staffing levels were not safe. This was a breach of Regulation 18 and 19 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 these regulations.

● Not enough staff were on duty to meet people's needs and keep them safe. This was especially a concern at night. Everyone we spoke with confirmed this. One person told us, "They don't come if you press the bell. I wanted to sit out in my chair yesterday and rang the bell. They didn't answer for ages and then said they were too busy. Things are too much trouble for them". A relative told us, "There are not enough staff on at times. There are many residents here who are in bed and need staff to assist them. There aren't enough to respond if more than two people need help".
● The provider relied heavily on agency staff to operate the service. Not all of the agency staff had staff profiles in place for the manager and provider to be assured of their skills and abilities.
● Satisfactory pre-employment checks were not properly carried out when staff were recruited to work in the home. This meant the provider could not be fully assured they were suitable for their job role, and safe to work with vulnerable people. For example, gaps or discrepancies in previous employment were not always investigated and resolved.

Staffing levels were not always safe or sufficient. Safe recruitment practices were not always adhered to. This was a continued breach of Regulations 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection
At our last inspection effective systems were not in place to prevent and mitigate risks of infection control. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, enough improvement had been made and the

provider was no longer in breach of this part of the regulation.

● Improvements to the environment and its cleanliness had been made. During our visit the home was adequately clean.
● There were cleaning schedules in place to guide and monitor cleaning practices and personal and protective supplies for staff to use, to minimise the spread of infection.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection, the rating for this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

At the last inspection, effective systems were not in place for the assessment and ongoing review of people's needs. This placed people at risk of harm. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement has been made at this inspection and the provider remained in breach of this regulation.

● People's needs, risks and choices were not adequately assessed, or care planned. Care was not always safe and medical advice was not always sought or acted upon in a timely manner when people needed help.
● A weekly multi-disciplinary meeting was set up with staff and others professionals to discuss changes or concerns about people's needs and care. Staff attending these meetings did not always come prepared, a manager rarely attended and the provider's commitment to the purpose of these meetings was poor. A relative also told us, "They are supposed to have monthly meetings with us and the GP. I came in for the meeting but it didn't happen".
● Nursing care was poorly delivered and there was a lack of any effective clinical oversight of the nursing care people received. This meant significant shortfalls in people's care were not identified and people continued to be exposed to the risk of avoidable harm.

Effective systems were still not in place to ensure people's needs and choices were met. People's care did not support them to live healthy, fulfilled lives with access to appropriate healthcare and support. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff lacked clear information about people's nutritional needs and people did not always receive the right diet or sufficient amounts of food and drink to mitigate the risk of malnutrition or dehydration.
● People's intake was not accurately recorded and there was little evidence of clinical or managerial oversight to monitor this or evidence of any effective action taken when people's intake was poor. A relative told us, "[Name of person] is underweight. I've asked for them to have some Ensure which they have had before. I've been waiting for 3 weeks and still no answer, they tell me it's the GP and SALT who are holding things up, but meanwhile [Name of person] is losing weight".

● We saw that one person's cultural dietary needs were respected. However, another person told us, "I like spicy food and sadly, the chef doesn't cater for my likes. The chef sent up a corned beef sandwich, which was dreadful". A relative told us, " I bring food in for [Name of person] because he doesn't always like the food here". A staff member also said, "The food is ok. We have no communication with the kitchen, I'm not sure how far I go to offer alternatives or what they are".

People's nutritional needs, risks and care were not assessed or delivered to mitigate risks to their health and wellbeing. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
During our last inspection we found that people's right to consent to their care in accordance with the Mental Capacity Act (MCA) was not respected. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was remained in breach of regulation 11.

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 MCA 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 when this is in their best interests and legally authorised under the MCA. 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 appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Information about people's ability to understand and communicate decisions about their care was contradictory and unclear. This was confusing for staff to understand and increased the risk of people's rights not being respected.
● When there were concerns about a person's capacity to consent to a specific decision, mental capacity assessments had not always been undertaken. Best interest decisions had also not been made with the involvement of relevant people.
● Where people's capacity impacted on their ability to take important medicines, a covert medicine care plan had been put in place, to allow staff to lawfully hide medicines in food and drink. However, these care plans were not always adhered to in the person's best interests.

People's legal right to consent to and make decisions about their care and treatment had not been supported in line with the MCA. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
At our last inspection effective systems were not in place to ensure people's care was delivered by appropriately trained, skilled and experienced staff. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was remained in breach of regulation 18.

