London and Manchester Healthcare (Deepdale) Limited

Finney House

Inspection report

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

Summary of findings

Overall summary

We inspected this service on the 30, 31 August and 1 September 2017. We returned on the 6 September to provide feedback on the inspection findings. The first day of the inspection was unannounced which meant the provider was not expecting us on the date of the inspection.

Finney House is a purpose built care home in the centre of Preston. The home is registered to support up to 64 people with nursing and residential care needs. At the time of the inspection there were 44 people living in the home.

The home is laid out over three floors. The ground floor area supports those with residential needs the middle floor supports people with nursing needs and the top was beginning to support people with nursing needs who were also living with dementia.

Each floor was designed with an open plan lounge and dining area. Long wide corridors were furnished with additional seating and desked areas. These were repositioned during the inspection to provide sight down each corridor making it both easier for staff to view the whole floor but also for people resting in the chairs to have view of more of the home.

The kitchen and laundry facilities were located on the first floor of the home and each floor was accessible by lifts and stairwells.

This was the first inspection of the service since its registration with the commission in October 2016.

At the time of the inspection the home was in the process of registering a new manager to the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found the home to be in breach of seven of the Health and Social Care Act (Regulated Activities) Regulations 2014. The home was also found to be in breach of two of the Health and Social Care Act (Registration) regulations 2009. We have also made 13 recommendations based on the findings of the inspection.

We found the high turnover of staff had led to inconsistencies in how the staff delivered the service. Different managers in the home had different styles and priorities and the homes policies and procedures were not embedded. This also had an impact on the quality of the audits undertaken, as the expected standard was not always clear.

The home supported some very poorly people and a high number of people at the end of their life. Staff

employed at the service did not have sufficient skills and knowledge to best support these people. Staff were kind and relatives spoke highly of them, but plans of care to support people at the end of their life were often developed too late.

The complexities of those who lived at the home were not supported by enough qualified nursing hours through the night. It was difficult to gauge the days as the senior leadership team were on site both days of the inspection and were supporting staff in the home. They were not on the rota so the hours they provided could not be guaranteed moving forward.

We found the home did not always make referrals to the safeguarding team when people were found to have unidentified injuries including bruises. We also found these injuries were not mapped appropriately through to healing and recovery. We also found that when particular people were seen to have regular bruising, assessments had not been made to identify potential risks and steps were not taken to mitigate them.

There were many people in the home living with varying degrees of dementia. Some applications had been made to the Deprivation of Liberty Safeguarding [DoLS] team to protect these people from unlawful restrictions, but this was not always the case. We saw capacity assessments which should be made prior to the application had not always been made and best interest decisions had not always considered the principles of the Mental Capacity Act 2005.

The home was not managing medications effectively or safely. Care plans were not person centred and medication records were poor. We found gaps in records without explanation and prescriptions that when recorded onto the medication records were not counter signed and did not include enough detail for staff to safely administer medicines.

Consent was not routinely acquired from people formally and where family members had given consent on behalf of their loved ones it was not clear if they had the authority to do so.

Records held by the home to support people living there were not clear as to what people's needs were and how the home were to meet them. Records were not always kept in a way that were either easy to understand or evidence that the correct support had been provided.

Complaints made to the home were not managed in line with the homes policy and from the records held it was not clear if they had been recorded, investigated or responded appropriately.

The provider had not sent the commission all the notifications for deaths, serious injury and other incidents as required as part of their registration.

We found the senior leadership responsive to the concerns raised and when possible we saw them take immediate steps to rectify issues. This included the better positioning of desks and closer monitoring of the medications in the home.

All the staff we spoke with were good intentioned and wanted to support the people in the home to meet their needs. Staff were also concerned about how the regulated activity was delivered with four or more staff telling us the home felt disorganised.

People spoke highly of the staff and told us they were caring and doing their best.

We found the home referred people for specialist support when required and had employed the services of a speech and language therapist to meet the needs of people in the home.

Management were aware of the difficulties the home had faced and showed willingness to address concerns moving forward.

Staff had begun to receive supervision and team meetings, resident meetings had also recently begun. We saw schedules for meetings for the coming year.

People living in the home spoke highly of the food and the dining experience with many describing some of the services of the hostesses in the home as 'hotel like'.

The environment was clean and the home was pleasantly decorated and furnished. We did recommend the provider complete further audits to understand the environment on the top floor and how it could better meet the needs of people living with dementia.

The home had a new manager who was due to start in post shortly after the inspection. We were assured they would be committed to develop and improve provision at the home.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms 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.

You can see what action we told the provider to take at the back of the full version 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?

Inadequate

The service was not safe.

Emergency plans had not been practiced and staff were unsure of the procedure. Evacuation plans could not be implemented in their current format. The home had a comprehensive business continuity plan ensuring people had a place of safety in the event of an evacuation.

There were not enough suitably trained and qualified staff to meet the needs of people living in the home.

Risks had not been appropriately assessed or managed. When risk had been identified action to support people was not clearly defined and risks were not mitigated.

Medication was not managed safely. Records were poor and information on prescriptions and person centred care were not available to ensure people received their medicines as they required.

Is the service effective?

Inadequate

The service was not effective.

We found records kept to support people against the risks of malnutrition and dehydration were poor, but people were referred for additional support as required.

