# Review of compliance

| Quality Care (EM) Limited<br>The Oaks Nursing Home | |
|---|---|
| **Region:** | East Midlands |
| **Location address:** | 114 Western Road<br>Mickleover<br>Derby<br>Derbyshire<br>DE3 9GR |
| **Type of service:** | Care home service with nursing |
| **Date of Publication:** | July 2012 |
| **Overview of the service:** | The Oaks is registered to provide the regulated activities of accommodation for people requiring nursing or personal care, treatment of disease, disorder or injury and diagnostics and screening. It is registered to provide care for up to 28 people of either gender who have dementia. |

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

## Our current overall judgement

**The Oaks Nursing Home was not meeting one or more essential standards. Action is 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 to check whether The Oaks Nursing Home had taken action in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 09 - Management of medicines
Outcome 16 - Assessing and monitoring the quality of service provision

## How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 8 May 2012, carried out a visit on 9 May 2012, talked to staff and reviewed information from stakeholders.

## What people told us

We spoke to people who lived at the service but their feedback did not relate to these standard.

## What we found about the standards we reviewed and how well The Oaks Nursing Home was meeting them

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

We have not followed up on the warning notice issued due to a change in circumstances in the home. This change in circumstances meant there was no longer any risk to the care and welfare of people at this time.

### Outcome 09: People should be given the medicines they need when they need them, and in a safe way

People were not fully protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and

disposal of medicines.

A change in circumstances within the home means there is no risk to people in respect of the management of medicines.

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

The provider did not have an effective system to regularly assess and monitor the quality of the service that people received.

A change in circumstances within the home means there is no risk to people in respect of assessing and monitoring the quality and safety of care.

## 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. We will check to make sure that this action has been taken.

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

In a previous review, we found that action was needed for the following essential standards:

- 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
- Outcome 07: People should be protected from abuse and staff should respect their human rights
- Outcome 12: People should be cared for by staff who are properly qualified and able to do their job
- Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

# 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**

The provider is compliant with Outcome 04: Care and welfare of people who use services

**Our findings**

**What people who use the service experienced and told us**
We have not followed up on the warning notice issued due to a change in circumstances in the home. This change in circumstances meant there was no longer any risk to the care and welfare of people.

**Other evidence**

**Our judgement**
We have not followed up on the warning notice issued due to a change in circumstances in the home. This change in circumstances meant there was no longer any risk to the care and welfare of people at this time.

# Outcome 09:
# Management of medicines

## What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

## What we found

**Our judgement**

The provider is non-compliant with Outcome 09: Management of medicines. We have judged that this has a moderate impact on people who use the service.

**Our findings**

**What people who use the service experienced and told us**
We spoke to people who lived at the service but their feedback did not relate to this standard.

**Other evidence**
The supplying community pharmacist had visited the service on 26 April 2012. They checked the safe handling of medicines. They told us they had made recommendations and areas for improvement to ensure that people's medicines were handled safely. The acting manager told us that some of these recommendations had been completed.

The safe handling of medicines was assessed by a pharmacist inspector. We looked at the storage of medicines, people's medicine records and care plans.

Medicines in the medicine trolley were stored neatly and in an organised manner which made it easy to locate people's medicines.

Medicines requiring refrigeration were stored in a separate locked refrigerator. The temperatures of the refrigerator were recorded daily and were within the safe storage temperature range for medicines. There were no room temperature records available. We saw that the temperature of the room was within the safe storage temperature range for medicines. The acting manager told us she would ensure daily room temperature checks were recorded. This meant that arrangements were in place for the safe storage of people's medicines.

We did not find there were Appropriate arrangements in place to ensure that stock checks could be done. We found a form used by the service for checking medicines dated April 2012. There were no checks made on the stocks of medicines or if medicines were given to people as prescribed. We saw records for the receipt of people's medicines but the dates of opening of medicines were not always recorded and any extra medicines available at the end of a month were not carried forward to a new month. The community pharmacist visited on 26 April 2012 and also recommended improvements should be made in this aspect of medicines management. We looked at one person's medication administration record (MAR) chart. We were unable to make checks on two prescribed medicines and could not determine if the medicines had been given as prescribed. This meant that it was not always possible to check if people had been given their prescribed medicines.

We found the records of refusal of medication were not always clearly documented. Staff were documenting when medicines were not given onto the MAR charts but the codes that were used did not match the codes provided by the supplying pharmacy. This meant that staff were not following correct procedure and this made it difficult to know why a person had not been given their prescribed medicine.

