Monread Lodge Nursing Home Limited

Monread Lodge

Inspection report

London Road
Woolmer Green
Knebworth
Hertfordshire
SG3 6HG

Tel: 01438817466

Date of inspection visit:
25 September 2017
27 September 2017
29 September 2017
09 October 2017

Date of publication:
28 February 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Monread Lodge is a modern purpose built home that provides accommodation and nursing care for up to 62 older people, some of whom live with dementia. At the time of this inspection 51 people were living in the home.

This inspection took place on 25, 27, 29 September and 09 October 2017 and was unannounced.

When we last inspected the service on 11, 12, 15 and 24 May 2017 the provider was not meeting the required standards in all of the areas we looked at. We found breaches of the regulations in relation to providing safe care and treatment, staffing levels across the home, and ensuring governance systems were effectively operated to monitor the quality of the service provided.

At this inspection we found that some improvements had been made, however there were areas that continued to require improvement, particularly in relation to the safety and wellbeing of people using the service and the service being well led. Following this inspection we referred our concerns to the local authority commissioning and safeguarding teams, and told the provider they must improve the quality of care people receive.

A registered manager was not in post. 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. The service at the time of inspection was supported by three interim managers, the regional manager and a senior manager.

People felt safe living at Monread Lodge. Staff were knowledgeable in relation to keeping people safe from harm and reporting incidents to management, however some incidents were not consistently reported and investigated. Staff awareness of people's current needs had improved however we found this was at times conflicting due to incomplete care records. People were supported by sufficient numbers of staff. People's medicines were managed safely and medicines were administered to people as the prescriber intended.

People told us they enjoyed the food provided, however, those people with specific dietary needs did not always have their needs met. Staff sought people's consent prior to supporting them, however records did not always accurately record people's consent to care and treatment. Staff told us they felt supported by the management team, and were receiving training and supervision in key areas. People were supported by a range of health professionals when their needs changed.

The consistency of involving people in their care was variable; however staff supported people in a kind and compassionate way. Staff were observed to have developed positive and caring relationships with people who lived at the home. When personal care was provided, this was carried out in a respectful way that promoted people's dignity but did not always take account of their needs and wishes.

People did not consistently receive support that met their changing needs and took account of their preferences and personal circumstances. People were able to pursue their individual interests; however there were not always sufficient opportunities for people to take part in meaningful activities. People and their relatives knew how to raise concerns and were kept informed regarding changes within the running of the service.

Improvements had been made to monitor and improve the quality of care people received by reviewing the systems used. However, these were not always consistent in identifying areas for improvement or maintaining these. We saw action plans were developed to support and drive improvement across the home, however at the time of inspection it was too early to measure their effectiveness and this will be further reviewed. People's care records, although being reviewed continued to require additional work to ensure these were accurate.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not consistently protected from the risk of harm or abuse.

People's care needs were not reviewed when required and staff were not always aware of people's changing needs.

People were supported by sufficient numbers of staff. Staff recruited had undergone a robust recruitment process to ensure they were competent and appropriate to work with people.

People's medicines were safely managed and administered when people needed them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's nutritional needs were not consistently met and staff did not routinely monitor and review people's weights and fluid intake.

People were asked for their consent appropriately before care or treatment was provided. However, where people were unable to make their own decision, staff had not followed the appropriate processes consistently.

People were supported by staff who had received training appropriate to their role.

Staff felt supported by their line manager, although the numerous changes in the home had affected their morale.

People were supported by a range of health professionals when required.

Is the service caring?

Requires Improvement

The service was caring.

People were cared for and supported in a kind and compassionate way by staff who knew them well.

People who lived at the home felt at times they were not listened to or involved in shaping their care.

People were supported in a way that promoted their dignity and respected their privacy.

The confidentiality of personal information was maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not consistently receive support that met their changing needs and took account of their preferences and personal circumstances.

There were not sufficient opportunities for people to take part in meaningful group activities relevant to their needs, and further activities were being developed.

People and their relatives knew how to raise concerns, however the changes in management meant people were not always confident that complaints would be dealt with expediently.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Staff and relatives told us the manager was not approachable or responsive to their concerns and they felt they were not able to contribute their ideas about the running of the home.