● Some staff had not completed sufficient training to do their job role. For example, 57% of staff had not completed MCA training, 43% had not completed dementia awareness training and 45% had not completed training in infection control and prevention.
● Nursing staff did not receive clinical supervision with regards to their nursing practice. This meant that poor clinical care was not identified and addressed.
● The supervision of care staff was ad hoc and not consistent. This meant failings in people's day-to-day care were also not addressed.

The provider had not ensured people's care was delivered by appropriately trained, skilled and experienced staff. Staff were not supported or supervised in their job role. This was a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
At our last inspection we recommended the provider consider and implement current guidance and best practice for orientation around the building and considered best use of the space available to support people using the service. The provider had not made improvements.

● The premises required improvement to ensure it was safe and suitable for people to live in. The environment was not dementia friendly, with little signage or aids to help people orientate themselves to their surroundings.
● Some people's rooms were personalised with items of their choice, but others were sparsely decorated and furnished, with a 'hospital' like appearance. This did not project a homely image or atmosphere.
● The dining areas in the home did not have enough tables and chairs for people to sit and eat their meals if they wished to do so. This meant opportunities for people to social and interact positively with their peers was missed. A positive dining experience has been shown to boost nutritional intake, mental and physical well-being.
● There was no suitable smoking area or shelter outside of the home for people who lived in the home to smoke. We observed vulnerable people being taken outside to smoke with no protection from the weather. On the day of our inspection, this included high winds.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection, the rating for this key question has remained the same. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Supporting people to express their views and be involved in making decisions about their care
- People were not always supported to express their views and make decisions about their care. People's care plans were not always reviewed in accordance with the provider's timescales or when a person's needs changed.
- Regular resident and relative meetings to gather feedback on the service and the support people received did not take place to discuss issues associated with living in the home and people's care.
- A satisfaction survey to seek feedback was circulated to people and relatives in February and May 2023. Poor feedback had been given in a number of areas, but there was no evidence that any effective action had been taken to make improvements.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
- People were not treated well or support appropriately which impacted on their right to dignity and respect. For example, one person's door was left wide open whilst they were in a state of undress. Another person sat for 20 minutes with wet food all down their front at lunchtime, before any action was taken by staff to help them change.
- People's overall quality of life was poor. Insufficient staffing and a lack of staff supervision resulted in care being ad hoc and task focused. Staff were often agency staff who did not always know people well and there was little effort to spend quality time with people to build trust and caring relationships.
- Staff did not always recognise or respond to people's basic needs. For example, one person was sat in the lounge all morning, staff did not speak or check on them until lunch. We had to ask for a blanket for them, as they were cold. Another person was sat in a vest and a cardigan on their upper body, a staff member told us "This is how night staff dress residents, usually agency staff". Despite this none of the day staff had adjusted this person clothing to ensure it was appropriate. This did not demonstrate a caring or compassionate culture.

People were not always treated well or with respected as their individual. Their needs and preferences were not met and they were not involved in discussions about their own care. This was a continued breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection, the rating for this key question has remained the same. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
At the last inspection, systems were not in place to ensure people's needs were assessed and planned for in a person-centred way. This was a breach of Regulation 9 (breached also in other domains) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Not enough improvement had been made at this inspection and the provider remained in breach of this regulation.

- People's care was not always planned or delivered in accordance with their needs and preferences.
- Records showed people did not receive adequate personalised care with regard to catheter and continence care, bowel monitoring, repositioning, food and fluids and wound care. They also did not always receive the medicines they needed to keep them safe and well.
- There were systems in place to check if people's care was safe and person-centred. These systems failed to drive up any improvement. Multiple audits showed significant failings in the delivery of person-centred care, but these failings were not addressed and continued to be repeated. This meant people were continually exposed to poor and unsafe care that did not meet their needs or preferences.
- People told us the high use of agency staff impacted on the quality of their care. Their feedback included, "I have a shower weekly. I'm reluctant to have more than that because if it's not the permanent staff then I feel they don't know me well enough to ensure that I won't fall as I have major injuries and they are not that familiar with the hoist and slings" and "My heart sinks if it's ad hoc agency staff…some don't speak English well, so don't understand my needs and what I'm asking for".

