Monread Lodge Nursing Home Limited

Monread Lodge

Inspection report

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24 May 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Monread Lodge is a purpose built care home and is registered to provide accommodation and nursing care for up 62 older people some of whom live with dementia. At the time of our inspection 56 people were living at the home.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 inspection took place on 11, 12, 15 and 25 May 2017. This inspection was in response to concerns we received regarding low staffing levels in the home. The inspectors arrived early in the morning of 11 May 2017 to inspect the service unannounced. On 12 and 15 May 2017 we contacted people's relatives by telephone, and on 25 May 2017 we met with the provider to seek assurances due to the nature of the concerns identified at this inspection.

At our previous inspection on 18 October 2016 we found a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not supported by sufficient numbers of suitably trained and skilled staff.

At this inspection we found improvements had not been made in areas relating to safe care and treatment, staffing levels, and governance systems to ensure the service provided was safe and of good quality. At this inspection we found a continued breach of Regulation 18, and new breaches of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to safe care and treatment, because people were not supported by sufficient numbers of staff deployed, and ineffective governance systems were in place to identify and improve the quality of care people received.

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.

People were not supported by sufficient numbers of staff. Staff did not respond promptly when people required assistance. Staff were knowledgeable in relation to keeping people safe from harm and reporting incidents to management, however patterns were not always robustly investigated and responded to quickly. Staff were not consistently aware of people's current needs and how to keep people safe from the risk of harm. People's medicines were not consistently managed safely and we found an incident where one person had not received their medicines as intended by the prescriber.

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

were available to the registered manager to use to monitor the quality of care provided, however they were not effectively used. Continual concerns regarding staffing levels raised at the previous inspection and subsequently by staff, people and relatives had not been addressed. People's records were not reflective of their current change of needs.

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 safe.

People told us they felt safe, however this view was not supported by the relatives we spoke with.

People were not supported by sufficient numbers of staff.

Risks to peoples safety and well being had been assessed, however staff were not consistently aware of the risks.

Peoples medicines were not managed safely, and people did not receive medicines as the prescriber intended.

People were supported by staff who had undergone a robust recruitment assessment.

Is the service well-led?

Requires Improvement

The service was not 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 not implemented. Where issues were identified, these were not remedied in a timely manner.

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

Staff felt supported by their line manager.

Staff did not feel listened to or valued by the registered manager.

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 12, 15 and 24 May 2017 and was unannounced. The inspection team consisted of two inspectors.

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 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 six people who lived at the home, 15 of their relatives, six staff members, the deputy manager, the registered manager and the provider. We looked at care records relating to seven people and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Monread Lodge. One person told us, "I do feel safe because I am in bed all the time." Another person told us, "I feel safe because I have my call bell." However, of the fifteen relatives spoken with, fourteen told us they were worried about people's safety. For example one relative told us, "I am very worried. I don't feel [person] is safe here, staff are very busy and they don't have the time to really care. I always have to ask them to do things". Another relative said, "I am so worried at times and I feel the need to be here." Other relatives spoke with told us they visited frequently as they were worried people may not always be safe.

At our previous inspection people, staff and relatives told us there were not sufficient staff available. At this inspection we found no improvements had been made. People, staff and relatives told us there were not enough staff deployed. One person told us, "Staff haven't got the time to get me up, so I stay in bed all the time. I am quite happy but if they would offer to get me up I would take to opportunity. I don't want to ask because I know there's not enough of them. They really need more staff." Another person said, "The trouble is that staff come and go and there is not enough staff here. I don't think it`s their job to take me out (in a wheelchair) because they have so much to do but I would go out if they would offer especially when the weather is so nice." One relative told us, "No there are not enough staff. You can see them running around and by the end of the day some of them look ill." Another relative said, "They need more staff. [Person] is not safe with the number of staff they have here."

We observed that staff were busy especially in the morning and people who required supervision, such as those at risk of falls were left in communal areas for long periods without staff being present. For example, in the morning on the dementia unit seven people were up at 8am sat in the adjoining dining and lounge area. The senior staff member was administering medicines to people whilst one care staff member was elsewhere assisting people to get up. This meant there was additional pressure on the staff member administering people`s medicines to also supervise people in the dining area, some of whom were assessed as at risk of falls, with one person who was assessed as being at high risk and had experienced a number of falls previously. However, they shortly after 8am moved from the main corridor to a side corridor so were no longer able to monitor people's safety which meant people who required monitoring to keep them safe from risks such as falling were unobserved.