Systems and processes for monitoring and reviewing the quality of care people received were in place, however not effectively managed.

People's care records continued to lack sufficient information to reliably inform staff how to meet people`s changing needs.

Staff felt supported by the interim management team and told us they now felt listened to and were able to contribute ideas to the running of the home.

Monread Lodge

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 was planned to check 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.

This inspection took place on 25, 27 and 29 September 2017 and 09 October 2017 and was unannounced. The inspection team consisted of two inspectors, and expert by experience and a specialist advisor. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a health professional with specialist knowledge in relation to skin integrity.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We reviewed a copy of the action plan that had been submitted to us after the previous inspection and also sought feedback from professionals within the local authorities safeguarding and continuing healthcare teams.

We also reviewed a copy of the provider's action plan they submitted to us following the previous inspection on 12, 15 and 24 May 2017. This document sets out how the provider will meet the requirements and regulations associated with the Health and Social Care Act 2008. We also met with the provider on the 7 September 2017 along with their senior management team to seek assurances from with regard the improvements required in Monread Lodge.

We carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

During the inspection we spoke with seven people who lived at the home, eight of their relatives, nine staff members, the interim manager and representatives of the provider. We looked at care records relating to nine people and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At this inspection, people told us they felt safe in the home. One person told us, "I never thought about it but I do [feel safe]." Another person told us, "I feel safe here." Relatives we spoke with told us they felt the home was safe and their relative was better looked after than at our previous inspection. However they told us there were further improvements needed to ensure their loved ones needs were fully met and they were cared for in a safe manner. For example, one person's relative said, "Things feel safer since the last inspection, but I still find that lots of agency staff cause us worries, they are not as good as the Monread lot."

Staff were however knowledgeable about safeguarding procedures and how to protect people against the risk of avoidable harm and abuse. They told us there were clear processes and procedures in place to monitor and report their concerns. For example, staff told us that if they found any bruising on a person's skin they reported these to the nurses or the manager. Staff were also aware of how to raise concerns in relation to whistleblowing, where they were concerned about the conduct or safety of care provided by either other staff or management. We found examples where staff had used this confidential approach to raise their concerns to management and found action had been taken to address this.

However, staff were not sure if the unexplained injuries we identified across the home, such as skin tears and bruising were investigated and reported to external safeguarding authorities. We found examples where people had sustained unexplained skin tears and bruises. In many cases these people could not communicate how they sustained these injuries or if they were cared for in bed there was no explanation on how they injured themselves.

Staff told us that in recent weeks since Monread Lodge stopped using agency staff, the numbers of skin tears reduced. All staff said they thought that these occurred because of agency staff not being sufficiently trained in safely moving and handling people with the differing types of hoist. When we reviewed the marks found on people we found that not all these skin tears and unexplained bruises were reported to either the interim manager, CQC or local safeguarding authorities so they could be investigated and measures put in place to safeguard people from harm. Staff also told us that the hoists used were not ones they were trained on, and felt this was a contributing factor to people banging themselves against the hoist. When this was discussed with the provider they immediately ordered replacement hoists that staff were familiar with.

However this meant people were not protected from the risks associated with improper treatment as safe practises were not followed. Where people had sustained an injury that could not be explained, such as from being hoisted, management had not ensured these were appropriately investigated, responded to and if required, reported to the appropriate authority. As a result this was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that staff were not consistently aware of the risks relating to individuals changing health needs. At this inspection, we found that improvements had been made in some areas, however care records did not consistently reflect people's changing needs.

We found staff were knowledgeable about risks associated with people`s daily living. Staff told us they knew people well and knew how to mitigate and manage risks to keep people safe. We observed staff using the hoist to transfer people to a wheelchair and support people to walk with their Zimmer frame and they did this safely whilst reassuring people throughout the process. They were also knowledgeable about people who were at risk of malnutrition and dehydration and they told us in detail how they encouraged people to eat and drink. However, we observed that people who were having food supplements to help increase their calorie and nutrients intake received these supplements just before they had their meals and as a result they only had a small amount of their meals. This meant that they were not benefitting fully from the supplements and their meals because these were not spaced out in the day.

