Monread Lodge Nursing Home Limited

Monread Lodge

Inspection report

Monread Lodge
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Hertfordshire
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Date of inspection visit: 15 September 2015
Date of publication: 11/11/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Monread Lodge provides accommodation and nursing care for up to 62 older people. There were 60 people accommodated at the home at the time of this inspection.

The inspection took place on 15 September 2015 and was unannounced. At our last inspection on 18 July 2013 we found the service was meeting the required standards at that time.

The home had a registered manager in post who had been registered since June 2013. 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.

CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually

Summary of findings

to protect themselves or others. At the time of the inspection we found that applications had been made to the local authority in relation to people who lived at Monread Lodge and a number of these were pending an outcome.

People told us they felt safe living at Monread Lodge. Staff were aware of how to keep people safe and risks to people's safety and well-being were identified and managed. However not all care plans robustly informed staff of how to support people, particularly those with behaviours that may challenge.

People and staff told us there were not always sufficient staff available to support people's needs. We observed at busy periods such as morning and lunchtimes that people had to wait lengthy periods to receive support.

People's medicines were stored safely, however not always administered or stored and managed safely.

Staff had the skills and knowledge skills necessary to provide people with safe and effective care and support. Staff received regular support from management which made them feel supported and valued.

People were supported to make their own decisions as much as possible, however, staff had completed mental capacity and best interest assessments for people without the required knowledge.

People did not always receive appropriate support or encouragement to eat and drink sufficient quantities.

People had access to a range of healthcare professionals when they needed them.

We had mixed views from people about their involvement with the care and support they received.

There were activities in place for people, however those confined to their rooms told us that they did not receive sufficient activities or time socially with staff or people. Visitors were however encouraged to visit at any time of the day.

We observed throughout that people's privacy was promoted.

There were arrangements in place to obtain feedback from people who used the service, their relatives, and staff members about the services provided.

People told us they felt confident to raise anything that concerned them with staff or management.

People's care records did not always contain sufficient detail to provide a comprehensive account of people's care needs.

There was an open culture in the home and relatives and staff were comfortable to speak with the manager if they had a concern.

The provider had arrangements in place to regularly monitor health and safety and the quality of the care and support provided for people who used the service; however actions were not always acted upon or prioritised in a timely manner.

Summary of findings

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 always safe.

Staff were aware of how to identify and report abuse.

Incidents and accidents in the home had been recorded and investigated.

Risk assessments had not always been completed where required.

People's medicines were stored safely, however not always managed or administered safely.

The home was clean, however people were observed to share slings when transferred.

Is the service effective?

Requires improvement

The service was not always effective.

People received support from staff who were supported to perform their roles.

Staff sought people's consent before providing all aspects of care and support; however capacity assessments had been carried out by staff who had not received the training to do so.

People were not always appropriately supported to eat and drink.

People were supported to access a range of health care professionals ensure that their general health was being maintained.

Is the service caring?

Good

The service was caring.

People were treated with warmth, kindness and respect.

Staff had a good understanding of people's needs and wishes.

People's dignity and privacy was promoted.

Is the service responsive?

Requires improvement

The service was not always responsive.

People were supported to engage in a range of activities however people who were unable to attend group activities did not always receive support to engage.

People's care records did not always contain sufficient detail to provide a comprehensive account of a person's needs and care.

People's concerns were taken seriously.

Summary of findings

Is the service well-led?

The service was not always well led.

People had confidence in staff and the management team.

The provider had arrangements in place to monitor, identify and manage the quality of the service; however identified actions were not always completed in a timely manner.

Audits had not identified that people's care records were not up to date to ensure they were accurate and comprehensive.

Requires improvement

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 15 September 2015 and was unannounced.

The inspection team consisted of one inspector and one 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.

Before our inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we observed staff support people who used the service, we spoke with nine people who used the service, four members of staff, and the registered manager. We spoke with two relatives to obtain their feedback on how people were supported to live their lives. We received feedback two health professionals. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed care records relating to four people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe at Monread Lodge. One person said, "Very much so, the home, staff and management care for us very well, I feel very secure." One person's relative told us, "It has its bumps in the road now and then, but I never worry about [Relative's] safety."