Personal care plans relating to people's medicines and management of medicines were not always current or kept up to date. We looked at two care plans. One person was prescribed a medicine to be given when required. There was no person centred information or guidance to explain the circumstances in which it would be necessary to give the person the prescribed medicine. When we asked staff for more information they were able to tell us but this was not recorded in the person's care plan. It is important for people who cannot communicate verbally that this information is available. One person was prescribed a medicine which required careful monitoring. The available information in the care plan stated that checks were required every week. The records showed that these checks were not being recorded every week. We were told that the doctor had changed the checks to be made once a month. This information was not documented in the person's care plan. We were told by the service that they were in the process of updating all care plans.

There were no arrangements to ensure that medicines given covertly had been assessed in accordance with the Mental Capacity Act 2005. Covert administration of medicines is when medicines are administered in a disguised form without the knowledge or consent of the person receiving them, for example, in food or in a drink. Whilst looking at one person's care plan we found a recorded entry dated 28 January 2012, which stated the person was being given their medicines covertly. There was no recorded information about the decision process and the people involved in making this decision This information was not documented on the current MAR chart. We would not have known the person was to be given their medicines in a disguised form. We were told by a member of staff that the person would usually take their prescribed medicines but when they refuse to take the medicine it would be placed in a small amount of orange juice. The community pharmacist was not aware that the person was being given their medicines covertly and had not been involved in the decision process. This meant that available information was not correct, proper procedure had not been documented and their was a risk that the person was being given medication without their knowledge or consent.

**Our judgement**

People were not fully protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.

A change in circumstances within the home means there is no risk to people in respect of the management of medicines.

# 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**

The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a moderate impact on people who use the service.

**Our findings**

**What people who use the service experienced and told us**
We spoke to people who lived at the service but their feedback did not relate to this standard.

**Other evidence**
We issued a warning notice to the providers requiring them to be compliant with the regulations in relation to this outcome by 17 November 2011. There had been significant change at the service since this time and we wanted to check the warning notice had been complied with.

The general manager showed us an internal auditing tool called 'Quality Care Services' (QCS) They told us there were plans to start using the tool to monitor the quality of the service provided, although it had not yet been fully implemented. The QCS contained planned audits for a range of areas throughout the service including care planning, catering, health and safety, safeguarding vulnerable adults and equipment safety checks.

The QCS was available on the computers at the service and there were also paper copies of the documents. We saw that staff were able to access the system to look at the policies and procedures of the home.

We spoke with the acting manager and asked her to provide us with any audits which were being completed to monitor the quality of the service provided. She showed us

some blank audits and told us she was planning to implement these. The audits were to include infection control, catering, medication, accidents, incidents and complaints.

An infection control audit had been completed by the community infection prevention and control nurse and we saw the acting manager had responded to any issues raised by providing an action plan with timescales for completion.

The general manager told us a satisfaction survey had been sent to the relatives of people using the service to gain their views on the quality of the service. They told us these had not yet been returned back from relatives.

This evidence showed that although there was evidence to show the service intended to monitor the quality of the service being provided, there was no evidence to demonstrate this had been achieved. There also remained outstanding areas of non compliance following this and our previous inspection on 30 April 2012 which demonstrated that the systems in place to identify, assess and manage risks to people using the service had not been effective.

**Our judgement**
The provider did not have an effective system to regularly assess and monitor the quality of the service that people received.

A change in circumstances within the home means there is no risk to people in respect of assessing and monitoring the quality and safety of care.

# Action
we have asked the provider to take

## 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 13 HSCA 2008 (Regulated Activities) Regulations 2010 | Outcome 09: Management of medicines |
| | **How the regulation is not being met:**<br>People were not fully protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.<br><br>A change in circumstances within the home meant there was no risk to people in respect of the management of medicines at this time. | |
| Diagnostic and screening procedures | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 | Outcome 09: Management of medicines |
| | **How the regulation is not being met:**<br>People were not fully protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.<br><br>A change in circumstances within the home meant there was no risk to people in respect of the management of medicines at this time. | |

| | | |
|---|---|---|
| Treatment of disease, disorder or injury | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 | Outcome 09: Management of medicines |
| | **How the regulation is not being met:**<br>People were not fully protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.<br><br>A change in circumstances within the home meant there was no risk to people in respect of the management of medicines at this time. | |
| 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:**<br>The provider did not have an effective system to regularly assess and monitor the quality of the service that people received.<br><br>A change in circumstances within the home meant there was no risk to people in respect of assessing and monitoring the quality and safety of care at this time. | |
| 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:**<br>The provider did not have an effective system to regularly assess and monitor the quality of the service that people received.<br><br>A change in circumstances within the home meant there was no risk to people in respect of assessing and monitoring the quality and safety of care at this time. | |

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| 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:**<br>The provider did not have an effective system to regularly assess and monitor the quality of the service that people received.<br><br>A change in circumstances within the home meant there was no risk to people in respect of assessing and monitoring the quality and safety of care at this time. | |

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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

**Compliance actions**: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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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| **Document purpose** | Review of compliance report |
| **Author** | Care Quality Commission |
| **Audience** | The general public |
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