Every staff member we spoke with could tell us the name of the people who were at risk to develop pressure ulcers or if they were at high risks of falls. Staff also detailed and we saw what actions they were taking to proactively mitigate the risks. For example, people who were at high risk of developing pressure ulcers had pressure mattresses in place and special air boots they wore to protect their heels from developing sores. People`s care plans on the dementia unit detailed the risks to their well-being and measures in place to mitigate these and these were regularly reviewed. For other people who had nursing needs their care plans were not as detailed about the risks and often these gave conflicting information to staff in how to mitigate these. For example, one person`s care plan detailed, and we observed, that they had a pressure ulcer on their right elbow. However the instructions on how and when to turn the person in bed to aid healing detailed that the person had the pressure ulcer on their left elbow and staff should only turn them on their back and right side. We saw that some staff ignored the instructions and turned the person regularly on their left side as well as their back. Other staff, however, turned them on their right and back. This meant that the person was not consistently receiving safe and appropriate care. This was an area that required improvement?

At our previous inspection we found that people's medicines were not administered when required, and systems were not in place to manage people's medicines safely. At this inspection we found improvements had been made. Since the last inspection the provider had contracted a new pharmacy to provide people's medicines and associated records. Although there were some minor issues while this was implemented, we found this did not impact on people receiving their medicines when required. We saw that staff followed safe working practices while they administered medicines and records checked were completed consistently. We observed staff administering medicines to people in a calm and safe manner. Medicines were stored appropriately in a well organised temperature controlled room. Medicine administration records (MAR) charts were signed after staff gave people their medicines. We checked the physical stocks of medicines held against the stock records in the MAR, and found these tallied. There were protocols in place for medicines prescribed on an as needed baiss to ensure staff had guidance in how and when to give people medicines prescribed on as and when required basis. Where people had their medicines reviewed by a GP or Consultant, staff ensured the amended dosage was given to the person following the prescriber's guidance.

However we noted one incident where a member of nursing staff had taken the decision to withdraw pain relief for one person. This person was having regular dressing changes and was unable to communicate with staff whether they experienced pain. The prescriber's instruction was for staff to administer pain relief prior to all dressing changes, however we found that the staff member had withdrawn this based upon their own clinical judgement. They had not informed the GP, other nursing staff, management team or relatives of this decision. We brought this to the attention of the provider who took immediate action to review the person's pain relief and take appropriate action to ensure peoples medicines were safely administered in line with the prescribers instructions.

At our previous inspection people, staff and relatives told us there were not sufficient staff available. Call bells were not responded to promptly and where a vast number of staff left the home, the registered manager had not reviewed the possible reasons for this, resulting in significant vacancies. At this inspection we found staffing throughout the home had improved, although further improvement would be required with on going recruitment to maintain the staffing levels.

People, their relatives and staff told us there was enough staff around to meet people's needs. One person told us, "A lot of staff left and new ones came. I think the numbers are better now." Another person said, "They come and help me. I think they are enough now. " One relative told us, "Staffing seems better now but it`s a shame so many girls left." Staff told us that they were happy with the staffing levels in the home and they felt there was team work now. They told us they had time to talk to people and provide personalised care and support because there were fully staffed and no agency staff were used.

We observed that although staff were busy, especially in the morning, they responded to call bells in a timely manner and people looked presentable and well groomed. We saw that when staff were talking to people they took their time to listen and address their worries. For example, we heard a person shouting from their bedroom and feeling anxious. Staff went in and talked to the person who visibly calmed down and told staff what they wanted. The staff member addressed their issue and explained them how to use their call bell.

Since the last inspection the provider had increased staffing in mornings and mealtimes to exclusively assist those people who required a higher level of care. We saw this staff member assisted those people cared for in bed and was able to spend the required amount of time assisting them with eating, drinking and personal care.

Staff confirmed to us that this recent measure had positively supported them when providing care as they were able to spend longer with other people. In addition to this the provider had reassessed the numbers of staff they required and were in the process of recruiting to a variety of positions across the home, whilst continuing to performance manage those staff whose skills did not meet the required standard. The interim management team now maintained a visible presence in the home, and had implemented a monitoring system to record and review the incidence of falls, incidents and injuries in the home. They used this information to review the staffing levels to identify emerging themes or patterns. People and relatives told us the interim manager was visible and approachable within the home. One person's relative told us, "[Manager] is always around, they have made the staffing better and have looked at the busy times to bring in more staff. Unlike the last manager, this one will muck in with the team if things get tough."