When we arrived at Monread Lodge we toured the home. There were three members of housekeeping staff who were undertaking various cleaning tasks in communal areas and people's rooms. The environment was clean, bright and well maintained. Each of the units carried out daily checks to ensure that cleaning tasks were completed. Where there were malodours present, housekeeping staff attended to these swiftly to minimise the presence. Equipment used to support people such as wheelchairs and hoists were cleaned and maintained regularly.

Staff were observed to use appropriate personal protective equipment when carrying out personal care tasks such as assisting people to the bathroom or when supporting them to eat. One person told us, "It's clean, much cleaner than most and they are quick to deal with any problems."

However, on one unit we observed staff use one person's sling to transfer five people.. This is not an appropriate method to use to ensure people are protected from the spread of infection and as slings are different sizes for different people this increased the risk of injury due to incorrect equipment used.

People's medicines were not always managed safely. We looked at 10 medicine administration records (MAR) for people. Each of these had been completed appropriately with no gaps or omissions. Each MAR contained basic medical details about the person and also used a photograph of the medicines so that staff were able to clearly identify the tablets. As required medicines were accompanied by a protocol that described when and why a person requires the medication and also the possible side effects that staff should monitor. Where there had been medicine errors, these had been thoroughly investigated by the manager and appropriate actions had been taken. We checked the stock count of three medicines and found the physical stock matched the audit record contained in the MAR.

However, we also saw that eight opened medicines had not been dated to indicate when they were first used. We continuously also saw at each medicine round, that staff wore a tabard that clearly stated they were not be disturbed. This is a policy that is designed to minimise the risk of errors through the staff member being disrupted. We saw that staff were administering people's medicines whilst also carrying out tasks such as preparing toast, tea, and supporting people. The manager told us that staff should not be interrupted when administering medicines. However when we spoke with one staff member they told us, "It is an issue, on the unit is me and two carers, so I have to do the breakfasts and medicines."

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

Some of the people we spoke with told us they felt there were sufficient staff to meet people's needs. However other people we spoke with told us that the responsiveness of staff varied depending on what was happening on a particular day. One person told us, "Most of the time, there are just enough staff, but if something happens out of the ordinary then they struggle and we have to be a little more patient."

We looked at how the manager had determined the staffing levels for the home. They told us they completed a bi monthly dependency assessment of people's needs. This took account of the level of support each of the 62 residents required and provided an overall level of hours required. They also showed us that when they recently had a shortage of staff, they had kept the occupancy substantially below the 62 residents they are registered to provide care for. The manager told us this was critical to them to ensure people were safe. For example we saw minutes from a staff meeting that noted three new residents were due in to the home so staffing would be increased in response to this.

However, they were unable to demonstrate to us how they reviewed staffing levels more frequently. Where people's needs changed week to week or day to day, they were unable to show us how they had considered this, and altered staffing levels accordingly. For example, on the day of our inspection, one person's health had deteriorated and they required further support from staff. This led to a knock on effect across the unit where medicines were not completed until 11.30am, and people were left waiting for their breakfast as staffing had not been sufficiently reviewed to manage the increased workload.

Requires improvement

Is the service safe?

Staff spoken with about protecting people from abuse were able to describe to us what constituted abuse and what signs they looked for when supporting people. We asked staff about reporting procedures, who all told us they would complete the relevant paperwork, and also inform the management. Staff were aware of how to report concerns through the whistleblowing reporting procedure. Staff were aware they were able to report concerns about possible abuse or poor staff practice to either the manager or their head office and also to report concerns to the local authority or the Care Quality Commission. One staff member told us, "We report everything here, bruising, falls, behaviour issues. I personally would report to my senior, but if nothing was done I would go to the deputy, the manager, and then if needed the social workers and you [CQC]." This demonstrated to us that the provider had taken reasonable steps to ensure staff knew how to identify aspects of abuse and how to report concerns outside of the organisation confidentially if required.

Incidents and accidents including those considered safeguarding had been investigated and referred to the local authority and Care Quality Commission where required. We saw that incidents reported had then prompted a review of people's care needs. However, there was no reflective learning from events and incidents carried out to enable staff to reflect and learn from accidents or incidents. The manager told us this was an area they were developing and planned to implement through team meetngs shortly.