People told us that on occasion staff were not quick in answering their call bells. One person said, "If I ring the bell in busy times I have to wait maybe ten minutes for them to answer." Another person told us, "If I ring the bell usually takes them between 5-10 minutes to answer." This was confirmed by relatives who told us when they asked staff to help people to go to bed or the toilet they had to wait up to 30 minutes because staff were busy. We asked how the registered manager monitored call bell response times and they told us they reviewed a random days call bell responses for 12 people a month. We discussed this with the registered manager who agreed that this was not a sufficient number to ensure call bells were monitored effectively as the sample size was not proportionate to the number of people in the home. People`s relatives told us in addition that they had visited the home on a few occasions and found their relative had the call bell removed. Staff confirmed to them that this was so they did not summon assistance when staff

were under pressure. This meant that people's safety was not promoted because staff did not promptly respond to people when they summoned assistance leaving them at risk of harm.

An extra member of staff did arrive on the dementia unit at 9am to assist people who needed assistance of two staff. However this further meant that people were sitting in the dining area without staff being present from 8am to 9.30am when staff started serving breakfast. One staff member told us, "We are not supposed to talk about staffing. However there isn't enough staff and people could be at risk because were are not around." Another member of staff said, "For a long time we didn't have an increase in staffing and people`s needs are changing. We need more staff especially busy times."

We looked at staffing records that demonstrated since the last inspection on 18 October 2016, 29 staff had left employment at Monread Lodge. Of these, 16 were care workers, four were senior care workers, three were nurses and two were deputy managers. Analysis of why people were leaving the home had not been carried out by the registered manager to enable them to review their processes. At the time of the inspection the registered manager was in the process of recruiting to vacant staffing posts. When we met with the provider, they told us they were providing administrative HR support to address the high number of staff leaving employment.

All the relatives we spoke with told us they had spoken with the registered manager or deputy manager at some point since the last inspection and informed them there were not sufficient staff available. They told us the registered manager responded that they were fully staffed and did not look further into the deployment of staff. As staff were not sufficiently deployed to meet people's needs and consequently people were at risk of harm or neglect as staff were not effectively deployed to meet people's needs, this was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not consistently aware of the risks relating to individuals. Staff told us about people who were at risk of falls and people who were at risk of malnutrition and weight loss. However, whilst we found that staff looking after people who were assessed as requiring residential care managed the risks appropriately, people assessed as having nursing needs had not always received care and support in a safe way. For example for one person in the nursing unit there was an identified risk of choking. The person had been assessed by the speech and language therapist as requiring a pureed diet and thickened fluids and that they were at an increased risk of choking because their physical condition may have been preventing the required positioning when staff assisted them to eat. The care plan for this person detailed that they should be in an up-right position when eating, however we found that staff were assisting them to eat lying down on their right side. When we asked the staff member if that was the correct position for them to be in they said the person could not be positioned up-right because they had a stroke. The care plan contained no assessment to support this and a choking risk assessment had not been completed. The registered manager told us that staff should have raised the bed when assisting the person to eat and that they would ensure an assessment was in place following the inspection.

People's medicines were managed safely for people with residential needs. We saw that staff followed safe working practices while administering medicines and records checked were completed consistently. We observed staff administering medicines to people. Medicines which were suitable were pre-packed by the pharmacy in individual pots for each person for the times of the day they were prescribed. Where medicines required to be kept in their original packaging, staff counted these after each administration and recorded the amount left on the Medicine Administration Record (MAR). We found that all the medicines we counted matched the records. Medicines for the dementia unit were not stored appropriately. The medicine trolley was kept in a room without ventilation. We found that the room temperature consistently reached 24

degrees and of a couple of occasions rose above 24,5 degrees. The recommended temperature to store medicines is below 25 degrees. If medicines are not stored properly they may not work in the way they were intended, and so pose a potential risk to the health and wellbeing of the person receiving the medicine.

Medicines administered by nursing staff were not managed safely. We identified that medicines were not safely checked in by staff when changed over at the end of the cycle. Whilst we looked at people's medicines we found one person had been prescribed a medicine to manage the symptoms of Parkinson's disease. This person was reviewed by the consultant in January 2017; and their medicine was increased. The persons MAR chart at the time of inspection recorded the old prescription, however the labels on the medicine had recorded the increased dosage. Staff had not ensured the increased dosage was administered since January. Had staff ensured they checked medicines when they booked them in, they would have identified the discrepancy and ensured the correct dosage was given for the following four months. This meant the person had not received their medicine as prescribed and safe practises around the management of medicines were not followed by qualified staff. We have referred our findings to the local authority commissioning and safeguarding teams.