The home had not acquired formal consent from people for the care and support they received. Assessments of capacity to ascertain if people could give their consent were not routinely completed and some decisions made in people's best interest were not made within the principles of the Mental Capacity Act 2005

There had been a high turnover of staff and the training and support provided to staff had not been sufficient. Staff were not competent in meeting the complex needs of people in the home.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

We found staff often forgot to involve people in decisions in how they received care. This included how they wanted their door left when they occupied their bedroom, and to ensure notes were made in care plan reviews if people had been involved in them.

We found staff spoke to people in the home with respect. People told us the staff were respectful.

Key choices in how end of life care should be delivered were not captured in end of life care plans in a timely way.

Is the service responsive?

Inadequate

The service was not responsive.

Activities advertised were not delivered. Some people told us they got out into the community, but most people told us there was nothing really going on.

We found care records did not always reflect the care and support people required. When support needs increased or changed this was not always reflected in people's records. Staff were unclear how to support the needs of some people.

The home did not manage complaints in line with their own procedures. There was not a clear record to show how complaints were managed, investigated ad responded to.

Is the service well-led?

Inadequate

The service was not well led

Records used to assess the quality of the service were not consistent. Some monitoring of service provision had not been completed for some months and actions required to improve the service were not always identified and managed.

The home had taken steps to deliver services above the requirements of the regulations. However the regulations had not been met.

The home had a comprehensive set of policies and procedures but many of them were not being used in the home. This left an inconsistency in delivery of the service.

The provider was not submitting the required notifications to the commission.

Finney House

Detailed findings

Background to this 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.

We inspected the home on the 30, 31 August and the 1 September 2017. We went to the home to give feedback on the 6 September 2017. The first day of the inspection was unannounced. The home were made aware of the following days of the inspection.

The inspection team consisted of four adult social care inspectors 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. On this occasion the expert by experience had personal knowledge of caring for someone living with limited capacity.

As this was the first inspection of this service we gathered information from all professionals who had worked with the home. This included the local Clinical Commissioning Group, the Local Authority commissioners and the safeguarding team.

We reviewed all the information we held about the service including notifications, information we held about other services managed by the same provider and registration information including the provider's statement of purpose for Finney House.

Whilst inspecting the service we spoke with 23 staff. This included members of the senior leadership team, the managers, deputy manager and unit managers at the home. It also included members of the nursing team and care team which included agency staff. We also spoke with the; hostess team, the domestic team, maintenance team, activities team and catering team.

We spoke with 21 people who lived at Finney House and seven people visiting those in the home. We also spoke with a visiting professional from St Catherine's hospice.

We looked at 21 people's care records and 15 complete care files. We looked in detail at nine of these, tracking the support people received to meet their needs.

We looked at nine staff files to ensure they were both safely recruited and suitably trained to meet the needs of people in the home.

We completed observational exercises including a SOFI (Short Observational Framework for Inspection), which helped us identify how care was received by people who were unable to communicate their needs and express their satisfaction.

We looked at other records including the Medicine Administration Records (MARs), monitoring information and meeting minutes. This helped us gather a comprehensive picture of the service provided and how the provider was meeting the requirements of the regulations.

We looked all around the home including the communal areas, office areas and people's bedrooms. We also looked at the available outside areas of the home and assessed the security and safety of the premises and equipment used within it.

Inadequate

Is the service safe?

Our findings

People we spoke with in the home mostly told us they felt safe. The primary concern raised was the inconsistency of staff. One person told us, "I sometimes feel safe, less so at weekends as they are temporary staff who don't know me." Another told us, "There is very rarely the same staff on, so you can't get to know them and them know you." Everyone told us all the staff were nice and doing their best.

The home had recently begun to use a dependency tool to determine if there were enough staff on duty to meet the needs of people in the home. We found the tool was very task focused and did not allow for the complexities the home were working with. This included the complex needs of people living in the home and the high turnover of both staff and people living in the home, which both had an impact on the time needed to deliver quality care and nursing support.

We looked at the rotas and found they did not always reflect the dependency tool. We also found the tool did not effectively reflect the needs of people in the home. The rotas were constantly changing due to staff shortages and sickness. At the time of the inspection there was a high use of agency staff with some night and weekend shifts having only one permanent member of staff on duty.

Every night staff member we spoke with told us there needed to be more staff. Each night during the inspection the lead nurse was an agency nurse. We spoke with two of them who both aired concerns with the role they were undertaking. Both of them told us they found the need for nursing input to safely support people in the home required more than one nurse on duty through the night.

People we spoke with through the night told us they had to wait when they rang the buzzer. It was clear the home was very busy and was supporting some very poorly people. We heard people shouting for support from their bedrooms and when we checked on them their call bells were out of reach.

We spoke with management about the high turnover of staff and were told many were not successful in their probationary period. The safeguarding team had recommended the home undertake exit interviews to ascertain why staff were leaving. The management team had been advised by their human resources company not to do this and therefore were not. Not doing this meant the provider did not collate detailed information as to why staff were leaving.

The allocation of staff was not always properly thought through. One night shift had two male workers on the residential unit and yet there were people who had requested to only be supported by female members of staff. When we spoke with the nurse about this they told us they had shifted staff around to ensure people's needs and preferences were met

The nurse on the nursing floor was responsible for large and complex medication rounds, but the complexities of this had not been included within the dependency tool. On the days of the inspection the morning round took up to three hours. We discussed this with management who said routinely it should only take up to two hours. If this was the case it would mean that the floor was without a nurse for up to six

hours in a 24 hour period.