We looked at the recruitment records maintained by the administrator and found that safe recruitment practises continued to be followed. All the records we looked at demonstrated potential staff accurately completed an application with full employment history, and were supported with appropriate professional references. Staff had all undergone a criminal records check prior to commencing employment and evidence of identity had been seen to help ensure that staff continued to be of sufficiently good character to work in the home.

Requires Improvement

Is the service effective?

Our findings

People told us they enjoyed the food and they were given plenty of choices. One person said, "I like the food, it`s nice." Another person said, "We have plenty of choices here and there is always a cup of tea and biscuits going around."

However, relatives also told us that they were not confident that staff understood their loved ones dietary needs and therefore they were not confident that these needs were met. One relative told us that often they had to challenge staff on what type of food was served to their relatives. For example, one relative told us that on the day of the inspection the meat served had been in gravy and their relative had intolerance to this and it could give them discomfort. They also told us this was not the first time they had to address this issue. Another relative told us that had been at times concerned that their relative was only offered sandwiches as an alternative to a hot meal because the main meal had ingredients they could not tolerate. They told us that only recently they felt more reassured that this will not happen again after they addressed this with the manager. The deputy chef on the day of inspection was not aware of people's specific dietary needs, for example those who may be diabetic or had allergies, and was not aware of those people who required food fortifying. Staff, people and relatives told us that people's dietary needs were better supported when the main chef was in the home, and on disclosing our findings to the management team, immediate action was taken to address this.

Where supplements were provided to people to support their weight, staff did not follow the guidance and best practise associated with their use. For example, we found that people were given their supplement prior to eating their lunch. This meant that people were full prior to eating and therefore did not eat their meal, which did not promote healthy eating or weight gain.

People were weighed regularly and where a weight loss was identified, staff involved the person`s GP and a dietician to ensure they had specialist advise in meeting people`s nutritional needs. However, we found instances when staff omitted or forgot to weigh people or record the weights in people`s care plans. For example, a person`s care plan indicated that they should be weighed weekly. However the care plan only evidenced monthly weights. This person was seen by their GP and the dietician and were having several food supplements prescribed to them during the day and also the dietician recommended fortified diet for them. However, a further 14 people were referred to the dietician service following our request for a full review of people's nutritional needs.

This meant that although people received food and fluids, this was not always appropriate or suitable for their particular need. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed throughout our inspection that staff sought people's consent prior to assisting them, and provided explanations to people when requested. Where people declined, staff respected their view, explained the potential consequences but left the person to then decide for themselves. For example, one person declined to have their wash. Staff were heard to explain to the person the importance of bathing,

particularly due to their skin condition, however, the person was fully able to make their own decision, and staff respected their view. We saw from care records we looked at that consents to care were signed, either by the person receiving care, or by the next of kin. However, these consents were not always signed by a person who had the legal authority to do so.

Staff understood the importance of giving people choices, and we observed numerous examples where staff sought people's consent. One staff member told us about a person who chose to stay in their room. Although the staff member encouraged them to engage in activity, the respected their decision but also kept an eye on them through the day. We further saw that staff asked people to make their own choice from the menu. One person confidently informed staff they did not require their assistance and that time, and asked them to leave them alone, which we saw was acknowledged and the staff member left. Once the person had calmed down, staff approached them, explained how they needed to support them and did so once the person agreed.

The Mental Capacity Act 2005 (MCA 2005) 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.

We found the provider had applied the principles of the MCA to all those we reviewed. We saw that capacity assessment had been completed for specific decisions such as the use of bed rails and these had been regularly reviewed. We found that staff were knowledgeable about the principles of the MCA and they followed best interest processes to help ensure that the way people received care and support was in their best interest. However MCA`s and best interest decisions were not always clear in what the decision was and why it was taken. For example, in a person`s care plan staff were prompted to contact the person`s relative before the person was taken to hospital so the relative could decide if this was in the person`s best interest. However in this case the decision seemed to be solely with the person`s relative and we had found no evidence that this relative had Lasting Power of Attorney (LPA) so they could take this decision lawfully. The provider advised us this was an area they were developing and improving at the time of the inspection, and assured us that all consents relating to people's care and treatment would be reviewed as part of the on-going care review process.

