### BUPA Care Homes (CFH Care) Limited

#### Oak Lodge Nursing Home

<table>
<thead>
<tr>
<th>Region:</th>
<th>South East</th>
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<tbody>
<tr>
<td>Location address:</td>
<td>45 Freemantle Common Road Southampon. Hants SO19 7NG</td>
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<tr>
<td>Type of service:</td>
<td>Care home with nursing</td>
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<tr>
<td>Date the review was completed:</td>
<td>June 2011</td>
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**Overview of the service:**

Oak Lodge is registered with the Care Quality Commission to provide nursing and personal care to 71 service users in the older persons category for people with dementia.

This is a purpose built service that offers all the residents single accommodation with en-suite facilities. Accommodation is provided over three floors with a variety of communal areas.

The service is situated on the outskirts of Southampton city and within a short distant from the facilities of Bitterne village. There is a
| good bus link to the city centre and the local railway station. |
| There is no registered manager at the home. |
Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Oak Lodge Nursing Home was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the 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 27 January 2011, observed how people were being cared for, talked with people who use services, visiting healthcare professionals, and a number of relatives. We also talked with staff, checked the provider’s records, and looked at records of people who use services.

What people told us

People told us that they acted on behalf of the residents and were encouraged to express their views and support the residents. They said they were involved in the care planning and that the staff were nice and had good interaction with the residents. They said the environment was appropriate and the home was always clean and ‘homely’. They told us that they were aware of how to raise any concerns they may have and they also attended residents’ meetings.

We heard that the meals were good and the residents were offered choices. People were concerned that food and fluid charts were poorly maintained and did not demonstrate what diets and fluids people had received.
People said that the privacy and dignity of the residents were not always maintained and staff did not attend to people’s needs at times. People have told us that the residents were not always moved appropriately and that put them at risk of harm.

**What we found about the standards we reviewed and how well Oak Lodge Nursing Home was meeting them**

This review focused on 16 of the essential safety of care and quality standards for people who use services.

We assessed the provider to be compliant with eight of the essential standards. We have identified five minor concerns; there is one moderate concern and two major concerns for the remainder of the essential standards

**Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run**

People acting on the residents’ behalf are encouraged to express their views and support the residents. However, some of the care practices do not always ensure that people’s privacy and dignity are respected while receiving care.

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

**Outcome 2: Before people are given any examination, care, treatment or support, they should be asked if they agree to it**

The registered provider ensures that people are supported and consent is gained when receiving care.

- Overall, we found that Oak Lodge Nursing Home was meeting this essential standard.

**Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights**

People’s care needs are not always managed in a safe and consistent manner. There is a lack of assessments of residents and monitoring when people’s conditions deteriorate and care plans are not reviewed to reflect the current needs of people.

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

**Outcome 5: Food and drink should meet people’s individual dietary needs**

People receive a balanced diet and choices are available to them. People who are at risk do not have their dietary needs monitored in a consistent manner and this may put them at risk of harm.

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

**Outcome 6: People should get safe and coordinated care when they move between different services**
There is a system in place at the home that ensures the residents receive care and support from healthcare professionals as required.

- Overall, we found that Oak Lodge Nursing Home was meeting this essential standard.

**Outcome 7: People should be protected from abuse and staff should respect their human rights**
There are processes in place and training in safeguarding is available to the staff. However the care practices do not protect people from risk of harm and this includes some poor staff practices.

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

**Outcome 8: People should be cared for in a clean environment and protected from the risk of infection**
There are some infection control procedures in place, however further development is needed to meet with the current regulation for infection control.

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

**Outcome 9: People should be given the medicines they need when they need them, and in a safe way**
The home has clear written procedures for the administration of medicines. However, the current practices at the home put people at risk of not receiving their medicines in a safe and consistent way.

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

**Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare**
People are provided with a clean, safe and homely environment that meets their needs.

- Overall, we found that Oak Lodge Nursing Home was meeting this essential standard.

**Outcome 11: People should be safe from harm from unsafe or unsuitable equipment**
There is a programme to ensure that equipment is safe and available to people as required.
• Overall, we found that Oak Lodge Nursing Home was meeting this essential standard.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job
There is an effective recruitment process in place and necessary staff checks are carried out to protect people living at the home.

