Review of compliance

Precious Health Care Limited Oakleigh House Nursing Home	
Region:	London
Location address:	Oakleigh Road Hatch End Harrow Middlesex HA5 4HB
Type of service:	Care home service with nursing
Date of Publication:	January 2012
Overview of the service:	Oakleigh House Nursing Home is a home for older people which is situated in a residential area of Hatch End. It is licensed by the Care Quality Commission to provide the regulated activities accommodation for people who require personal or nursing care, diagnostics and screening and treatment of disease, disorder or injury for up to twenty people.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Oakleigh House Nursing Home was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 8 November 2011, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

People told us that they were comfortable and content at the home. They said that there were enough activities for them and they could choose whether to be involved.

People told us that staff were polite, pleasant and friendly towards them and that they respected the privacy and dignity of people living at Oakleigh House Nursing Home. They said that meals were pleasant and nutritious and that they were given a choice.

People told us that appointments with medical professionals were arranged on their behalf when necessary and that they had regular access to their GP.

Each of the people we spoke with told us that they felt that most of their needs were being met.

However, we found evidence that a lack of established monitoring procedures by the provider may have meant that not all of the needs of people living at Oakleigh Nusring Home had been met.

What we found about the standards we reviewed and how well Oakleigh House Nursing Home was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People were encouraged to express their views about the service and were involved in the

planning of their care, treatment and support.

Overall, we found that Oakleigh House Nursing Home was meeting this essential standard.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

Whilst the provider had begun to check that care records were up to date and correctly completed, some aspects of care planning were out of date which potentially could pose a risk of care delivery not always being safe and effective.

Overall, we found that improvements were needed for this essential standard.

Outcome 05: Food and drink should meet people's individual dietary needs

People living at the home were supported to maintain a good standard of nutrition and hydration.

Overall, we found that Oakleigh House Nursing Home was meeting this essential standard.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People living at Oakleigh House received safe care as there were clear procedures and actions in place to manage, investigate and stop alleged abuse. However, these procedures had not always been reviewed for effectiveness.

Overall, we found that Oakleigh House Nursing Home was meeting this essential standard but in order to maintain this we suggested some improvements.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

People living at Oakleigh House Nursing Home had their needs met by staff who were fit and appropriately qualified to do their job.

Overall, we found that Oakleigh House Nursing Home was meeting this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

People at the home were protected from the risk of unsafe care because the provider had begun to improve the monitoring and risk assessment systems. However, there was limited evidence recorded of monitoring procedures having taken place.

Overall, we found that improvements were needed for this essential standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People told us that staff were polite, pleasant and friendly towards them and that they respected the privacy and dignity of people living at Oakleigh House Nursing Home.

During our inspection we observed various interactions between staff and people using the service. We saw that staff were polite and respectful and offered people a choice of refreshments, giving them sufficient time to make their decision.

Other evidence
We looked at care plans for several people. People's needs and preferences were clearly recorded at the front of the plan demonstrating the involvement of them or their representatives in their care planning. A full assessment of people's long term needs was recorded within the plan at the point at which they began to use the service. Where people were able to provide their own personal care this was recorded clearly in the plans. When we spoke to those people they confirmed that this had been their choice and they were supported to maintain this independence.

A quarterly newsletter produced by the activities co-ordinator had been distributed to the family and friends of people living at the home to keep them up to date with news about the service. The updates included staff changes and feedback on the results of a

quality assurance survey conducted in the summer of 2011.

Our judgement
People were encouraged to express their views about the service and were involved in the planning of their care, treatment and support.

Overall, we found that Oakleigh House Nursing Home was meeting this essential standard.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People told us that they were comfortable and content at the home. They said that there were enough activities for them and they could choose whether to be involved. During our inspection the activities co-ordinator was setting up a game of bingo with the people who were in the residents' lounge. We spoke with people who preferred to remain in their rooms. They told us that the co-ordinator visited them regularly and ensured that they had the choice of participating in activities in their room, such as arts and crafts.

Most people told us that their needs were met at all times. However, we found evidence that the care planning for some people was not up to date. One person who did not receive regular visits from relatives or friends said that it was sometimes difficult to get someone to shop for personal items on their behalf.

Other evidence
We had received information from two other agencies that the home had not been meeting the needs of people living in the home.

The provider told us that she had been reviewing all care plans to ensure that the most up to date information was in place. The provider also told us that she was checking that staff were recording changes in people's needs and health appropriately and reporting this information in a timely manner. We looked at a number of care plans and saw that these reviews had begun but were not yet completed. Staff had begun to record daily wound review checks and observation checks. However, records of

escalating concerns to the GP were not always clear.

We also noticed that whilst people's needs and preferences had been recorded when they began to use the service, they had not been updated to reflect any changes. Risk assessments had been carried out but were not always updated.

The care plans showed that people had been referred to relevant medical professionals on an as needed basis. They also recorded where people had chosen not to receive care from professionals such as the chiropodist.

Our judgement
Whilst the provider had begun to check that care records were up to date and correctly completed, some aspects of care planning were out of date which potentially could pose a risk of care delivery not always being safe and effective.

Overall, we found that improvements were needed for this essential standard.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
People living at the home told us that meals were pleasant and nutritious and that they were given a choice.

During our inspection we saw people being gently encouraged to eat and drink at regular intervals.

Other evidence
We looked at records of nutrition and hydration needs. People had been screened when they began to use the service to check whether extra support for food and fluid intake was required. We found regular recording of fluid and food intake for people deemed to be at risk of poor nutrition and hydration.

