Monread Lodge Nursing Home Limited

Monread Lodge

Inspection report

London Road
Woolmer Green
Knebworth
Hertfordshire
SG3 6HG

Tel: 01438817466

Date of inspection visit:
08 September 2021
15 September 2021

Date of publication:
14 December 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two 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.

Service and service type
Monread Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. We visited the service on 08 and 15 September 2021.

What we did before the inspection
We spoke with 14 relatives about their experience of the care provided. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with 11 members of staff including, nurses, care staff, housekeeping, kitchen staff, the registered manager, deputy manager and two senior managers for the provider.

We reviewed a range of records. This included eight people's care records, accident and incident records

and multiple medication records. We looked at records relating to the management of the service including audits, meeting minutes and the service improvement plan. We provided feedback to the registered manager and senior management team on 24 September 2021.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We referred our findings to the local authority commissioning team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Monread Lodge

Detailed findings

Background to this inspection

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Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

- Risk to people's health and well-being were not always assessed and mitigated. We found that air mattresses for people at high risk of developing pressure ulcers were not set correctly. The deputy manager told us they did not maintain a record of correct settings for staff. This did not demonstrate a safe process of assessing risks to people and the use of pressure relieving equipment.
- Injuries had been reported to management, but this did not prompt a review or referral to health professionals input to re-assess the equipment which put people at risk of harm. One person had suffered a skin tear to their leg whilst using their wheelchair independently. Staff did not seek a specialist assessment to consider alternatives when a person cut their leg whilst using their wheelchair independently or when people had been found with bruising due to entrapment between their bed and the bedrail.
- A short summary assessment was in place to provide staff with a quick overview of people's care needs like mobility and risks of falls. These were not up to date and led to a risk of agency staff or new staff being unaware of how to support people safely.
- We found two people were prescribed medicines that were to be administered at specific times. We asked staff why medicines for these people were not administered as prescribed. They told us, "It's because they are both at the end of the corridor so that is when we get to them."
- The risk of cross contamination was not mitigated fully. The staff room area was not kept clean or in line with current infection prevention and control (IPC) guidance. We found that bins used to dispose of used personal protective equipment (PPE) were overfilled and the lid open. The provider and registered manager had been advised by the infection prevention and control audit carried out by the deputy manager prior to this inspection to remedy the above actions but had failed to do so.
- Staff were not aware of how frequently to clean high use touch points and what chemical to use. Two bathrooms had a strong, unpleasant odour and the floor was stained and looked unclean. Covid-19 care plans were not in place at the time for people's records we reviewed.

The lack of assessing risk and taking action to mitigate risks to people's health and well-being was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Medicines were only managed and administered by staff who had received appropriate training. Competency assessments were carried out to ensure staff remained safe to administer medicines.
- Records were accurately maintained, and stocks of medicines (including controlled medicines) tallied with the stock recorded. Staff completed medicines records when administering medicines, and kept a record when people refused.

● The provider's infection prevention and control policy was up to date. Shielding and social distancing rules were followed and we observed that staff were using PPE effectively and safely. People were admitted to the service safely, and visits for people were being provided in accordance with current guidance. The registered manager ensured that testing was in place for people using the service and staff.
● Following the inspection, the registered manager and the provider took immediate action to address some of the concerns we detailed above.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Safeguarding concerns were not always reported to local safeguarding authorities. For example, incidents between people which resulted in harm. Staff were not aware of safeguarding concerns raised or the outcomes of those.
● The registered manager investigated when concerns were raised by people, however this was not robust and did not prompt action to be taken to keep people safe. People repeatedly raised with the registered manager that staff had directed them to use their incontinence aids if they needed the toilet. The only action recorded by the registered manager was that they raised this with staff in one handover. Staff told us they have reported this as well, but nothing happened as a result and this was still happening.
● Staff were not able to describe to us where they have reflected on incidents, or trends emerging through audits to develop their practice.. Lessons learned were not embedded in practice. These were discussed in team meetings, but failed to address identified areas of risk or to share good practice in response to identified themes such as a person sustaining numerous falls, or repeated incidents between people using the service, unsafe use of equipment or a lack of maintaining people's personal care and dignity.
● A complaint against the service was substantiated by the Local Government Ombudsman (LGO) in relation to consent arrangements not being followed. The LGO had found improvements were required, and this inspection identified the same, however staff had not been supported to understand how to improve through reflective practice.

People were not kept safe from the risk of harm and abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they received safeguarding training and they knew the signs and symptoms of possible abuse. They told us they reported their concerns to the management team in the home and were aware of reporting, if needed, to local safeguarding authorities and using the whistleblowing policy when needed.