Where people had been prescribed medicines for specific medical conditions they had not always received the treatment as prescribed by their GP. For example a person had difficulties with their breathing. They had two medicines prescribed for them by their GP in form of inhalers to help alleviate their symptoms. However nursing staff recorded on the MAR six times in the two days prior to the inspection that the person had not been able to use the inhaler. They had not reported this to the GP or thought to report to the registered manager to request an appropriate device to enable people who cannot use an inhaler. In addition the GP had prescribed medicines for the person to be administered via a nebuliser. A nebuliser is a device which generates vapours for people to breathe in through a facial mask. We found that the only time the person had this was when their relative visited and found them struggling to breathe and asked staff to set it up. The staff explained that this medicine was prescribed on an as needed basis and could be given up to six times a day when the person showed signs of breathlessness. We saw this person struggling to breathe and staff only administered the nebuliser when the relative prompted them.

Due to the staff not being aware of the risks to people's safety and wellbeing, and a lack of safe management of medicines, this is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of when to report incidents that may mean people were not safe. We saw minutes of meetings demonstrated that staff had also raised concerns regarding staffing levels and deployment. The registered manager was able to share with us examples of when staff had raised concerns when they suspected a person was at risk of harm or abuse. The registered manager described to us an incident recently where they were concerned a person may be at risk of financial harm, and had acted appropriately.

We looked at the recruitment records maintained by the administrator and found that safe recruitment practises were followed. All the records we looked at demonstrated potential staff accurately completed an application with full employment history, and were supported by 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 were of sufficiently good character to work in the home.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection people and their relatives told us that they thought the home was well run. They told us that they would approach a member of the management team if they needed to. At this inspection we found the view of people and relatives had changed significantly. All but one of the relatives we spoke with told us they felt the management team did not listen to them and did not take on board their views in regards to the management and improvement of the home. All the relatives we spoke with told us they had previously raised their concerns about staffing levels in the home. Relatives told us the registered manager dismissed their concerns with comments such as, "The home is fully staffed," and "I'll look into it and come back to you," however did not communicate with people or relatives to inform them how they would seek to make improvements. People's relatives told us they did not always raise their concerns with the registered manager for fear of reprisals and consequences to people living in the home.

One person's relative told us, "What's the point of going to a meeting, firstly they just stick a notice on the board, which changes anyway, and we can't always get to them because we work. Then [registered manager] doesn't want to listen, they are quite intimidating at times." A second relative told us, "I gave up going to the manager to raise anything. They always have an answer for everything and are not very friendly." This showed that the registered manager had not consistently encouraged open communication with relatives of people who used the service. However, the registered manager did show us examples of emails they had sent to relatives at the time of the inspection inviting them to attend the March meeting and also subsequently sent a copy of the minutes to people also.

Minutes of relative meetings held in December 2016 noted that the previous CQC inspection report had been discussed with people's relatives. Although the minutes noted senior managers felt there was little evidence to support this, relatives continued to raise concerns about continuity of staffing at weekends, which was further supported by a second relative querying staff sickness at weekends at that time. Within this meeting there was also a discussion held about people not liking to escalate or raise issues with management. A series of action points were raised, including a revisit of the dependency assessment used to calculate staffing levels, and for both the registered manager and regional manager to contact human resources to look at staff retention issues. In a subsequent meeting held in March 2017, the same issues were raised by people's relatives, particularly with regards to weekend staffing levels. Staff turnover was discussed by people's relatives once again, but no feedback or evidence was provided in response to demonstrate that work had been undertaken to establish the reasons staff were leaving as documented in the previous meeting.

Within the minutes of the staff meeting held on 01 February 2017, staff raised concerns that some night staff may be sleeping whilst on duty. The management team had not carried out a night check in response to this, and only did so for the current year subsequent to our inspection.

There were systems in place to monitor and improve the quality of the service. These included audits and checks. However these were not effective in identifying areas that required improvement. The front cover of the MAR charts had a note by the registered manager to ensure staff conducted daily stock checks of

medicines. This had not been completed or identified by the registered manager as an on-going issue. We further found that stocks we counted of people`s medicines did not tally with the stocks recorded on their MAR. The provider asked the registered manager on a monthly basis to review the number of incidents and accidents that occurred in the home. This assessment showed that for April 2017, 35 people had been found on the floor, having fallen unwitnessed by staff. There were no investigations or specific actions to identify why these may have occurred or how to mitigate future occurrences.