We found there were not enough suitably skilled and trained staff to meet the needs of people in the home. This is a breach of Regulation 18 (1) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

A number of safeguarding referrals had been made both by the home, professionals visiting the home and family members of people in the home. The safeguarding team had completed investigations of concerns and made a number of recommendations and developed protection plans for the home to reduce the risks to people in the home. During the inspection we reviewed the completion of these. We found the home had either not implemented or not sustained all of the recommendations given by the local safeguarding team to ensure people were kept safe.

One concern was around the evidence collated from body maps completed for people in the home. We found the safeguarding team had identified concerns in July 2017. Recommendations were made to ensure that body maps were completed and records were kept on the progress and healing of bruising, marks and wounds. We would also have anticipated that if some people were regularly found to have unexplained bruising or marks to their body that the home would risk assess and manage this to ensure the person was kept safe. This had not happened. We saw two body maps for different people that identified up to 14 bruises and marks. The provider was reminded to ensure that safeguarding alerts were raised when people were found to have marks that were unexplained. When reviewing information we found that alerts had not routinely been made in this instance.

We reviewed the circumstances around the home using restrictive practice. This included people's inability to leave the home, the use of bedrails, lap belts on wheelchairs and tipped chairs to reduce the risk of falling. We found that restrictive practice of this type was not formally assessed under the Mental Capacity Act 2005. This meant that people who lacked capacity to consent to this type of support could have been illegally restricted.

We also looked at the eight people with DOLs applications to restrict them from leaving the building. We found the appropriate assessments had not been properly completed. Staff were unaware of who was restricted and whether it was done so lawfully.

When people are not protected against potential abuse by either referral to appropriate agencies or by assessment and care planning it is a breach Regulation 13 (1) (2) (3) (4) (b) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found that 82% of staff had completed safeguarding training in the last 12 months and had a general understanding of what constituted abuse.

We looked at risk assessments and their associated care plans for people living in the home. We found care plans were not informed by the risk assessments and risk assessments were not updated when risks increased. For example, one person had become more distressed as the end of their life approached. They had begun to fall more and ask for assistance more especially through the night. Staff had identified this and had recorded this in the daily notes and reviews for the person. However, risk assessments were not updated and care plans were not developed to meet the changing needs of this person and provide guidance for staff on how to better support them. St Catherine's hospice had recommended the introduction of a medication to reduce the person's anxiety, but it had not been followed through and the person was not in receipt of the medication at the time of the inspection.

Another person was seen to be very emotional and appeared frustrated. When we looked at this person's care plan and risk assessments this had not been identified and managed appropriately.

We looked at choking assessments for three different people and found they were not clear at identifying the risks and developing plans to mitigate and reduce those risks. This included assessments that just covered fluid intake and others that just covered solid food intake. The assessments were ambiguous as to the risks and needs of these people.

We looked at a number of body maps which identified large numbers of bruises and marks. There were no corresponding risk assessments to identify potential reasons and preventative action.

When risks are not identified or plans are not developed when they are identified, there is a risk people will not get the support they need. When risks are identified and actions not taken to reduce and manage risks to people living in the home it is a breach of Regulation12 (1) (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We observed medicines being administered on two days of the inspection. We found effective systems had not been developed to ensure nurses administering medicines had all the information they needed to safely administer them. We saw one nurse was presented with a hard medication to administer to someone who they understood received all their medication via a PEG (Percutaneous Endoscopic Gastrostomy) directly into their stomach. This nurse could not find information to inform them of how to administer the hard pill. The nurse eventually gathered information from other staff that the pill should be dissolved and administered through the PEG.

We also spoke with a nurse who had worked a night shift who had been asked by someone in the home for their medication. The nurse could not find a Medicine Admiration Record (MAR) to inform them of the prescription for the medication. The nurse did not have access to the controlled drugs cabinet to ascertain if the medicine was available to be administered. The nurse eventually gathered the required information and access to the cabinet from other staff on duty and administered the medication.

We looked at the available records to support staff with administering medicines. We found some MARs had a front cover with a photograph of the person and high level details of any allergies, but some did not. We looked at five MARs in detail and found three of them did not include this important information. Photographs of people to the front of MARs information are beneficial when there are agency staff or new staff working in post to allow them to safely administer medication to the right person.

We saw information for one person was contradictory around their allergies. Handover sheets identified they had an allergy to codeine. This was not recorded on the front sheet of their MAR and their list of medicines in their care file had codeine listed as prescribed. We asked one staff about this who confirmed the allergy, but different information left a risk of mistakes in administering medication that someone was allergic to.

We found hand written MARs were not counter signed when medicines came into the home. We found prescriptions for the administration of medicines were not clearly recorded on the MAR and we found the signatories list was not up to date. These all left risks of unsafe medicines management.

We also noted there were gaps in the MARs charts, which did not allow the reader to ascertain if a medicine had been administered and refused or not administered, or not needed. We also reviewed the process for the disposal of medicines and found whilst a list was written of all medicines to be disposed of, this was not signed by the person handing the waste medicines over for disposal, or by the person collecting the

medicines to be disposed of.

We looked at records to show us if staff were competent to administer medicines and when they had last received appropriate training. Seven staff were identified by the management team on the 23 August 2017 as requiring competency testing for medicines administration. The records showed this should have been done in April 2017. There was not any evidence on the day of the inspection that these had been completed. We saw most staff had completed medication training in last 12 months.