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). Staff told us about people who lacked capacity to take certain decisions and had restrictions applied in order to keep them safe. Staff demonstrated they followed the least restrictive process to keep people safe. For example, using bedrails to prevent people rolling out of bed and for others they used a low raise bed and a crash mat. For those people identified to be deprived of their liberty the appropriate consents had been requested.

People told us that they felt staff were sufficiently trained and skilled to care for them. One person told us, "They know what they are doing." One relative said, "I think they [staff] are trained and some of they are quite knowledgeable." Staff told us they had regular training and they were happy with the support they received from the manager. One staff member said, "It is the first time I feel supported in a long time. The training is good and the manager listens." A second staff member said, "The Head of Clinical Standards has been mentoring me and I have really learned a lot more about care in areas that weren't available to me before. I am grateful because they have set me some challenges that I find really useful."

Staff told us there were regular meetings they attended and were kept up to date with the changes happening in the management structure in the home. They told us there was a good communication between the different roles and everyone knew what the expectations were from the provider. They told us they had thorough handover between each shifts and also a `10 to 10` meeting every day where all the managers and seniors gave updates about people and their changing needs.

We saw that staff involved health care professionals in people`s care once they became aware this was required. Care plans evidenced involvement from GP, dieticians, chiropodists and opticians among several visiting professionals.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. One person said, "The girls are all nice and caring." Another person said, "I do think they are kind and very friendly." One relative said, "They are very respectful and they are patient."

People received care from staff in a kind, caring and respectful manner. Staff were friendly, courteous and smiling when approaching people. We observed sensitive and kind interactions between staff and people who used the service. Staff addressed people using their preferred names and it was clear that staff knew people well.

Staff ensured they knocked on bedroom doors and greeted people when they went in to assist them. Staff stopped and talked with people, offering reassurance and explaining things to people in an unhurried way. Impromptu conversations and joking between staff and people helped to create a relaxed and warm environment.

We observed that people`s privacy and dignity was promoted. People looked presentable and well groomed. People`s hair looked clean and combed and men had been shaven and peoples nails were clean and maintained. Staff were seen to ensure they helped people to change their clothing if this got stained whilst eating.

Where people required support with personal care, staff identified this and approached people sensitively addressing the need quietly and without drawing attention to the person. The considerate manner that staff adopted when going about their daily routines created a sense of calm and a warm homely feel in the home where people were smiling and seemed happy. However, we found that people who required hearing aids to assist them with communicating were not routinely put in for people. This caused people difficulty in talking with staff about their needs or just day to day discussions. The interim manager told us, "We are starting the fundamental basics of care and dignity all over again, and part of that is to support staff to ensure these things are addressed."

The consistency of involving people in their care was variable. Within Knebworth unit we found this to be considered and reflected within care records, however within the remainder of the home, care records were sterile, lacking the necessary details to bring the document to life. People and relatives confirmed that the 'Peoples voice' was an area that continued to need improving. Although communication between people and staff had improved, there remained further work to ensure people felt their views and opinions were listened to. One person said, "They phone if [Person] is unwell, have a discussion when we visit, and honestly things are a lot better, we at least get some information. However, feeling listened, valued and that our views matter, that is a long way off, but I feel confident it is coming." We found that the only consistency in recording people's preferences and wishes was within Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions. People, relatives, staff and their GP were involved in discussing this and people`s views were listened. Where peoples wishes around resuscitation were met, we saw a clear record that considered the persons views, in addition to appropriate medical advice. To ensure people's views and

choices were both consistently documented and reviewed as necessary was an area that required improvement.

People`s personal information was kept securely locked in the office to ensure confidentiality was maintained. Staff were careful to keep their voices lowered when discussing people's needs so not to be overheard, and appropriate training and policy was in place to manage people's personal information.

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us they felt the responsiveness of the service to their changing care needs had improved, but still required further development. One person's relative told us, "There has been a lot of activity with the environment, recruiting staff, and changing the manner the staff provide care, but there remains a long way to go before I would say they respond to [Persons] needs." This comment encapsulated the views of those we spoke with who all confirmed that work had begun in this area but required further improvement.

