# Review of compliance

| G & A Investments Projects Limited<br>Oakwood Residential Home | |
|---|---|
| **Region:** | South East |
| **Location address:** | 192 West End Road<br>Bitterne<br>Southampton<br>Hampshire<br>SO18 6PN |
| **Type of service:** | Care home service without nursing |
| **Date of Publication:** | January 2012 |
| **Overview of the service:** | Oakwood Residential Home is registered to provide accommodation for persons who require nursing or personal care. The residents of the home are generally older and some have dementia. The service is provided by G & A Investments Projects Limited. |

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

## Our current overall judgement

**Oakwood Residential Home was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.**

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 and carried out a visit on 16 November 2011.

## What people told us

Residents told us that they enjoyed the food, the staff were very good and responsive.

Visitors told us the home was very flexible, looked after their relatives well and that their relatives were happy at the home.

## What we found about the standards we reviewed and how well Oakwood Residential Home was meeting them

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

People have their care and welfare needs met.

We found that Oakwood Residential Home was compliant with this outcome.

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

The management and staff have improved their knowledge of safeguarding and deprivation of liberty, which has resulted in staff being clearer in how they protect individuals living in the home.

We found that Oakwood Residential Home was compliant with this outcome.

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

Residents are given their medication as prescribed but improvements could be made to reduce risks associated with medication.

Overall, we found that Oakwood Residential Home was not meeting this essential standard and we propose to take improvement action to address these concerns.

**Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills**

Residents are supported by staff who have received training.

We found that Oakwood Residential Home was compliant with this outcome.

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

Systems are in place to review the quality of the service provided.

We found that Oakwood Residential Home was compliant with this outcome.

## Actions we have asked the service to take

We have asked the provider to send us a report within 14 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 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 spoke with a resident who told us the quality, quantity and food was good. They told us the staff were very good and that they had answered the call bell in the middle of the night and got the blanket which the resident asked for. The resident felt the staff were happy to do this.

A visitor told us that the resident rang the call bell at night to ask for tea and staff always brought it to them.

A visitor told us the home was very flexible. Their relative had been able to bring their own furniture. The staff asked for the GP to visit when necessary and had, 'stood by' the relative when they were very unwell, providing a supportive environment for them to get better.

Both visitors said their relatives were happy at the home.

**Other evidence**
We spent time sat in the main lounge of the home and observed how staff supported the residents. We saw that staff were patient with residents who were walking slowly and they gave them clear verbal information about where they were walking. We also saw that staff gave clear instructions when helping residents to get out of chairs. We watched a staff member talking with two residents, getting them another cup of tea when they asked for it, noticing when one of the residents needed a tissue and a cushion. After lunch, a resident asked to go to their room and staff assisted them in the

way the care plan described the task. Staff were considerate when supporting people.

We looked at care plans for four residents. We found that these contained a good amount of detail about how residents liked to have their needs met. We spoke with staff who generally confirmed this was how they worked with individual residents. Risk assessments were in place and reviewed monthly by the key worker. Care plans showed individual preferences, including what time residents liked to go to bed. We looked at records and spoke with staff who confirmed that residents did go to bed at times which suited them. Residents were being supported in ways which suited their individual needs.

We saw from records that healthcare professionals visited the home when necessary and information was kept on file. One person needed a specific dressing on their skin at all times and there were detailed instructions about this in the care plan. We saw that the care plan was being followed.

We looked at the book where night staff wrote their notes. Staff had recorded when they had undertaken personal care, including changing the bed linen when necessary. The records also showed that staff provided residents with food and drinks throughout the night, if they so wished. The personalised care continued throughout the night.

As we walked around the home we saw evidence of activities on the wall, such as 'touch and feel' pictures. A sign on the wall indicated that there were daily activities in the afternoon. An activities co-ordinator was employed for eighteen hours a week and care staff also conducted activities. We saw that one resident had their pet dog with them in the home. Residents were able to choose how they spent their time.

**Our judgement**
People have their care and welfare needs met.

We found that Oakwood Residential Home was compliant with this outcome.

# 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**

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

**Our findings**

**What people who use the service experienced and told us**
We did not speak with people about this outcome.

**Other evidence**
The local authority safeguarding team had been working with the management of the home to improve outcomes for a resident. Incidents had occurred which should have resulted in action being taken under the Deprivation of Liberty Safeguards and had not all been reported to us. The manager had been supported to make an application under this legislation and had since identified other residents it may apply to.

