Lotus Care (Finch Manor) Limited

Finch Manor Nursing Home

Inspection report

Finch Lea Drive
Liverpool
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23 July 2020

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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 85 older people. The service is purpose built and the accommodation is in five units over one floor. Each of the units support people living with different conditions such as dementia and nursing needs. At the time of the inspection there were 78 people living at the service.

People's experience of using this service and what we found
People living at Finch Manor did not benefit from a service that was safe or well-led.

People did not always receive their medicines safely. Medication was not managed, stored and administered in a safe way.

Care plans were not consistent and did not contain the most up to date information about people's health care needs and requirements. Care records lacked person centred detail. Risk assessments were not always in place or adequate to minimise risks to people. Care records were not maintained so people's care, support and treatment had not always been accurately documented and monitored.

The service did not always identify and report accidents and incidents appropriately and refer incidents to safeguarding for investigation when necessary. Incidents were not analysed effectively meaning that people were exposed to a risk of harm.

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; the policies and systems in the service did not always support this practice. There were no assurances that people made their own decisions about their care and treatment.

Assurance and auditing processes did not assess, monitor and drive improvement in the quality and safety of the service being provided. Governance systems were ineffective and did not mitigate risk to the health and welfare of people living at the service.

Systems in place to monitor the physical environment had improved since the last inspection, although it was not evident that a major recommendation made by the fire service had been implemented.

The appearance of the physical environment had improved since the last inspection. New bathrooms and flooring had been installed and corridor walls had been newly painted. It was recognised that the service was still in the process of a full refurbishment.

Safe recruitment practices were in place for staff. People's relatives spoke positively about the staff and care received by their loved one.

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

Rating at last inspection (and update)
The last rating for this service was Inadequate (published 21 October 2019) and there were multiple breaches of regulation.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, we found not enough improvement had been made and the provider was still in breach of regulation. We also identified new breaches of regulations, meaning that the service had further deteriorated.

Why we inspected
We undertook this focused inspection to check the provider had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained Inadequate. The service is therefore in 'Special measures'. This is based on the findings at this inspection.

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

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

We have identified repeated breaches in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) at this inspection. We have also identified new breaches of Regulation 11 (Need for consent), Regulation 13 (Safeguarding service users from abuse) and Regulation 14 (Meeting nutritional and hydration needs).

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

As the service remains in 'special measures', 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 the 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?

Inadequate

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not always well-led.

Details are in our well-led findings below.

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 23 July 2020 and was unannounced. The team consisted of two inspectors and a medicines inspector. Inspection activity ended on 31 July 2020. This is the date we received and finalised review of documents requested from the service.

Service and service type
Finch Manor 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the registered manager and the operations manager. We looked at records in relation to people who used the service including six care plans and multiple medication records. 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.

After the inspection
Due to the risks of Covid-19, we did not speak with people living at the service, instead, we sought feedback from people's loved ones and spoke with four relatives. We also spoke with five members of staff.

We requested further documents from the service and continued to seek clarification from the registered manger 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 Inadequate. At this inspection this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection we found that medicines were not always managed and administered safely. This meant that people were at risk of not receiving their medicines as prescribed, and in line with best practice guidance.

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

At this inspection we found not enough improvement had been made and the provider remained in breach of regulation 12.
• The management of medicines was ineffective and placed people at risk of harm. Not enough improvement had been made since the last inspection. We also found medication errors during this inspection which had not been found by the service's own auditing processes.
• Medicines were not stored safely in the medication room and waste medicines were not stored in line with best practice guidance.
• People's allergy status was not always completed or accurate on their records. This meant people were at risk of being given medication which they may be intolerant of.
• For people who were diabetic, records about the administration of insulin/monitoring blood sugar levels were incomplete. Safe blood sugar ranges were not recorded and there was no guidance for staff on what action to take in the event of blood levels being outside the safe range.
• People's prescribed thickener (thickener is used for people with a swallowing disorder and helps minimise the risk of choking) was not managed safely. Staff did not always record the amount used when added to drinks so there was no evidence that this was being done correctly.
• For people on variable doses of medication, the actual dose given was not consistently recorded, meaning it was not clear how much medication people had received.
• For time specific medications, staff had not always documented the time of the administration, meaning it was not possible to determine if a correct amount of time had elapsed between doses.
• Controlled drugs were not always managed safely. We identified a loss of a considerable amount of morphine. We spoke to the registered manager about this who was unable to explain the loss. We advised the manager to report the incident to the control drugs reporting service.