Peoples care needs were not consistently responded to as their health needs changed. On the nursing units, people's care plans were not always sufficiently detailed. For example, we saw that where people were identified at risk of choking, a management plan was not in place for staff on how to mitigate this risk. One person who had breathing and swallowing difficulties was seen to be left slumped in bed, where they should have been sat upright to minimise the pressure on their breathing among other concerns. Where people`s behaviours could be challenging at times we found that there were no plans for staff to follow as to how to effectively deal with this behaviour. One person had struck staff on two separate occasions when receiving personal care; however this did not prompt a review of this need. The management team where in the process of reviewing all people's care plans, and had started with those considered to be more complex and with the highest needs. Although the plans that we looked at for these people were more comprehensive and personalised, there was a considerable number to review.

People`s care plans on the nursing unit lacked personalisation and were not reflective of what people liked, disliked or their preferences regarding the care and support they received. There were little details for the reader to understand people`s condition and related needs when they moved in the home, and to establish what their progress was or if their needs changed. Nursing care plans around wound care management lacked detail and were inconsistent in evidencing if people`s wounds were healing or not. When people attended hospital, information was not obtained with regard discharge planning, and one person was not assessed prior to returning to the home following a fall. This resulted in them experiencing a further fall and resulting injury, with no amendments made to their care plan to meet their changing need. This incident has been referred to the local authority safeguarding team, a professional regulator and CQC are currently considering our enforcement options in relation to this incident.

Where people had not received an appropriate assessment where their needs had changed, this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that people were occupied and engaged throughout the day of the inspection with activities such as pampering session in the morning with nail care, hand massage and tea and cake followed by musical entertainment in the afternoon. There were a range of activities organised daily and people could chose if they wanted to join in. Those people who were cared for in bed had staff popping in and out of their room through the day talking to them, and offering similar activities to them as those in the communal areas. The additional care staff member's role was to dedicate their time when not assisting people with their meals to meaningfully engage with these people. At the time of the inspection, the management team

continued to review and implement new activities that people could engage with, either socially around the home or on their own.

People and relatives told us that they could raise their issues with the manager or staff if they had any. They told us they found that manager responsive to their concerns and measures were implemented to try and solve these, however these did not work in all cases. For example a relative told us about their repeated complaints about the laundry service in the home. They told us they often found that their loved ones clothes were left in their basket in the laundry and staff failed to appropriately dress the person as clothes were not available in their room. Relatives however told us that where complaints were escalated to the Regional Manager, they felt their concerns were not addressed, and in some cases people did not receive an adequate response. We looked at a sample of complaints received, and although we found that the management team responded to complaints raised to them, where complaints were escalated, the response time was variable and not in line with the providers published complaints policy. The management of complaints was an area that required improvement

Since our previous inspection, meetings had been held with relatives and people who used the service. These were well attended and representatives of the provider also attended to answer concerns people had about the home following the departure of the registered manager and deputy manager, as well as findings from CQC and the local authority. Relatives who attended this meeting told us they found it to be useful and a new change from management. One relative told us, "We had meetings before with the old manager but I have found that this new bunch seem to be dedicated to making changes and being truthful."

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection relatives and staff told us the registered manager was not responsive to concerns raised with them and was not visible around the home. People's relatives told us they did not raise issues or concerns with the registered manager for fear of repercussions and previous lack of action from them. Governance systems to monitor the quality of care provided were not effectively used. Continual concerns regarding staffing levels raised at the previous inspection in October 2016 had not been addressed. At this inspection we found the provider had made improvements however further improvements were still required to ensure the service was well led.

Staff we spoke with confirmed that things in the home were improving and felt the steps taken so far were having a positive impact on them and people living at the home. However they also acknowledged further work was needed. One staff member said, "At the beginning [Provider] was flummoxed, it was good to see them become more human as they understood, and we are now becoming more involved in the running of the home." A second staff member said, "Morale is low but we see the progress, the changes are for the good of the residents, the management are now approachable and take our ideas on board."