However, care records we looked at all contained risk assessment for people but these profiles had not always identified possible risks with measures to minimise their impact on the person's health and welfare. For example, staff were able to tell us about one person who presented with behaviour which could challenge others, particularly when providing personal care, or when encouraging them to eat their meals. When we looked at the corresponding care records we found there was no guidance for staff on how to support the person in these areas.

We looked at how incidents and accidents were managed in the home. We saw that where an incident had occurred, staff had completed the appropriate form which had then been reviewed by a member of the management team. Management then reviewed the incident and took appropriate actions, and if required referred the matter to the local authority. One staff member told us that the managers actively encouraged them to report any incidents or accidents. However, care plans had not always been robustly reviewed in response to incidents.

Care plans we looked at all contained risk assessment profiles for people. These profiles identified possible risks with measures to minimise their impact on the person's health and welfare. However where people had a risk linked to a behaviour which may challenge others the actions staff needed to take to support people were neither explicit nor consistent to guide staff. The possible triggers were listed but were not linked to individual assessments of aspects of daily living. For example a person who found receiving personal care challenging had nothing in their care plan which showed how they might be best supported. The only entry we saw noted, "[Person] to step into the bath and then follow risk assessment'." However a personalised description of how to support the person safely was not available. Another further comment written stated, "If you are not able to support [person] call management." This meant that where incidents had occurred whilst supporting people, care plans did not provide sufficient detail for staff to be able to positively support the person in a manner that reduced the risk reoccurring.

We reviewed recruitment records for four staff members and found that safe and effective recruitment practices were followed which ensured that staff did not start work until satisfactory employment checks had been completed. Staff we spoke with confirmed that they had to wait until the manager had received a copy of their criminal record check before they were able to start work at the home. This ensured that staff members employed to support people were fit to do so.

Requires improvement

Is the service effective?

Our findings

People told us that staff asked them for their agreement prior to supporting them, and that they were able to access healthcare support whenever they required this. One person told us, "The food is nice, and they keep an eye on us all the time, if our weight drops or we are not eating for any reason they are quick to pick it up."

Staff were observed to seek people's consent throughout the day in a positive and respectful manner, and also respect people's decisions when they refused. For example, one person had chosen to spend their day in bed. Staff were seen to approach the person and offer assistance but respected their decision when they said no. Staff were observed to return on subsequent occasions to check if the person still wished to remain in bed.

Staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and had a basic understanding of the Act. We saw assessments of people's capacity in care records and best interest decisions for day to day care and support had not always been completed or were completed by sufficiently trained staff. For example, we saw one do not attempt cardiopulmonary resuscitation (DNACPR) form had been signed by the GP and a senior carer. We looked at how the person's capacity had been assessed and how consideration had then been given to the persons wishes through a best interest decision. We saw that there was no record of discussion with the person's family, and the assessments did not contain sufficient detail for the senior carer to make the decision with regards capacity.

We asked the manager what training had been provided to the care staff so they could competently complete the assessments. We saw from the training record that staff had received basic awareness training for MCA and DoLS, however this did not provide a framework for staff to assess people's capacity. The manager told us that the senior management team had provided training in this area, however neither manager was an accredited trainer, and despite our request to review the content, we were unable to. This meant that staff who completed capacity assessments, did not have the necessary skills and training to do so. We did not find evidence that decisions taken were not in the person's best interests, however, there remained a risk that staff may not sufficiently assess a person's capacity and make subsequent decisions that are in their best interest. The manager discussed this with the providers training department to ensure that those staff who complete assessments have had suitable training.

The manager told us they had submitted all the relevant DoLS applications for people who were at risk of being deprived of their liberty to keep them safe. We saw that some people that were nursed in bed and were using bed rails to ensure people did not fall out. However, the manager had not considered whether a DoLS was required for these people, and had not submitted one. They showed us that this issue had been identified through a monitoring visit by the local authority and assured us they were in the process of reassessing people, and were due to submit the applications shortly.