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Basic information about people's communication needs was written in their care plans. However, this information was often contradictory, which meant staff lacked clear direction on how to communicate with people effectively.
- Little consideration had been given to how to support people who were unable to communicate verbally or who lived with dementia. For example, there was a lack of accessible picture menus available to assist people to make appropriate mealtime choices and a lack of dementia friendly signage around the home to

help people move around the building independently.
● The use of unfamiliar agency staff and a lack of continuity with regards to people's care increased the risk that the needs of people with limited communication would not be recognised, understood and met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People were at significant risk of social isolation and loneliness. There was little in the way of any meaningful activities for people to engage with. Most people sat all day in their lounge or alone in their bedrooms. People we spoke with, and the staff team confirmed this. One staff member told us, "There are not enough activities. We try our best, but they are not specific or tailored and there is not enough"
● People were able to have regular visitors and we saw that visitors were welcomed into the home.

End of life care and support
● 42% of care staff had undertaken training to ensure they had the skills to effectively support people at the end of their lives. The provider could not evidence that nursing staff had completed the training required.
● There was little evidence that people's end of life wishes were discussed in the event that their health declined. This increased the risk of their wishes and preferences not being respected.
● There was nobody receiving end of life support at the time of the inspection.

People's individual needs and preferences were not appropriately support and people did not receive person-centred care. The systems in place to monitor this was inadequate. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Improving care quality in response to complaints or concerns
● The people and relatives we spoke with knew how to make a complaint. Some told us that they had made several complaints. Their comments included, The Managers will talk to me, and I have complained a lot but often I just get on with it" and "I do complain but sometimes they don't listen to me".
● 10 complaints were received during July to December 2023. Complaints related to the quality and safety of people's care. The complaints had been investigated and responded to by the manager.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care

At the last inspection, the governance systems in place to assess, monitor and mitigate risks were not robust. The provider failed to have sufficient oversight of the quality and safety of the service. This was a breach of Regulation 17 (breached also in other domains) of The Health and Social Care Act 2008 (Regulated Activities) Regulations. Not enough improvement had been made at this inspection and the provider remained in breach of this regulation.

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

- The systems in place to monitor the quality and safety of the service were not effective. Service audits had identified multiple and significant failings in people's care. Despite this, no robust action had been taken to prevent these failings happening again.
- Staffing levels and the high use of agency staff impacted on the quality and safety of the service and people's experience of care. There was no system in place to reliably assess the level of clinical care people required and the number of nurses they needed on duty. This meant that people did not receive the nursing care they required to achieve positive health and wellbeing outcomes.
- A culture of learning and continuous improvement was not promoted. For example, accident, incidents and safeguarding were repeated and there was no evidence that any learning was shared with the staff. There was also no evidence of any reliable follow up to ensure learning was embedded within service delivery to improve practice and safety.
- The findings of this inspection and the previous five inspections completed by CQC have continued to identify overwhelming failures in the management and governance of the service. The provider has continually failed to take responsibility for the shortfalls in people's care and make the necessary improvements.
- The provider's ability to understand and drive forward any improvements was not evident.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- People's care was not planned or delivered in a safe, effective, caring or responsive way to ensure good outcomes for people were achieved.
- There was a lack of partnership and effective multidisciplinary working with other external health and social care professionals, as well as with people living at the service and their relatives. This resulted in poor care outcomes and missed opportunities to improve care standards.
- Accurate and complete records were not effectively maintained regarding people's care and treatment.

There was little evidence of any reliable health or care monitoring to ensure people were in receipt of the care they needed.
● People were not empowered to be involved in their care and their feedback was not sought to ensure their care continued to meet their needs.

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
● The manager and provider had not always notified CQC about notifiable events with regards to people' care. There were a number of safeguarding incidents pertaining to care failings resulting in avoidable harm, which had not been reported. Providers are required by law to submit the required notifications to CQC without delay. The information provided in notifications helps CQC to decide if further action is needed to ensure people's safety.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● Some referrals were made to other professionals when required for their specialist advice and support, however professional advice was not always followed or sought in a timely manner
● Staff meetings with managers took place but there was little evidence that staff meetings with care staff, domestic and ancillary staff took place for them to be able to share their views and concerns.
● There was a lack of investment and value placed on building a consistent, well trained and supported staff team. The high use of agency staff impacted on the development of good team dynamics, with staff members who communicated well with each other and worked together to provide good care.

The governance arrangements in place did not mitigate risks to people's health and welfare. The management and leadership of the service was poor. Fundamental standards of quality and safety were not achieved. People were exposed to significant avoidable harm. This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.