At this inspection we found that people's care records continued to lack up to date information regarding people's changing and current needs at that time. Improvements had been made since the last inspection in some areas, and we found that the care records for people in Knebworth Court were generally up to date and illustrative of people's needs. However those people within the main part of the home, and with nursing needs, did not have the same complete care records. For example, we found where wound charts had been completed to record a wound had been observed, however no documentation was seen in the corresponding record to say how the wound occurred and did not contain a skin integrity plan to manage this. One person was found to have a wound on a pressure area, however the care plan inaccurately recorded the person should then be placed on to this pressure area. A second person was seen to be slouched in bed, when we spoke with staff about their needs they were aware this person had difficulty breathing; however there was not a care record in place to address this.

People`s care plans on the nursing unit continued to lack personalisation and were not reflective of what people liked, disliked or their preferences regarding the care and support they received. The interim managers told us that care planning across the home was an area they were focusing on. Work had begun reassessing people's needs and developing their care plans, however staff had started with those people considered to be most at risk, and had not at that point fully reviewed all people. Whilst people's health needs were reassessed, this meant people continued to be at risk of poor care as an accurate record was not developed to instruct staff how manage the risks to their welfare.

Governance arrangements in the home, although had improved since our last inspection, continued to not support effective improvement through assessing and monitoring the care provided. Although the provider and interim managers had undertaken a significant amount of work in a short period to address this, we found incidents continued to be unreported, and monitoring of people's weights in the home was ineffective. We further asked the Regional Manager to supply CQC with a copy of the provider's quality audit

of the home, which they told us they would do. However, this audit was not received by CQC to demonstrate how the provider monitored the service regularly. The provider had developed an improvement plan, and shared this with management, staff and people, however when we spoke with the interim management team and regional manager, it was clear that the service had been responding to the immediate risks, without one person maintaining oversight of the on-going issues. The management team told us it was unfortunate that some of the areas of the improvement plan had not been acted upon as swiftly as they would have wished, and felt that the lack of stable and consistent leadership was a factor. With the appointment of a new registered manager imminent, it was felt this would then enable the areas for improvement identified to gain stable improvement over the coming months.

At our previous inspection we spoke with the registered manager regarding the condition of furnishings and carpeting in Knebworth Unit. They assured us they would renew chairs, furnishings and carpets as they acknowledged these were unclean and contributed to the malodour on the unit. However at this inspection no action had been taken to address this in a timely manner. We received a purchase order from the regional manager to confirm these works were planned, however action was required to have been taken before this inspection.

This meant that although some improvements had been made, accurate records of peoples care needs continued to not be maintained and systems to monitor and improve the quality of service were not consistently effective. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection the home did not have a registered manager in post. Since our last inspection the registered manager had left the home, along with the deputy manager. The provider had immediately put in place interim management support following our last inspection, and then increased this at the departure of the registered manager. People, relatives and staff were more positive at this inspection regarding management, and felt more confident in approaching management for support. One relative said, "I find the managers are now good and listen to me. I can now raise any issues when I am visiting." One staff member said, "It is so nice to be able just to knock on the manager`s door and to feel valued by them. They will stop what they are doing and take an interest in what I have to say."

Staff told us that the culture of the home was to be transparent among the time with the challenges facing staff, and keep staff informed of the improvements made. This we were told helped bring about a culture of openness and honesty within the home. A newly employed staff member told us, "The manager was very honest and they told me in the interview that the home needs improving. I was introduced and they showed me around. There is a lot of work going on now." Although some staff told us morale was low at times, we found that the interim managers had discussed through team meetings matters relating to the home and improvements required.

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 Person Centred Care. Regulation 9 1 (a) (b) 3 (I) People did not receive care that was appropriate to their needs in order to meet peoples nutritional and hydration needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe Care and Treatment Regulation 12 (1) (2) (a) (b) Peoples needs in relation to their care and treatment were not assessed as their needs changed and reasonable practical actions were not undertaken to mitigate such risks.

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 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) Systems and processes were established but not operated effectively to prevent abuse of

service users.

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 Good Governance Regulation 17 (1) (2) (a) (b) Systems and processes although established were not operated effectively to assess, monitor and improve the quality and safety of the services provided. In addition these systems and processes were also not effectively operated to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service.