Staff we spoke with told us they felt supported by the manager. They told us they felt they were able to approach the management team for any support or assistance. Staff we spoke with told us they received regular training and meetings with their line manager to review their development and set objectives. One staff member told us, "I have asked for additional training in areas I am interested in like palliative care and [Manager] is looking to get me on the course. The office door is always open and I feel that I have gained a lot of new skills since coming here." A second staff member told us, "Induction is massive, it is thorough and covers everything. Even though I was an experienced carer I had to go through all the training and shadowing exactly the same as someone with no experience. I have had two probation reviews and supervision already and I've only been here 2 and a half months. It's good to know I am supported and backed up."

When people first moved into Monread Lodge they were routinely placed on a food and fluid chart. The manager told us this was to ensure they captured people's nutritional needs and could identify any further support people required before an issue developed. People's weights were routinely recorded on a monthly basis, and where people had either lost of were at risk of losing weight, then they were reviewed more closely. Where people required support with their nutritional needs they were referred swiftly to a specialist such as a dietician or speech and language therapist.

People's views about the food were mixed. One person told us, "It's pleasant, not amazing, but there are a lot of us here to cook for so I am happy with what we get." A second

Requires improvement

Is the service effective?

person said, "I've got jam sandwiches with no jam in, I can't eat that and I can't reach my own jam to put it in but I shouldn't need to. My porridge was cold when they brought it." This person was observed to eat two mouthfuls of their breakfast and was not offered a warm alternative when staff took it away. People told us that the food was not particularly varied. A number of residents said they were bored and fed up with potatoes every day, and that in many cases they left them without eating them.

We observed lunch across two of the units at Monread Lodge. Each dining room was busy, and staff were observed to support people with their meal. However, people were sat at the dining table on one unit 30 minutes before lunch arrived and on the second unit 45 minutes before lunch arrived. We saw that people became agitated or had fallen asleep whilst waiting for their meal to be brought to them.

Where people chose to eat their meal their rooms, they waited for a longer period to receive their lunch. For example, lunch was due to be served at 12.30pm. At 1.10pm 15 people in their rooms had not received their lunch. People told us they had not been told why lunch was delayed, however they were hungry. One person told us, "Since the cooks gone it's more chaotic." A second person told us, "It's just silly, all the staff are helping others, so we have to wait for our lunch, when either they could have two sittings or get the nurses to help out and bring the lunches."

The manager told us that the cook had recently left the home. They had found a temporary replacement who was managing the kitchen whilst a permanent replacement was found. They told us that they had been a carer previously, but also had experience in catering. They said that there had been some difficulties in the kitchen whilst they got used to their role, however the lunch was ready on time. A review of the dining experience had requested the manager consider utilising two separate sittings, owever this had yet to be implemented. However, as discussed with the manager, we observed the deployment of staff at lunch time meant not all people who required assistance, received this in a timely manner. The manager was in the process of reviewing mealtimes to ensure people receivied their meal in a timely manner,

Staff told us that the menu had not changed since December. The interim cook said they were addressing the issues with the management. They told us, "I've spoken with the managers about the difficulties and they listen. We are looking at meals and changing things and also about how we present food to make it more appealing and attractive." People spoken with told us that they had noticed improvements recently with the food, however also said they would like a variation. One person told us, "It's potatoes every day, they are either boiled, roasted, mashed or chipped, every combination you can imagine and sometimes boiled and mashed." On one unit a hot trolley was used to bring the lunch out, however it was not regularly temperature checked by staff to ensure the food was within safe temperature levels.

People had access to a range of other healthcare professionals, such as GP's, tissue viability nurses, social workers, mental health teams, opticians and dentists to name but a few. People felt their health needs were managed well. One person told us, "Whatever we need they [staff] are quick to get on the phone and book an appointment for us, they are exceptionally quick about that." One visiting health professional told us, "I have no concerns about Monread Lodge, when someone is unwell they call immediately and follow the treatment plans we set and keep us up to date."

Good

Is the service caring?

Our findings

People we spoke with all told us that they felt the day care staff were caring and attentive, however also had reservations about the night staff. One person told us, “The day time carers are amazing and dedicated but they are so busy.” A second person told us, “The staff are really considerate but one or two of the night staff are not good.”