Staffing and recruitment
● There were not enough staff effectively deployed to meet people's needs safely. People sat in communal areas in the morning for over an hour and a half, without help from staff to eat or drink. Care plans identified they required assistance from staff but, as this was not provided due to staffing, these people did not eat.
● People in their bedrooms were asleep in their chairs whilst their breakfast was left on the side table for a number of hours. Staff administered people's medicines but failed to prompt them to eat and drink whilst being in their rooms.
● People experienced a delay when summoning assistance. We reviewed call bell logs and found delays frequently in excess of 10 minutes, with one example of a 21-minute delay. This significant delay had not been identified by the registered manager or the provider.
● Staff told us there were not enough staff in the dementia unit. One staff member said, "Staffing [issues] are more about the deployment. The dementia unit is forgotten as its right at the back. In flash meeting we discuss it and things improve then a few days and it goes back."
● People were not receiving the support they needed to keep safe. Staff were not present for most of the

falls people living with dementia had in the communal areas. For example, one person had experienced three falls in a period of five hours, staff were not present for any of these to know how it happened and take preventative actions.

There were not enough staff deployed to safely meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection the provider increased staffing in the dementia unit and they started to review the dependency assessments in place to establish if this was accurately reflecting people's needs and the staffing required.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

● The process for assessing people's capacity and decision making did not meet the principles of the MCA. People's capacity assessment and best interest forms were completed with the same generic wording suggesting the assessments were prepopulated and staff only changed people's names when they completed the care plans. People, and their relatives when appropriate or legal appointee, were not always involved in decisions. People did not have easy access to information about independent advocacy services.

● People were at risk of their liberty being unlawfully restricted. We found examples where MCA and best interest assessments had been completed after restrictions had been placed on people's freedom. Best interest decisions had no evidence that staff had considered the least restrictive measures possible when restricting people's freedom in order to keep them safe. For example, in relation to use of bed rails or being under close supervision.
● Do Not Attempt Cardiopulmonary Resuscitation [DNACPR] decision had been put in place during hospital admissions. However, these were not reviewed when the persons condition improved or when they moved back to the home after a period in hospital. National guidance is in place to ensure that when a person moves care setting, their decisions are reviewed.

Not following the MCA principles when carrying out assessment of capacity and best interest decisions was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Staff carried out assessments of people's needs prior of them moving into the service. Care plans and risk assessments were developed from these assessments to ensure people's needs could be met in the home.

● Staff updated care plans; however, these updates were not consistently completed when people's needs changed. We found inconsistent information in care plans about people's mobility, nutrition and falls.

● Staff were not always following recommended best practice guidance and assessment tools to establish risk levels for people and to develop effective care plans. For example, the progress of people's wounds could not be monitored effectively, due to lack of recording.

● Positive behaviour support plans were not developed for people whose behaviour at times challenged others. ABC charts were not effectively used and analysed to try and identify and prevent triggers for people's behaviours. An ABC chart is an observational tool that allows staff to record information about a behaviour.

Staff support: induction, training, skills and experience

● Staff told us they received training when they started working in the home and they had refresher training in subjects considered necessary by the provider. These included safeguarding, infection control, dementia awareness and other training relevant to staff roles.

● Staff told us they found the training provided helpful; however, they had no time to read people's care plans and understand the level of need and support they required. One staff member said, "The training is helpful, but we should be asked to read people's care plans to understand and know what and how they need us to support them. We don't have time to do this."

● Staff told us they found that managers were approachable. One staff member said, "The management is okay. They could do a bit more for staff (listen and support). They are trying to do their best." We confirmed that although staff felt managers could be more supportive, they received supervision with their line manager to review their performance.

Supporting people to eat and drink enough to maintain a balanced diet

● People were not always supported in a timely manner to eat their meals whilst hot. We saw that in the main dining area staff supported people in a calm and pleasant manner, however in the dementia unit or where people were eating in their bedroom they were left for long periods of time without being encouraged or supported to eat and drink.

● During the inspection the provider and registered manager re-deployed staff in a more effective way so that at mealtimes every staff member could support people with their meals.

● Food and fluid charts were used to monitor people who were at risk of dehydration or malnutrition. These were not always completed accurately, totaled for intake over 24-hour period or indicative or what fluid target people should meet. Staff had no clear guidance on when it was expected for them to raise concerns if people had not drunk or eaten enough.

● People's weight loss was monitored and, where needed, people referred to dietician support. This was in addition to the fortified meals the kitchen staff prepared.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Health professionals we spoke with had mixed views about how staff enabled effective communication. One health professional told us staff were not consistently following their advice, which impacted on people's treatment and support plan. They told us staff were not recording in sufficient detail the care and support that people needed for them to be able to effectively assess people's needs.

● Another health professional told us they found staff knowledgeable and referrals made were appropriate and completed in a timely manner when people's needs changed.