We spoke with the GP who told us that he did not consider that incidences of urinary tract infections were unusually high given the very advanced age of the majority of the people living at the home.

During our inspection people were served with morning refreshments and lunch. This time was protected to ensure that people had time to eat and drink what they wanted and that staff were able to support or encourage people to eat and drink.

Our judgement
People living at the home were supported to maintain a good standard of nutrition and hydration.

Overall, we found that Oakleigh House Nursing Home was meeting this essential standard.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are minor concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People told us that they felt safe and well looked after at the home.

However, we found insufficient evidence of monitoring by the provider in order to identify and prevent the risk of abuse.

Other evidence
The provider told us that if safeguarding issues arose they would co-operate with the local authority's adult safeguarding procedures and take relevant action where necessary. The provider had put appropriate systems in place to identify and prevent safeguarding issues and act appropriately in response to information to ensure that people in the service were protected from harm. These included more detailed record keeping and daily checks and observations on people using the service.

We saw staff training records which showed that all staff had received training in safeguarding vulnerable adults in March 2011. The provider had arranged update training for all staff to be completed by early 2012.

The provider told us that they had put in place a system for monitoring records and staff in order to identify potential safeguarding concerns. However, there was no written record of these checks having taken place.

Our judgement
People living at Oakleigh House received safe care as there were clear procedures and

actions in place to manage, investigate and stop alleged abuse. However, these procedures had not always been reviewed for effectiveness.

Overall, we found that Oakleigh House Nursing Home was meeting this essential standard but in order to maintain this we suggested some improvements.

Outcome 12:
Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is compliant with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
People told us that they considered staff to be efficient and capable of doing their jobs.

Other evidence
The manager told us that staff had received training in all aspects of their role. We checked staff files and training records and found that staff had received full training appropriate to their role during induction and that this had been updated during 2011.

The appropriate and relevant employment checks had been carried out prior to staff commencing work at Oakleigh House Nursing Home. Those checks demonstrated staff qualifications and fitness for their roles.

Our judgement
People living at Oakleigh House Nursing Home had their needs met by staff who were fit and appropriately qualified to do their job.

Overall, we found that Oakleigh House Nursing Home was meeting this essential standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are moderate concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People told us that the views of themselves and their relatives were asked for through an annual survey.

Other evidence
We saw an overview of the summer quality assurance survey in which the comments and suggestions of people living at Oakleigh House Nursing Home and their relatives were summarised. Details of how aspects of the service had been reviewed as a result of the outcomes of the survey were identified. This information was captured in the newsletter that had sent out to relatives and made available to people living in the home during November 2011.

There was some evidence of learning from incidents. Monitoring and risk management systems were being improved and lines of accountability within the home were becoming more clear. However, these practices were not clearly established at the time of our inspection.

Whilst the provider told us they had put in place a monitoring system for care plans, there were no records of care plan audits available. The registered manager had introduced daily checks on observations and wound care in order to ensure these were being carried out by nursing staff. These were recorded.

Our judgement
People at the home were protected from the risk of unsafe care because the provider

had begun to improve the monitoring and risk assessment systems. However, there was limited evidence recorded of monitoring procedures having taken place.

Overall, we found that improvements were needed for this essential standard.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: People living at Oakleigh House received safe care as there were clear procedures and actions in place to manage, investigate and stop alleged abuse. However, these procedures had not always been reviewed for effectiveness. Overall, we found that Oakleigh House Nursing Home was meeting this essential standard but in order to maintain this we suggested some improvements.	
Diagnostic and screening procedures	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: People living at Oakleigh House received safe care as there were clear procedures and actions in place to manage, investigate and stop alleged abuse. However, these procedures had not always been reviewed for effectiveness. Overall, we found that Oakleigh House Nursing Home was meeting this essential standard but in order to maintain this we suggested some improvements.	
Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse

	Why we have concerns: People living at Oakleigh House received safe care as there were clear procedures and actions in place to manage, investigate and stop alleged abuse. However, these procedures had not always been reviewed for effectiveness. Overall, we found that Oakleigh House Nursing Home was meeting this essential standard but in order to maintain this we suggested some improvements.

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Whilst the provider had begun to address the concerns about care which were brought to their attention by the primary care trust and the local authority, aspects of care planning were out of date which potentially could pose a risk of care delivery not always being safe and effective. Overall, we found that improvements were needed for this essential standard.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Whilst the provider had begun to address the concerns about care which were brought to their attention by the primary care trust and the local authority, aspects of care planning were out of date which potentially could pose a risk of care delivery not always being safe and effective. Overall, we found that improvements were needed for this essential standard.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Whilst the provider had begun to address the	

	concerns about care which were brought to their attention by the primary care trust and the local authority, aspects of care planning were out of date which potentially could pose a risk of care delivery not always being safe and effective. Overall, we found that improvements were needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: People at the home were protected from the risk of unsafe care because the provider had begun to improve the monitoring and risk assessment systems. However, there was limited evidence recorded of monitoring procedures having taken place. Overall, we found that improvements were needed for this essential standard.	
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: People at the home were protected from the risk of unsafe care because the provider had begun to improve the monitoring and risk assessment systems. However, there was limited evidence recorded of monitoring procedures having taken place. Overall, we found that improvements were needed for this essential standard.	
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met:	

	People at the home were protected from the risk of unsafe care because the provider had begun to improve the monitoring and risk assessment systems. However, there was limited evidence recorded of monitoring procedures having taken place. Overall, we found that improvements were needed for this essential standard.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 7 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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