We spoke with staff who said they had undertaken training in the safeguarding of vulnerable adults. They were aware that the home had procedures in place, should there be an allegation or suspicion of abuse, and knew who to report to. Staff also said they were more aware about individual needs relating to residents wanting to leave the home without staff support.

**Our judgement**
The management and staff have improved their knowledge of safeguarding and deprivation of liberty, which has resulted in staff being clearer in how they protect individuals living in the home.

We found that Oakwood Residential Home was compliant with this outcome.

# 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**

There are minor concerns with Outcome 09: Management of medicines

**Our findings**

**What people who use the service experienced and told us**
We did not speak to people about their medication.

**Other evidence**
We did not look at the whole outcome for medication but we saw medication being given throughout the inspection.

Medication was given to residents one at a time and the records were signed afterwards. Medication was given to people in the way that was stated in their care plans and we saw staff offering painkillers, where necessary. The medication round took a long time but staff told us they always gave painkillers first, so that the doses were spaced evenly. The medication administration records were completed without any gaps.

There were care plans in place for all but one of the medications which were to be given, 'when required', such as paracetamol, which were clear and individual. However, one resident had recently been prescribed a sleeping tablet to be used when required, but there was not a care plan in place. The manager said this would be addressed.

We were told that staff had received training in administering medication, however, the training was covered in four hours.

We spoke with staff who were not able to tell us what the specific tablets were used for,

or what side effects may be experienced. The management team felt that this was not knowledge that could be expected of care staff. However, the guidance for care homes, produced by the Royal Pharmaceutical Society of Great Britain, states that staff should be aware of what the medicines are intended to treat.

**Our judgement**
Residents are given their medication as prescribed but improvements could be made to reduce risks associated with medication.

Overall, we found that Oakwood Residential Home was not meeting this essential standard and we propose to take improvement action to address these concerns.

# Outcome 14:
# Supporting staff

## 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 competent staff.

## What we found

**Our judgement**

The provider is compliant with Outcome 14: Supporting staff

**Our findings**

**What people who use the service experienced and told us**
Residents told us that the staff were good and that they responded to their requests, both during the day and at night.

**Other evidence**
Staff told us they had completed training in fire safety, first aid, infection control, health and hygiene, deprivation of liberty and safeguarding adults.

The home has a training matrix in place which showed which staff had attended each course and who was yet to do so. There were a number of residents with dementia, and three staff had undertaken a course in dementia. The manager told us that further training in dementia had been booked recently but the trainer had cancelled the training.

We were told that all training courses, including the dementia course lasted for four hours. Six staff had not undertaken training in the Deprivation of Liberty Safeguards and the manager told us they would attend training at one of the other homes in the company.

**Our judgement**
Residents are supported by staff who have received training.

We found that Oakwood Residential Home was compliant with this outcome.

# 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 compliant with Outcome 16: Assessing and monitoring the quality of service provision

**Our findings**

**What people who use the service experienced and told us**
We did not speak with people about this outcome.

**Other evidence**
We asked the manager to tell us about how they monitored the quality of the service provided at Oakwood Residential Home. We were told that the quality assurance programme was divided into 16 sections, such as medication and care planning. The manager was responsible for completing this on a daily basis and reviewing on a monthly basis.

Questionnaires for residents, relatives, staff and visiting professionals were included as part of quality assurance programme. The views of residents were therefore sought.

**Our judgement**
Systems are in place to review the quality of the service provided.

We found that Oakwood Residential Home was compliant with this outcome.

# 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 13 HSCA 2008 (Regulated Activities) Regulations 2010 | Outcome 09: Management of medicines |
| | **Why we have concerns:**<br>Residents are given their medication as prescribed but improvements could be made to reduce risks associated with medication.<br><br>Overall, we found that Oakwood Residential Home was not meeting this essential standard and we propose to take improvement action to address these concerns | |

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.

# 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

| | |
|---|---|
| **Document purpose** | Review of compliance report |
| **Author** | Care Quality Commission |
| **Audience** | The general public |
| **Further copies from** | 03000 616161 / www.cqc.org.uk |
| **Copyright** |  |

## Care Quality Commission

| | |
|---|---|
| **Website** | www.cqc.org.uk |
| **Telephone** | 03000 616161 |
| **Email address** | enquiries@cqc.org.uk |
| **Postal address** | Care Quality Commission<br>Citygate<br>Gallowgate<br>Newcastle upon Tyne<br>NE1 4PA |