We saw numerous positive interactions through our inspection where staff were attentive and provided care in a sensitive and dignified manner to people. Staff addressed people by their preferred names and when spoken with demonstrated a good understanding of people’s care needs. One person we spoke with told us, “The carers in the day are so kind, I couldn’t fault them.” One staff member we spoke with told us, “I love making sure that people get what they want and what they need. I’ve tried to get out (of care) several times but I always come back.” This carer was observed to show a genuine interest in the people they cared for and this attitude by staff was demonstrated throughout our inspection.

However, people were not as complimentary about the night staff. People felt that staff were rude and abrupt and did not respond to them. One person told us, “The night staff are really noisy. They chat nearby and keep me awake all night” A second person told us, “For some of the night time one’s it all seems to be a bit much trouble, I would like the day carers to work the nights.” We spoke to the manager about this who told us they planned to carry out a visit to monitor the care people receive.

People told us they were able to make their own decisions and that staff supported them remain as independent as possible. Where people were able to manage their own care and support needs, staff were seen to encourage them to do so. For example, one person was supported to have a shave, and where they struggled to do so, staff intervened only to assist the person when they asked them to. The person told us, “They help me with the shower and make sure I am dry but then they encourage me to sort myself out when I can. That’s good. I like it.”

People’s privacy and dignity was respected. A visitor told us that their family member was always well presented which respected their dignity. We saw that, if people were in their bedrooms, staff knocked on the door and waited to be invited in before entering the room. We noted that staff closed people’s doors before providing any personal care to them. Visitors told us they felt welcome to visit any time. People were able to spend time with their visitors in the privacy of their own room without being observed.

Requires improvement

Is the service responsive?

Our findings

People's needs had been assessed. However, the assessments had not always been used effectively in planning people's care. Care plans and relevant risk assessments had not been fully developed which meant information that staff needed to support people was not available to them. For example, one person's risk assessment had identified they had diabetes and recorded in the relevant care plan that they were to monitor the persons sugary intake. Staff we spoke with were aware of how to support the person through a controlled diet, however were not aware of areas such as signs and symptoms or eyesight difficulties.

Staff told us about one person who had complex needs and became resistant and at times aggressive when they attempted to provide personal care. Each staff member we spoke with told us how they would support this person, and although each account was positive and supportive, each was different and did not follow a consistent approach. When we looked at this persons care records, we were unable to locate a care plan to address this to ensure staff followed a consistent approach. This meant that staff did not have clear guidance on each person's specific needs to enable them to respond to these effectively. The manager showed us an action plan they had developed following a review of the home by the local authority. In this we saw that they had identified reviewing people's care records as an immediate need and were in the process of doing so and would ensure that all staff had an up to date and consistent knowledge of peoples support needs.

People experienced varying levels of social interaction and opportunities. A weekly plan of activities based on people's interests was available that included planned group activities. On the morning that we visited we observed that some people were helping with food preparation, making the bread and butter pudding and cutting up beans which had been grown in the gardens as part of the activity programme for lunch later that day. This was popular with some people one of which told us, "I don't do a lot but I like helping prepare vegetables."

The home had a number of lounges and quiet areas where people were able to spend time. We observed that the smaller lounges offered people an opportunity to talk and spend time either together with friends or with their families. There were a number of different themed areas to provide stimulation to people living with dementia. For example, the farm area appeared to be a popular area for people to spend their time, as we saw this frequently used by different people. A number of activities and outings had been provided to people including visits to a local garden centre, music and growing vegetables.

Where people were unable to leave their rooms, staff made every effort to provide impromptu entertainment or simply to pop in for a chat. However staff also told us that at times it was difficult to provide this level of care, as staffing levels fluctuated due to staff sickness. One person told us, "If they were less busy then they could talk to me. It's upsetting when I can hear everyone singing or laughing and I can't join in from here."

People had access to a clear complaints procedure and they felt able to use it. Information on how to make a complaint was prominently displayed in the service. The complaints policy gave timescales for responses and actions so that people knew what they could expect to happen and when. It told people how to take their complaint further should they not be satisfied with the provider's response. We looked at the provider's record of complaints received. We saw that these were clearly logged and were responded to in a timely way.

Requires improvement

Is the service well-led?