• Overall, we found that Oak Lodge Nursing Home was meeting this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs
The home has a planned duty roster with domestic and catering support for the staff. However, people’s support needs are not always met in an effective manner with long delays at times in receiving help.

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

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills
There are planned training and supervision arrangements to support the staff in their role.

• Overall, we found that Oak Lodge 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
There are some systems for the auditing of care at the home, however these are not adequate and action plans are lacking to ensure that issues identified are resolved.

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

Outcome 17: People should have their complaints listened to and acted on properly
There is a complaints process in place and people are confident to use it. People are confident that their concerns are addressed.

• Overall, we found that Oak Lodge Nursing Home was meeting this essential standard.

Outcome 21: People’s personal records, including medical records, should be accurate and kept safe and confidential
The personal records at the home are all held individually and securely.

- Overall, we found that Oak Lodge Nursing Home was meeting this essential standard.

**Action 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. Any regulatory decision that CQC takes 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.
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 1: 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

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<tr>
<th>Our judgement</th>
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<tr>
<td>There are minor concerns with outcome 1: Respecting and involving people who use services</td>
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<tr>
<th>Our findings</th>
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<tr>
<td>What people who use the service experienced and told us</td>
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<tr>
<td>Most people were not able to tell us about their care. However, some of them said that they were happy living at the home and that the staff were kind.</td>
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<tr>
<td>Other evidence</td>
</tr>
<tr>
<td>As part of our visit, we spoke to a number of the relatives visiting the home throughout the day and they were complimentary about the staff and the support that their relatives were receiving. They told us that they were aware of the care plans and had helped the staff and provided information about their relatives. There was evidence in the care records that we looked at that their relatives were involved and consulted about the care.</td>
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<tr>
<td>At different times during the day, we observed the staff interacting well with the relatives and they provided them with information as required. People said that they were involved in making decisions as appropriate about the care of their relatives.</td>
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We received concerning information from healthcare professionals before our visit about some care practices. During our visit we observed that people’s right to privacy and dignity was not always respected. For example, we observed a resident walking in a state of undress and the staff failed to take action. Another resident was dressed in clothing that was too big that left them exposed as their trousers kept falling down whilst walking in the corridor.

**Our judgement**
People acting on the residents’ behalf are encouraged to express their views and support the residents. However, some of the care practices at the home do not always ensure that people’s privacy and dignity are respected while receiving care.

Overall we found that Oak Lodge Nursing Home is not compliant with this essential standard and improvements are needed.
Outcome 2: Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:
- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
- Can be confident that their human rights are respected and taken into account.

What we found

Our judgement

The provider is compliant with outcome 2: Consent to care and treatment

Our findings

What people who use the service experienced and told us
The residents were unable to tell us about consent to care and treatment so we cannot report what they said.

Other evidence
We spoke to people who told us that they had been involved in and given consent about care of their relatives.

During our visit, we observed that staff interacted well with the residents and explained what they would be doing before supporting them with personal care.

The manager reported that they had systems in place to gain consent. For example, the home had best interest meetings with the relatives. The home had information available to enable them to contact the local Deprivation of Liberty Safeguards team and the Advocacy Service should either of these be required to support the residents.
**Our judgement**
The registered provider ensures that people are supported and consent is gained when receiving care.

Overall we found that Oak Lodge Nursing Home is compliant with this essential standard.
Outcome 4:  
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 major concerns with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

Some of the residents were unable to tell us about their care plans. However, some of them were able to tell us that they liked living at the home and it was a nice place.

Other evidence

As part of our review, we spoke to a number of the relatives who were visiting the home. They told us that they were happy with the care that their relatives were receiving. They said that the staff were available and that they felt the residents were treated kindly and their needs were being met. People said that they were able to leave their relatives and ‘not have to worry’.

We looked at some care plans as part of our visit and we observed staff practices and their interactions with the residents. The care plans contained a ‘map of life’ where information had been provided by the residents’ relatives. These included family and other relationships, likes and dislikes, hobbies and past occupation. The manager said that this information was used to develop activities for the residents. The home also had activity coordinators and we noted that activity plans were available in the residents’ records.
The care plans contained details of assessments such as moving and handling, risk of falls, skin integrity, dementia and personal care. The care records also contained some assessments of people who had been identified as at risk of choking and a speech and language therapist assessment was available in some plans. Staff we spoke to were aware of those people who required pureed diets and thickened fluids. Information regarding thickened fluids and their consistency was available to the staff.