We found the home was not safely managing the storage, administration and records for people's medicines. This is a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008

On the last day of the inspection we noted a dog had entered the home. We asked to see the risk assessment for dogs in the home. Dogs and other pets can be beneficial in supporting some people with their wellbeing. However, there are risks associated with having animals in nursing homes, including aggravation to some people's chest conditions, such as COPD [Congestive Obstructive Pulmonary Disease] or asthma. The home did not have an active risk assessment for dogs in the home, but one was provided shortly after the inspection. The home had a policy for allowing dogs and pets on site, but the risk assessment provided to the commission did not follow the provider's policy. We recommend the provider ensures that policies developed for the home to follow are either followed or reviewed to ensure they reflect current practice.

We looked at records the home held for accidents and incidents. We found reports were written when these occurred. However, the speed in which these were used to update care records, including risk assessments was unclear. We saw accidents and incidents were recorded on a monthly log and there was a quarterly audit completed. However, this was quite basic and did not include detail to drive improvements. We saw three different templates had been used to record accidents and incidents since the service opened. We saw an action plan was developed and where people were identified at risk, referrals were made to the falls team. We recommend a consistent, timely and more complete method of accident and incident reporting, assessing, investigating and monitoring is developed.

The home had developed Personal Emergency Evacuation Plans (PEEPs) for people in the home. However, these were very basic and simply identified the level of assistance required to leave the building. We reviewed these in line with the evacuation plan and found the plans could not be implemented due to the staffing available on site. On the day of the inspection we were told the home had not practised an evacuation with the staff in the home and less than 50% of staff had received training in this area. Following the inspection we met with the provider who assured us an evacuation had been practiced in May 2017. There were no records of this and no actions identified that we or the home could review for improvement. We recommend the provider develops and practises a plan that can be implemented by trained and competent staff ensuring all people in the home can be kept safe in the event and need of either a full or partial evacuation.

We saw the home had a business continuity and contingency plan which identified associated risks that could lead to evacuation or temporary interruption to the service. We found the provider had identified suitable arrangements for both short and longer term evacuation.

We looked at how the home ensured the environment and equipment were fit for purpose and kept safe for the people living in the home. We found the home had taken steps to ensure equipment and facilities were professionally tested including the gas and electric installations, lifts, hoists and fire equipment. We saw a recent fire risk assessment had identified a number of outstanding actions and steps had begun to meet the requirements of the risk assessment and shortly after the inspection evidence was provided to show they

had been met.

The building was new and cleaning staff were employed to maintain standards. Each floor had two sluice rooms. We found at least three of these were open on the day of the inspection. This meant that people had access to the cleaning materials that were stored in them. We recommend the staff ensure these rooms are locked at all times.

Staff told us they had the available personal protective equipment they needed to do their job including aprons and gloves. We saw a good stock of this equipment.

We looked at nine personnel files and found that staff were safely recruited with appropriate checks to ensure they were suitable for their roles. Information was available to assure the provider of the staff members identify, including photographic identification. We found some gaps within interview notes and application forms around employment. We were assured by the provider that these areas had improved for the more recent recruitment rounds.

Inadequate

Is the service effective?

Our findings

We were given most of our feedback from people in the residential unit as people on the nursing unit were generally very poorly. People told us staff worked well together and felt they understood what was needed. We were told the food was good and people could eat in the dining room or in their bedroom if they wished. One person told us, "I get to eat my meals where I like, sometimes in the dining room, sometimes in my room. It's up to me." Another told us, "The food is good but it generally always is."

There had been a high turnover of staff in the months prior to the inspection. This meant that many new staff had not completed the annual mandatory training. We had concerns around some of the safety training including first aid and moving and handling, which had been completed by fewer than 61% of the staff team.

We also had concerns around the complexity of people being supported by staff in the home. Records we reviewed showed the home had 66 deaths since October 2016. This showed us that the home were supporting a large amount of people at the end of their life and on palliative care. However, staff only had basic e-learning available to them and this had only been completed by 20 of the staff at the home. Supporting people at the end of their life is a specialist role and staff need additional training to ensure they understand people's end of life care needs and are competent to deliver the appropriate support in a dignified and responsive way.

We found staff were not supported to deliver the complexities of the role they were to undertake. Staff did not receive appropriate training and knowledge to gain the skills and competence to support people at the end of their life. There were not enough clinical staff employed on the nursing floor with specific competence in admission assessments and end of life care planning. There was not an employed and trained person in moving and handling, first aid and a competent fire marshal on shift 24 hours a day. When there are not suitably qualified, skilled and competent people to deliver the regulated activity it is a breach of Regulation 12 (1) (2) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The home worked with the local hospice services to support people at the end of their life. We would however recommend more work was done with this service, as the home supported a high number of people at the end of their lives.

We reviewed the available information to ascertain if people living in the home had consented to their care and treatment. In most of the files we looked in the consent documentation was blank. A care plan matrix audit was completed by management at the home in July 2017, which reviewed five people's care plans. This audit stated that all five had consents in place. We reviewed four of the five care files. We found three of them had applications for Deprivation of Liberty Safeguards (DoLS) submitted to the Local authority. One of the others did not have any consent in place and the final file had some documentation signed, but it was unclear who it had been signed by.

When people are unable to consent to their care and treatment staff should make every attempt to gain

consent before care and treatment is given. We found the home had employed their own Speech and language Therapist and they were working with the home in developing prompts and cues for people to give consent that may have communication problems or have limited and fluctuating capacity. We saw a key fob had been introduced which held pictures of tasks to support people in their daily lives. Pictures included commonly recognised scenes for needing the toilet, being hungry, thirsty or tired. We were told staff had these on their person but we did not see them used.