Our findings

People who used the service, relatives and staff members thought that the home was well-led. They told us that the home manager was approachable and supportive. One person said, "If there is anything that needs fixing or sorting out then [manager] is on it in a flash." The manager told us that the culture and ethos that they tried to project in the home was, "To be open, homely, family orientated and friendly." During our inspection staff and people consistently mentioned these words when describing living or working in Monread, and our observations of staff with people demonstrated staff worked to a shared ethos.

The manager undertook a wide range of audits, checks and observations designed to assess the quality of all aspects of the service delivery. These included areas such as medicines, care planning and delivery, health and safety, the environment, accidents and incidents, complaints, infection control and mealtimes. Information about the outcomes of these checks, together with any areas for improvement identified, was reported to the provider each month with details of actions taken and the progress made.

We reviewed a report of a quality monitoring visit undertaken in May 2014 by representatives from the local authority Adult Care Services. The home had achieved an overall score of 84.3% with no areas of serious concern identified. In the section for management and quality assurance systems the service had achieved 100%. Where areas had been previously identified, such as best interest decisions and DoLS assessments being completed, we saw the manager had taken appropriate action to resolve this.

The provider had a range of systems in place to assess the quality of the service provided in the home. These included regular quality monitoring visits undertaken by members of the provider's senior management team on a monthly basis. The audits completed were thorough and considered people's care records, involvement, the environment, complaints and concerns and health and safety matters among other areas. We looked at recent audits that had been completed and found that although actions plans were developed to address concerns, these had not always been achieved.

An audit completed on 19 August 2015 identified that people were waiting for their meals for up to twenty minutes. We found that this continued to occur, and on the day of our inspection was in excess of this. The action plan had identified this as a concern and gave a completion date on 11/09/2015. It recorded that, "Consideration was to be given to the waiting time for residents at mealtimes, and the usefulness of separate servings to be considered." At the time of our inspection this had not occurred. We also saw that this audit identified that people were to be provided individual slings and they were to be held in each person's room. "The action plan recorded this was to be completed by 01/10/2015, however we observed people continued to be hoisted with a shared sling and new ones had yet to be ordered. This was an area that could have been rectified sooner than October 2015. Inconsistencies in the completion and prioritisation of the identified actions suggested to us that although quality monitoring systems were effective in identifying areas that required improvement, they did not always ensure actions were carried out expediently.

People's care records when reviewed did not always contain sufficient detail to provide a comprehensive account of a person's needs and care. We saw that information relating to people's health needs or preferences was either not always included, or was difficult for staff to locate. One staff member told us, "In some areas the care plans give us enough information, but things like people's histories are limited, or it's hard to find." This information was therefore not readily available for staff to know how to support each person. We also found that mental capacity assessments and best interest decisions did not record sufficient detail to evidence how the decision had been reached and how the views or people or relatives were considered. However the provider was in the process of implementing an electronic care plan, and all care plans were to be reviewed as the staff adopted this new method. The manager also told us that they were in the process of ensuring that people's care records were personalised to meet their needs and this area would be addressed.

A range of meetings were held in the home, not only for staff but also for residents, however, none had been held for relatives. Minutes of these meetings showed us that a range of issues were discussed, and that people and staff could share their views and opinions about aspects of the quality of care people received. However, actions set in the previous meeting were not addressed, and deadlines for actions were all marked as on going. Where responsibilities

Requires improvement

Is the service well-led?

for actions were given to people, the minutes recorded these as simply, “All.” This meant no one person or team was responsible for completing each actions and therefore areas of improvement may not be achieved.

A questionnaire had been sent to people and their relatives in 2015 and the results had been analysed. In addition the provider had sent a survey to staff and although the results of the recent survey were not available we were able to see the results of the 2014 one completed. This showed that overall staff were satisfied with working at Monread Lodge, where concerns had been raised by people, the manager had developed a service action plan to address these concerns.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 **Safe Care and Treatment** **Regulation 12 (1) (2) (g)** There were not systems in place to ensure the proper and safe management of medicines. **Regulation 12 (1) (2) (h)** People were not always protected from the spread of infection when being assisted with personal care.

This section is primarily information for the provider

Enforcement actions

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