We found no evidence that people had been harmed however, there was a failure to manage medicines safely. This placed people at risk of harm. This was a continuing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection
At our last inspection the provider had failed to provide enough oversight of checks in place to monitor health and safety concerns in the service. We also found people's risk assessments had not been completed effectively and some people did not have appropriate risk assessments in place. This meant people were at risk of avoidable harm.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider remained in breach of regulation 12.
• At the last inspection, checks to monitor the safety of the environment had not been completed, which placed people at risk of harm. At this inspection we checked to see if improvements had been made and found that they had. However, a recent report conducted by the fire service in January 2020 recorded that 'people were at risk of fire.' The report made several recommendations for improvement, one of which included the installation of sprinklers. There was no evidence that the service had installed the sprinkler system and it was not referred to in their plan for improvements.
• Not everyone had appropriate risk assessments in place. This meant that staff did not always have guidance on how to manage and mitigate any identified risks to people.
• Although the registered manager told us that the service had adequate stocks of PPE (personal protective equipment). We observed there was an inconsistent use of PPE amongst staff, we did not see all staff wearing PPE in line with best practice guidance, to help minimise the spread of the coronavirus infection.

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 continuing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• At the last inspection we found that standards of cleanliness were poor in some parts of the service and bathrooms were in need of refurbishment with some being out of use. At this inspection we found improvements had been made, new bathrooms and flooring to communal areas had been installed and corridors had been repainted. It was recognised that the programme of refurbishment was ongoing.

Learning lessons when things go wrong
At our last inspection the provider did not have an effective system to monitor trends arising from accidents and incidents and using this information for learning, to help improve the quality of the service.

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

At this inspection we found not enough improvement had been made and the provider remained in breach of regulation 17.
• Although a system was in place to monitor any incidents or accidents, the recording of the information was not effective for monitoring any trends and prevent any future risk and reoccurrence. We found evidence of serious incidents and accidents within people's care records which were not recorded as part of the incident log. This meant there was no effective analysis of incidents. The service did not show that an effective system was in place to learn from lessons and improve practices going forward.

We found evidence that people had been harmed and systems were either not in place or robust enough to

prevent reoccurrence of incidents. This placed people at risk of continued harm. This was a continuing breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• Incidents and accidents which required safeguarding referrals to appropriate external agencies, were not being made in line with the service's own safeguarding policy or that of the Local Authority. This meant that causes of actual and potential harm to people were not being investigated appropriately to help minimise the risk of reoccurrence.

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. We found evidence that people had been harmed and systems had not operated effectively to both identify and investigate evidence of abuse.

Staffing and recruitment
• Some staff told us that there wasn't always enough staff. Rotas were done one week in advance meaning that staff cover and absences couldn't always be properly planned for. Staff told us they were often moved around the different units meaning that people didn't always receive continuity of care.
• Staff had not completed the relevant training they needed to meet people's needs, including dementia care and those requiring intervention to manage more challenging behaviours.
• Recruitment of new staff was safe. Pre-employment checks were completed to help ensure staff members were safe to work with vulnerable people.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has remained inadequate. 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.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support

At our last inspection we found systems to monitor the service were either not in place or fully embedded to demonstrate safety and quality was effectively managed.

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

At this inspection we found not enough improvement had been made and the provider remained in breach of regulation 17.
• There has been a failure to act on past feedback to further improve the service. This has potentially increased the risk to people in the areas of consent to treatment, safeguarding from abuse, safe care and treatment and monitoring risks to welfare. This did not demonstrate that the provider was committed to improving care.
• Risks to people's health, safety and well-being were not identified and mitigated. This included risks to people's health and well-being from conditions such as diabetes, epilepsy, skin integrity and dietary needs.
• Systems in place to assess and monitor the quality and safety of the service were ineffective and had not identified the concerns found at our inspection.
• Although monthly medication audits were undertaken, they failed to identify the issues found during our inspection.
• Audits had not highlighted that care plans did not always reflect people's current needs. Reviews and audits of both care plans and care records did not identify the concerns found at our inspection.
• Care plans were inconsistent and did not contain the most up to date information. Advice from external health care professionals, such as dieticians, had not always been incorporated into people's care plans. For other people who required emotional support, care records did not contain guidance for staff on how to manage and respond to such needs.
• People's care records did not provide enough detail to enable effective care to people. As people's care needs were not documented appropriately, this meant people were at risk of not receiving appropriate care and treatment.
• Some staff told us that not all care plans contained enough information and they would ask senior members of staff if they were unsure of a person's needs.