We saw staff asking people if they wanted drinks and being given options for their meals on the ground floor. On the nursing unit staff appeared to have knowledge of people's preferences and discussed this amongst themselves prior to serving up meals for particular people. We did not see anyone engaging in any activity or task of which they showed any disapproval of.

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 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw a total of 18 applications had been made for DoLS. We saw eight were on a current DoLS register which stated three had been granted. To note two of the people named in the care plan matrix audit of consent in files completed in July 2017 as having application for DoLS submitted were not on the register. Information was confusing and different information was held in different places. We could not ascertain the correct and current picture for applications of restrictive practice through the DoLS applications submitted.

We looked at the care file information for the applications made. We found capacity assessments had not been completed and where there was information referring to best interest decisions these were not supported with evidence of least restrictive practice. It was clear there was much work to do to ensure the home were working within the principles of the MCA 2005.

A Regulation 11 audit had been completed in December 2016 the same audit was completed in March 2017 in a different coloured pen. The audit had a number of items ticked as if completed. We checked three of these and found this was not the case at the time of the inspection.

We found capacity care plans were generic templates with spaces to put people's names. We found decision specific assessments had not been undertaken and evidence had not been collated to show where people had power of attorney representations to make decisions on behalf of those who lacked capacity. We saw DoLS applications had been made for short term placements, which had now become longer stay placements and yet the application had not been amended or resubmitted.

We also found one person who had been assessed as lacking capacity by an external professional was not following their diet plan to keep them healthy. The home had completed a best interest decision stating the person had the capacity and had made an informed decision not to follow the guidelines from the Speech

and Language Team (SALT). From the information reviewed this was clearly not the case. We bought this to the attention of the management who ensured the care plan reflected the current picture.

We found the home was not supporting people who lacked capacity within the principles of the MCA. We found applications for DoLS were not supported by appropriate assessments and decisions made were not always in people's best interest. Consents were not routinely acquired and where they were they were not always given by those who had the authority. This is a breach of Regulation 11 (1) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

The home had external catering contracts for the food provided to the people in the home. The company were told of the specific diets people required and these were provided. The catering company had scope to provide diets of different consistency and with low levels of certain food components such as fat, sugar or salt.

People we spoke with told us they liked the food and we saw they were given a choice. We saw snacks provided between meals and people could be given toast and other toaster snacks when requested. The chef was keen to develop a nutritional menu from local produce and was in the process of introducing more home cooked foods to the menu.

We looked at the records the home used to support people with their hydration and nutrition. We found a number of the nutritional care plans and assessments were only partially completed. Some records were not correctly completed and some people's records held inconsistencies. For example, one person's MUST (Malnutrition Universal Screening Tool) had a one recorded weight which was recorded the same day as another weight record in their care plan and there was an 8KG difference between the two weights. We also saw one person's record recorded their height differently. The height of people is used to calculate people's Body mass index (BMI), which is a good indicator of risk of potential malnutrition. When records are not consistent it can lead to incorrect assessments of risks.

We looked at the additional records the home had implemented when people required more support with their hydration and nutrition and found these were consistently poor. This meant the records were not effectively capturing the information required to better support people. For example, food and fluid charts used to record people's dietary and fluid intake were too basic to be beneficial. For example, they would record toast or full English breakfast, but would not include the detail of how much was eaten of that offered and what was eaten from the full English e.g. the sausage or beans. Without this detail the records were not beneficial in identifying foods that could be encouraged to be eaten more of, to reduce risks of malnutrition.

We saw that people were assessed as requiring their weight to be monitored either weekly or monthly and we saw records showing this was mostly carried out. However, this information was not always routinely used to update assessments and care plans.

However, we saw from the records we reviewed that where people had begun to lose weight the action taken had led to reductions in weight loss. We also found the home referred people to dieticians and specialist teams when required

We recommend the provider ensures records are accurate to allow appropriate assessment and identification of any additional support required.

We saw details of people's diets and their allergies were recorded on the daily handover sheets. We also saw monthly Key Performance Indicators had commenced each month, which included details if people had lost

or gained weight. This gave staff important prompts on how to support people with their diet.

We saw people were supported with their meals, as was required and we saw people were respected and unrushed with their meals.

The service is a newly built home and the environment and layout of the building is clean and efficient. The home has wide open corridors to better support people's mobility. The newly placed desks will allow staff a better view across the floor and of each other. This will enable staff to respond to issues and concerns in a more timely manner. However, more consideration of the environment is required to better support those people living with dementia. We recommend the provider completes the Kings Fund 'Enhancing a Healing Environment' Audit to make the best use of the available space.

There was a comprehensive set of mandatory training available. This was mostly delivered by electronic learning. However, there had also been classroom practical training provided for moving and handling, basic life support, fire training, infection control and safeguarding since the home had opened.

We saw the home completed an induction with new staff and those recruited more recently told us they worked shifts shadowing more experienced staff. A supervision matrix had been drawn up in July 2017 and each staff member had supervision scheduled every three months for the coming 12 months. However, only 70% of the supervisions scheduled for August 2017 had taken place. We were assured that the new registered manger would ensure these were completed. Again we saw three different templates had been used for supervision and this made it difficult to track improvements or actions from meeting to meeting. However, due to the high turnover of staff there were very few who had received more than one supervision meeting.

We saw evidence that team meetings had become more regular and were scheduled moving forward.

We saw the provider referred people to specialist services when required to better support their general health. This included referrals to the falls team and speech and language therapists. The home had also employed their own speech and language therapist as they recognised a growing need for this input. This meant people had access to this service in a more timely way and when the service assessed the need for it. We saw they had already begun working with people to better develop communication tools with staff.