The provider carried out monthly monitoring visits at the home and a senior manager conducted an assessment of the quality of care people received and set actions from this to be completed. We saw from the February 2017 audit that they noted the registered manager had been under additional pressure previously as they did not have a deputy manager in post. However they commented that the deputy was in post at that visit and that they hoped the actions set would be rectified with no delay. In this February audit, the regional manager commented that it was accepted practise for call bells to be allowed to ring for three minutes and that the emergency call was then not perceived as urgent. They noted that, "This needs to change." However this was still an area in need of improvement in the April audit with no indication of what had been done to improve staff response times. The registered manager told us that they considered three minutes to be an appropriate duration, and did not review sufficient call bell responses during the month. Other areas that had been identified with little improvement since January 2017 were care file audits, cleaning, mealtimes, including sufficient staffing available to assist and actions from relatives meeting to be addressed.

Although the registered manager told us that a significant number of staff had left since the last inspection, they had not carried out exit interviews to understand the reasons why staff left. In addition, actions set in meetings to review this with the human resources team had not been completed and did not feature in subsequent provider visits to ensure it was completed.

Each area identified in need of improving in each provider visit was also found at this inspection, and demonstrated that people living at Monread Lodge suffered continued poor care due to a lack of responsive management within the home to address and improve areas identified that fell below the required standards.

We met with the provider subsequent to the inspection to raise the concerns with them about the feedback received from people's relatives. They told us they were aware there had been staffing issues within Monread Lodge, in addition to vacancies in key positions, such as the deputy manager role and nursing staff. They told us they would send a manager to support the home on a full time basis, and that the human resources manager would support the home with both identifying why staff were leaving, and also with on-going recruitment. Subsequent to this meeting the provider met with the registered manager and sent us an action plan that addressed areas such as nurse competency, monitoring call bells, reviews of people's care with relatives, review of the auditing procedures and staffing levels.

Staff told us they had regular supervisions and they felt supported by their line managers. One staff member told us that they felt the registered manager had been supportive of them, and that they gave them the confidence to continue in their role and further develop their skills by undertaking additional training. However most staff also told us that they did not feel listened to by the registered manager regarding a variety of concerns or suggestions they had made including staffing issues. Relatives told us they didn't want any repercussions coming back from the registered manager on their loved one so they avoided complaining. Other relatives told us even if they raised concerns there was little evidence that the registered manager listened to them. For example with the exception of three relatives all the other relatives we spoke with told us that there was not enough staff in the home and they had raised this on several occasions with

the registered manager without any result. One relative told us, "All I get from the manager is, "We are fully staffed! So I stopped going to her. I just feel sorry for the [staff], they work very hard." Some relatives also told us that they were missing out on the opportunity to attend relatives' meetings because the advert for these meetings was put up on the notice board on very short notice not giving them the opportunity to make arrangement to attend. One relative told us, "It`s like they [managers] don't want you to attend. The notice is up sometimes I think minutes before the meeting."

People's care records lacked up to date information regarding people's current needs. In some circumstances the care plan reviewed was not reflective of the person's needs at that time. We found that Mental Capacity Assessments were not in place for areas such as the use of a sensor mats, people's nutritional assessments were not all completed accurately and changes in people's mobility needs were not updated as required. These issues were not identified through audits or reviews of people`s care records.

Since the last inspection little improvement had been made to ensure people were supported by sufficient numbers of staff and that the staffing levels were monitored and adjusted according to peoples changing needs. We found that systems in place to monitor and improve the quality of care were ineffective at identifying and addressing poor practise. People were not provided with the opportunity to provide feedback to the registered manager regarding the running of the service, and did not feel listened to when they did so. Therefore these concerns constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager did not ensure risks to people's safety and welfare were accurately assessed and care provided in line with those needs. People did not receive their medicines in a safe manner.

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 The provider and registered manager did not ensure systems were effectively used to monitor and improve the quality and safety of care that people received. Staff and relatives were not encouraged to share their views on the management of the service, and an accurate and contemporaneous record of peoples care needs was not maintained.

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 The provider and registered manager did not ensure there were sufficient numbers of suitable and qualified staff deployed to safely meet peoples needs.