• Incidents had not been fully analysed to provide effective learning and so help drive forward the quality and safety of care.
• Where audits had highlighted issues, adequate action plans were not in place and it was not evident if actions had been carried out from one audit to the next. Actions had not been assigned and a time frame had not been implemented, meaning there was a lack of accountability of actions being completed.
• Although manager's meetings took place, minutes were poorly completed and there was not a clear audit trail of actions set in one meeting to the next.
• The registered manager did not adhere to their responsibilities in line with regulatory requirements. We found evidence of serious accidents and incidents which had not been notified to CQC.
• Although there was evidence that some referrals to external agencies such as external health care practitioners had been made, people's care plans had not been updated to reflect the professionals' latest guidance. This meant that people were at risk of not receiving the care they had been recommended.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the safety and quality of the service was effectively managed. This placed people at risk of harm. This was a continuing breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider failed to act in accordance with legislation regarding the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. We were referred to a 'DoLS tracker' as evidence of people who lacked capacity. Some DoLS applications were made as far back as 2015. There was no evidence that applications had been granted, renewed or re-visited.
• It was not evident that care and treatment had been provided with the consent of the relevant person. Mental capacity assessments had not always been completed for people when needed and there was no evidence best interest's decision meetings had taken place for people who had been assessed as not having capacity.

This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although we found no evidence that people had been harmed, we could not be assured that people were involved about decisions about their care and support.

• Information regarding people's nutrition and hydration needs was not always recorded in their care records. There was a lack of guidance for staff on how to support people with their dietary requirements.
• Where people had been assessed as needing a specific diet, it was not evident that nutritional and hydration intake had been monitored and recorded to prevent unnecessary dehydration, weight loss or weight gain. Some people's nutritional records were incomplete. Audit processes had not highlighted that records were not being maintained and that people at risk of weight loss had not always been weighed monthly.

This was a breach of Regulation 14 (Nutrition and Hydration) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although we found no evidence that people had been harmed, we could not be assured that people were receiving appropriate support with their nutritional and hydration 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
• Systems and processes did not operate effectively to prevent abuse of people. It was not evident that the registered manager understood their individual responsibilities and took appropriate action where abuse

occurred or was suspected. The registered manager did not send us statutory notifications to inform us of any events that placed people at risk. This meant that CQC were not alerted to the current level of risk at the service.

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

• We requested sight of minutes of resident meetings and quality assurance surveys, but these were not provided to us.

• Feedback was sought from people's relatives and staff. Relatives told us that the home had kept them fully updated with their loved one's care during the lockdown period and they were able to contact the home at any time for an update.

• Staff attended regular team meetings but told us their views were not always listened to and acted upon by the management team.

• The service didn't always work effectively with others such as commissioners, safeguarding teams and health and other social care professionals. Safeguarding teams and commissioners were not always advised of notifiable events.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent It was not evident that people using the service had given consent before any care or treatment was provided. Where people lacked the capacity to give consent, the service had not acted in accordance with the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse, improper treatment or the risk of abuse. Systems and processes did not operate effectively to prevent abuse. The provider did not take action as soon as they were alerted to suspected or alleged abuse. The manager did not understand their responsibilities to respond to concerns or follow local safeguarding arrangements to ensure that allegations were investigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs For people who required dietary intervention, nutritional and hydration intake was not monitored and recorded to prevent unnecessary dehydration, weight loss or weight gain. People's care records were not updated with external specialist nutritional advice.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People using the service did not always receive care and treatment that was safe. Risks to people had not been appropriately assessed. People were not protected from harm or the risk of harm and risks had not been mitigated.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance, assurance and auditing systems were not effective and did not assess, monitor and drive improvement in the quality and safety of the care and treatment provided. Systems and processes did not mitigate risks to people. Care records were incomplete and did not include evidence that people had made decisions in relation to their care and treatment.

The enforcement action we took:

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