Requires Improvement

Is the service caring?

Our findings

People and relatives we spoke with mostly told us the staff were kind and treated them well. One person told us, "Everyone's very pleasant, its grand here." Another said, "The girls that work here are really nice, it's a nice place to be and very well looked after." Another said, "Staff are very caring and will do anything for you." Two people told us staff can get stressed when they are very busy and you have to wait. One person told us, "If you keep asking they can get a bit bossy, but I understand as things are unpredictable."

People and the visitors told us they can get out and about in the community including to the local football ground to watch a match. People told us of trips to the park and to the supermarket.

On the day of the inspection we did not receive a consistent message as to who living in the home was in receipt of end of life care. We were made aware of two people who were approaching the end of their life. We looked in the files of these people and found there was not a developed end of life care plan. These are important to ensure the wishes of people are followed at the end of their life. End of life care plans are ideally developed from reviews of earlier plans including advanced care planning and preferred priorities of care. People were coming into the home for palliative care, which was provided to people with life limiting conditions and these care plans were not routinely developed. This meant that end of life care plans were more difficult to develop and implement as soon as it was known people had reached the last days of their life. End of life care plans needed to be considered earlier. When assessments were not completed on key support needs and plans of care were not developed to support people in a person centred way it is a breach of Regulation 9 (1) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Finney house had over 60 people coming to the end of their life in the home since October 2016. The home had accepted some very poorly people who had chosen to end their life at the home. One family member told us the home was a much better environment than the hospital for the last days of their loved one's life. The home received support from St Catherine's hospice that came into the home weekly to support staff with some people at the end of their life.

Some people told us they had been involved with reviews of their care and these were primarily assessments by the Local Authority and commissioning support unit to determine the level of care required. When monthly reviews were undertaken of care plans, each care plan asked had the person been involved in the review. We did not see any of these that had been signed to say the people whose plans they were had been involved. There was no recorded explanation given as to why they had not been involved or why they had not signed if they had been involved. We recommend the providers ascertains why the care plans were not signed to show the person had been involved and develops a system where a record is made if they have been but are unable to sign.

We saw in some care plans that good person centred information had been gathered on people's preferences including their likes and dislikes. However, we also saw an equal number of care plans where this information was not available. We saw a note on the wall to say one visitor was not to be admitted to visit one person in the home as requested by the person's family. We looked in the care file for this person to

see if the person had been involved in the decision and there was no documentation available. There was no evidence of a best interest meeting or a reason why the person should not be admitted. We did not speak to the person about this, as did not want to cause undue stress or anxiety, but we recommend the provider ensures appropriate procedures are followed to ensure the person is involved in this decision if they have the capacity to do so. If they do not then the required assessment and best interest decision process is followed.

Throughout the day we saw people's bedroom doors were either: ajar, open or closed. We saw staff ask before entering people's rooms, but on a number of occasions we saw they did not leave the door as they found it. They did not ask the person in the room how they would like their door to be left. As we walked past another room we overheard two staff supporting one person with their meal. The staff did not engage the person in the conversation they were having, which included how long it had been since they last worked together. We recommend the provider reminds staff to ensure the people they were supporting are involved with decisions around how their care was delivered.

Throughout the day of the inspection we saw staff and people interacting in a positive way. Staff spoke to people as they went past their rooms or walked through the lounge. Communication was always dignified and respectful. There was also a friendly banter between people and people and the staff, which allowed for the development of positive relationships.

We saw people's bedrooms included their personal possessions and were made their own space. We saw the home and everyone living and working in it was well presented. The home had a visiting hairdresser who attended once a week and we saw people enjoyed access to this support.

Visitors told us they could visit whenever they wanted and we were told by a number of visitors that staff often invited them to stay for meals at the home and to dine with their family members.

Inadequate

Is the service responsive?

Our findings

We asked people how they spent their days. People told us they generally entertained themselves. One person told us, "I like colouring in my book." Another said "I can read and write, so I spend my days doing one or the other." We asked about activities arranged by the home. One person told us, "There's not really a lot going on, but sometimes I get taken out to the garden."

We looked in the care plans and in many of them the aims and outcomes sections were not completed. This did not give staff the information they needed to ascertain what people wanted from the care and support they received. On the day of the inspection we identified a number of scenarios where staff required additional guidance on how best to support people. This included one person who was seen to get upset. We asked a staff member about this who told us the person often cried. We asked why and how staff supported them. They did not know why they cried and there was no clear guidance on how staff should support them in the person's care plan.

Another person's care needs had changed as they approached the end of their life. Their care plans did not reflect this. Support that had been recommended by specialist services had not been provided.

We also saw a number of care plans which were generic and simply left space for a person's name to be inserted. We saw on one occasion the wrong name was inserted into the plan. We also saw five care plans where the care plan referred to the person in the opposite sex to what they were. For example the care plan referred to the person as he and the care plan was about the support to be provided to a lady.

The home had recently begun to use an electronic system for writing daily records and reviews of people's needs. This information had not been used to update people's care plans.

We came in early on two mornings and found six people's call bells out of reach. This included one person who was attempting to climb over their bedrails. We entered their room to ring the bell for staff to come and support the person, but one could not be found. We found a hostess close by and took them back to the room and neither they nor we could find the call bell. The hostess waited with the person whilst we found a member of staff to support the person. This person was at risk of not receiving the care and support they needed.