Adapting service, design, decoration to meet people's needs

● The environment in the unit where people with dementia lived was not dementia friendly. There were no contrasting colours to help people's orientation or objects of interest people could pick up and occupy their time with.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People's care records were not always contemporaneous, accurate or complete. Care plans we reviewed were inconsistent and had conflicting information recorded throughout. For example, for one person the care plan was contradictory as to whether their diabetes was insulin or diet controlled. For another person if they were able to walk independently or needed the hoist.

● Most daily records were handwritten and illegible. This meant it was difficult to interpret any changes to people's health needs or resulting actions required. Within a monthly analysis the registered manager had completed about the service they confirmed that action had been taken, such as updating of the care records. However, we found numerous examples where care records had not been updated appropriately.

● Daily care records such as food and fluid charts did not include a target for people and were not always completed. Comments on how people ate, or drink were conflicting and had not been identified as inaccurate by staff. For example, one staff member noted, "Ate very well, even eating dessert, which was yoghurt, [Person] is settled now." Another staff member reported directly under the above comment for the same person that, "[Person] had lunch but barely ate due to the pain."

● Care records, particularly MCA and best interest assessments, had been 'copied and pasted' across several people's assessments. For example, a nutritional assessment for a person had different people's names on the same page. This had not been identified by staff or management in the home.

The provider had failed to ensure an accurate, complete contemporaneous record in respect of each person living at the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 [Regulated activities] regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● We found several incidents where people had suffered harm or been exposed to a significant risk of harm. The provider and registered manager had not followed their legal responsibility. Where something went wrong with people's care, or had the potential to cause, harm or distress they had not kept the person, or their advocate informed. We found no evidence where managers had apologised, offered an appropriate remedy or provide support to put matters right. Management did not explain fully the short- and long-term effects of what had happened.

● The registered manager was asked to show us where they had followed Duty of Candour where people had sustained an injury or been at risk of harm. They told us they were not able to show us this evidence as

the process had not been followed.

The failure to act in an open and transparent manner when things went wrong was a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

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

● The service was not safely managed. Monitoring and oversight by the management team and senior managers did not identify concerns found at this inspection. Systems were in place to audit the quality of care people received but these were not effective in identifying issues or driving improvement.

● The registered manager and the provide carried out audits, for example, call bell audits, care plan audits and audits of accidents and incidents. These were ineffective in identifying trends and patterns and have not led to improvements. We found people experienced delays when they summoned assistance and there was an increase of incidents of physical aggression between people.

● The increased behaviour that challenged incidents between people living with dementia had resulted in injuries. This had not prompted the registered manager to seek additional training for staff to acquire skills to prevent these incidents. The training staff received was basic dementia training and breakaway techniques in circumstances of aggression and physical assault, not prevention. There were no reviews of the patterns of incidents to determine any triggers for these and implement preventative measures. Not taking any action led to these incidents to reoccur over an extended period.

● The registered manager and the provider failed to effectively action shortfalls identified by the local authority through their monitoring visit. For example, in July 2021 it was found that positioning charts had significant gaps and numerous MCA, best interest decisions and DoLS assessments were not following the principles of the MCA. We still found the same concerns at this inspection.

● The provider failed to make improvements needed in a timely manner to improve the quality and safety of the care people received. They carried out an internal audit which reviewed the quality of care people received in August 2021. Some areas needed improvement were identified including the issues found by the Local Authority in May 2021, these were still outstanding. The action plan developed did not provide enough detail on how to monitor the improvements or target dates for completion. required.

Systems and processes in place did not effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of people living at the service. This was a further breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 [Regulated activities] regulations 2014.

● We provided feedback to the registered manager and representatives of the provider. They acknowledged the numerous concerns found and immediately assigned a manager to support the new registered manager in their day to day role at the service. Two management support staff were also deployed to the home alongside the quality improvement team to address the improvements required. Staffing was reviewed which led to an increase of staffing.

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

● People's feedback about the quality of the care they received was not always acted upon. People raised in meetings that staff were not always listening to their choice of when they want to get up or go to bed. They also raised concerns about waiting times to use the toilet. The registered manager raised this with staff in handover, however they took no further action when people continued to give feedback about this not improving.

● When needed staff involved health and social care professionals in people's care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure mental capacity assessments and best interest decisions were carried out following the Mental Capacity Act 2005 principles.

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 Regulation 12 (1) (2) (a) (b) (e) Risks to the health and safety of service users of receiving the care or treatment were not assessed when their needs changed. Actions to reasonably mitigate any such risks were not put in place. Equipment used for providing care to a service user was not safely assessed or maintained.

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) Systems and processes were not operated effectively to prevent abuse of service users. Systems and processes were not operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence

of such abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour Regulation 20 (1) (2) (a) (b) The registered person did not act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

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) Sufficient numbers of staff were not deployed to support service users in a timely and safe manner.