We found a number of care plans had not been updated or reviewed for up to three months. People's needs had changed and plans of care and assessments had not been updated to reflect this. People who had come into the home on short term care plans had not routinely had their care plans updated when they had stayed longer than the 21 days.

When care plans are not appropriate for the person whose plan it is, do not inform the reader on how best to meet someone's needs, needs and risks are not identified and care provided does not reflect people's preferences it is a breach of Regulation 9 (1) (3) (a) (b) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found the information used to record the care people had received to be inconsistent. Parts of some plans would identify needs and other plans did not include actions to meet those needs. For example, water low assessments scoring people as being at very high risk of pressure damage. The plan of care stated the person required to be turned every two hours to reduce this risk and yet there was no evidence this had happened. We also saw a number of body maps which identified bruises and marks to people's bodies, but these were not reassessed and improvement was not recorded.

We saw a falls risk assessment which stated one person had not fallen, but within their daily records it stated they had. We found contradictory information around people's capacity where one care plan stated the person could make their wishes known and another stated they could not communicate their needs. We saw that scores on some assessments had increased, but it was not clear as to the reason why and new plans of care had not been written to guide staff in how best to support them.

We found the home did not keep an accurate and complete contemporaneous record of the care and support people needed and how it was delivered this is a breach of Regulation 17 (1) (2) (a) (b) (c) of the health and social Care Act 2008 (Regulated Activities) 2014.

The home had a comprehensive policy and procedure for managing complaints. This included detail of how complaints should be responded to, investigated and managed.

On the day of the inspection we found where complaints were made they were not officially recorded and managed in line with the home's procedure. There had been two complaints made recently about the performance of staff and a formal complaint made by someone's family who had moved on from the home. We could not find any of these complaints in the complaints folder

The home had received 14 complaints since May 2017. There was no evidence in the complaints folder to show that all the complaints had been appropriately investigated. There was no clear evidence to show what actions had been agreed from the complaints and no evidence to show lessons learnt had been shared with the staff team or had led to changes in procedure.

We saw an audit had been completed in January 2017 on the complaints received. The same audit was recompleted in March 2017 and did not identify any concerns. A different audit was completed in July 2017, which identified the need to develop a tool to ascertain if there were any themes or trends to the complaints received. This was signed off as completed in August 2017, but there was no evidence either in the complaints file or the audit file that this had been completed.

We found the home had not managed complaints in line with their own policies and procedures and had not responded to complaints, recorded or managed complaints in line with the requirements of the regulations. This is a breach of Regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

In reception there was an activity calendar which detailed activities to be held that day. Each floor also had a calendar of events. We found the calendars differed and on the days of the inspection the activities on the boards did not take place. One afternoon the board said baking would take place and we saw an activity coordinator ask people what film they would like to watch. We understand activities could change for any number of reasons but the activity coordinator did not ask people if they would like to bake. We recommend the provider seeks the opinions of people in the home as to what activities they would like to do and develops a programme of activities that meets people's preferences.

Inadequate

Is the service well-led?

Our findings

We could not speak with many people about how the home was managed. People who we could speak with, told us they liked the home and it was well placed in the city and designed well.

We reviewed the available information the home used to monitor the quality of the provision at the home. We also looked at the audits and monitoring completed to show how the home was meeting the requirements of the regulations.

We found inconsistencies in audits and monitoring and found that some of the records had not been completed for some months. This included the daily walk around by the manager or deputy manager and the record of the provider visits. New audits and records had begun to be used, but there was no way of tracking the information clearly from the previous record. We found the audits were not identifying the concerns noted by the inspection team.

Procedures put in place to better manage the clinical risks in the home had stopped in March 2017. This included the nurses daily to do lists and the morning checklists. Weekly clinical meetings had not been completed since November 2016. The new monitoring of clinical risks had not begun again until August 2017 and was not embedded or developed effectively to manage the changing risks the home was working with at the time of the inspection.

We saw between three to five care plans were audited each month but with the high turnover of people in the home there was no way to evidence improvement. Most people would be admitted and discharged without their care plan being audited.

We saw audits contained action plans which were not signed off and some that were signed off as complete when the action had not been undertaken. There were times we were assured by the management that actions had been completed but were no longer being implemented. This included the Regulation 11 audit completed in March 2017, which stated items had been completed to meet the requirements of the regulation, which when reviewed had not bee. A care plan matrix competed in July 2017 included details of consents which were captured under regulation 11. The matrix identified the five files reviewed had consents in place. We found they did not. Care plan audits completed in July 2017 were completed again three weeks later and many of the actions remained outstanding. When effective systems are not developed to assess and monitor the quality of provision and drive improvement where concerns are identified it is a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The home had been open for approximately 12 months at the time of the inspection. In that time there had been three managers. We spoke with 11 staff who told us the home had been unsettled for some time. We found offices which held key information on how to deliver the regulated activity were disorganised and there was piles of paperwork in the office on the nursing unit which required action. This included accident records, information about medicines and partly written assessments and care plan updates. The home

needed consistent leadership to improve and organise systems to safely deliver the service. The senior leadership team assured us the new manager had the skills and experience to bring order to the home.

When we looked through records held by the home including management information and people's care records, we noted a number of themes that could have been developed through team meetings and supervisions to support improvement. These included inconsistencies, procedures not being followed and a lack of appropriate support and training which impacted on staff competence to undertake their role.

The home had a set of policies and procedures which were not routinely being used to develop the service and support the management to meet the requirements of the regulations. We noted a number of the home's polices were not being followed. This included the medicines policy and associated procedures, the complaints policy, the pet's policy, the pre-assessment policy and the safeguarding policy. When services are not following best practice guidance and their own policies and procedures it becomes more difficult to identify where there are concerns in the quality of the service. Where concerns are not identified and issues are not addressed it is a breach of Regulation 17 (1) (2) (a) (f) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Records held at the home contained different information and this did not correlate with the information held by the commission. As part of a provider registration, homes are required to send notifications to the CQC on specific incidents. This includes when there is an allegation of abuse of a service user, when external professional and clinical support is requested for a service user following a serious injury. A police incident and other categories of information. At the time of the inspection the commission had not received any serious injury notifications from the home. A serious injury notification should routinely be sent to the commission when someone is taken to hospital following an accident or unexpected admission or is injured as stated on the notification. This includes fractures and pressure sores. We also noted that some notifications should have been sent where allegations of abuse were made, that had not been. We found the home in breach of regulation 18 of the Health and Social Care Act (registration) regulations 2009.

Provider's also needed to inform the commission when people they are supporting pass away. During the inspection we noted a higher number of deaths had occurred in the home than we had received notifications for. We found the home in breach of Regulation 16 of the Health and Social Care Act (registration) Regulations 2009.

At the time of the inspection one manager had just left and another was about to begin in post. The new manager had applied to the commission to be registered. The home was being supported by the senior leadership team and a manager from another home, who was in the home most Fridays. A member of staff had been promoted to deputy manager who was overseeing the management of the nursing team most days.

The home were using a high number of agency staff at the time of the inspection. Two people who had been left in charge of the home told us they had not received an effective handover to complete their roles. They told us they did not have all the information they needed and that there were not enough staff to support people.

We shared all this information with the senior leadership, who undertook an anonymous survey to allow staff to openly share their concerns. The director of operations completed a functional team exercise to support staff with supporting each other. We were assured the results of this would be used to drive improvements and the confidence of staff.

The home had a very high turnover of both staff and people in the home. This meant that improvements made were not sustained. For example, when actions had been implemented following safeguarding alerts to ensure provision was safe the changes in procedures had not been embedded into practice so new staff understood what was expected of them. Care files were different in their format and structure. This meant information was difficult to find. We found changes were made quickly when concerns were identified, but the changes were not shared in a systematic way with the staff team. This meant they did not understand the rationale behind the change or the need for it to continue. This in turn impacted on their understanding of how to complete their role. Staff meetings had only just begun to take place and the agenda was not structured. New staff coming into post could not rely on the home's policies and did not have access to other information from which to learn procedures. This meant they relied on their own experiences of delivering care. We recommend the provider develops a structured and consistent agenda for team meetings and develops a shared understanding of the policies and procedures of the home.

The senior leadership team were dealing with issues as they arose. However, there were no systems in place to embed the changes made. There was no delegated key person for important roles for example, no lead person for admissions or discharge, safeguarding or infection control. The home, specifically the nursing unit had seen a massive throughput since it opened. From 1 June 2017 to the 31 August 2017 there had been 61 admissions to the home. For the same time period they had been 18 deaths and 31 discharges. Staff at the home were not equipped to deal with the complexities and needs of the people living in the home, as this changed from one day to the next. There were not enough staff to manage the constant changes and staff did not have the correct skills to manage the home in this way. We recommend the provider identifies key staff for key roles and they develop systems to embed the requirements of the role.

We spoke at length with the provider about the concerns of the commission in relation to the registration, purpose and future direction of the home. The provider acknowledged they could not effectively meet the needs of people admitted on the short term placements from the local hospitals and agreed to stop admitting them shortly after the inspection.

The provider had developed a number of initiatives that went above the requirements of the regulations. These included a community library for the over 65, where free hot drinks were available.

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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (3) (a) (b) (c) Care and support provided to people was not always appropriate , did not meet their needs and did not reflect their preferences. Assessments of people's needs and preferences were not carried out with the person and care was not routinely designed to meet their needs and preferences. relevant people were not always enabled to understand the available options to care and treatment and be involved in discussions around risks and benefits of particular choices

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 Regulation 11 (1) Consents were not always acquired from people in the home. If people did not capacity to give consent this was not appropriately assessed. When others were given consent on behalf of people in the home information had not been acquired to ensure they had the authority to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 12 HSCA RA Regulations 2014 Safe

personal care Treatment of disease, disorder or injury	care and treatment Regulation 12 (1) (2) (c) Staff did not have the skills, qualifications, knowledge and competence to safely support the people living in the home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) (4) (b) (5) People were not protected from abuse. Incidents were not always sent to the local authority safeguarding team when required. Protection plans and recommendations from the safeguarding team were wither not implemented or not sustained. Where people's activity was restricted appropriate assessments and decisions were not always made and the principles of the Mental Capacity Act 2005 were not followed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 (1) (2) The provider did not have evidence to show that all complaints had been managed effectively. there was not a clear system of managing, recording, investigating, responding and learning from compliants

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 Regulation 17 (1) (2) (a) (b) (c) (f) An effective system had not been established to

ensure compliance with the regulations. Good practice guidelines were not routinely followed and quality audit systems were not effective to identify concerns and drive improvements.

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 Regulation 18 (1) There was not enough suitably skilled and competent staff to meet the needs of people living in the home

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
Treatment of disease, disorder or injury	Regulation 12 (1) (2) (a) (b) (g) Assessments were not always completed to identify potential risks to people. When risks were identified action was not always taken to mitigate the risks Medicines were not managed safely

The enforcement action we took:

served an urgent NOD to restrict admissions to the home