We found that the care plans contained some details of identified risks and how these should be managed. However, these were not consistent and lacked reviews and updates in order to accurately reflect the current needs of people. These included when people had lost weight and care plans had not been updated to show the action taken. Another person had a swallowing assessment and needed a pureed diet and the care plan had not been updated to reflect this. A care plan for another person did not contain details of oral hygiene following assessment and recommendations from healthcare professionals. Other concerns related to the staff failure in monitoring people’s deteriorating health and keeping appropriate records as required.

The care record for one resident stated they were on a pureed diet due to them being at high risk of choking. The daily records seen showed that they had been receiving other food that may put them at risk. The staff said that this had been highlighted to them and an action plan was being put in place but we did not see evidence of this. The staff said that this person was allowed to have chocolate and agreed that the care plan had not been updated and more details were needed in order that this could be managed safely.

We received concerning information from a healthcare professional about a resident who was moved incorrectly. The staff were not aware of this person’s needs as some thought that this person was able to move and others said a hoist was needed. The resident’s moving and handling care records had not been updated.

The healthcare professionals also raised a concern about there being an insufficient amount of slide sheets which were used to assist in the moving and handling of the residents when they were in bed. This was discussed with the manager who reported that some slide sheets had been purchased and the provider was looking into this.

We noted that falls assessments and care plans were not always reviewed and updated following a fall which meant that risks were not managed effectively.

The staff maintained a daily record of care given in the residents’ plans and staff said that these were completed to inform practice and continuity of care. We found that these were also not consistent where the daily record of care was missing.

One of the residents was receiving extra support from an agency. Concerns were
raised about the lack of information and access to this person’s care plans as these were not available to the staff from the agency. This was being looked at by the healthcare team and we were told that the agency staff would be receiving training in order to support this person with their care needs.

**Our judgement**

People’s care needs are not always managed in a safe and consistent manner. There is a lack of assessments of the residents’ needs and care plans are not reviewed to reflect the current needs of people.

Overall we found that Oak Lodge Nursing Home is not compliant with this essential standard and compliance actions will be made.
Outcome 5: 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

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<tr>
<td>There are minor concerns with outcome 5: Meeting nutritional needs</td>
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<tr>
<th>Our findings</th>
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<tr>
<td>What people who use the service experienced and told us</td>
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<tr>
<td>People we spoke to said that the food was very nice and that they liked the meals that were provided.</td>
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<tr>
<td>Other evidence</td>
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<tr>
<td>The home used a screening tool to assess the nutritional needs of people. We found that these were completed on admission. Care plans were developed and records seen contained details of type of food that people needed such as pureed and diabetic diets. People said that the meals were good and that their relatives enjoyed the food provided. They said that a choice of meal was available and two people said they were asked about their relatives’ food likes and dislikes. The staff said that the chef had a list of foods that the residents liked or disliked and choices were available to the residents.</td>
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<td>There was a small kitchenette that was attached to each floor which the staff called the ‘unit’, where breakfast, snacks, and hot and cold drinks were available at all times. The staff we spoke to said that this worked well and we observed that people were provided with hot and cold drinks throughout the day.</td>
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<tr>
<td>We observed the lunchtime meal on the day of the visit. We found the meals were nicely presented and looked balanced and appetising. Pureed food was served</td>
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separately on the plate and not mixed up together.

We looked at the records of food and fluids as maintained at the service. We had received concerns that the food and fluids records were not always completed. The staff said that there were some people who had been identified as at risk and they were having their diets recorded. Although there were some records of food and fluids maintained, these were not consistent with large gaps that put people at risk of dehydration and malnutrition. In some instances, the record for a whole day was missing.

There was a lack of information about which of the residents were having their nutritional needs monitored to inform the staff practices and to ensure that care was provided in a consistent manner. Some people had food and fluid charts, for some, however their care plans seen did not reflect this. Staff we spoke to were unsure whether these residents were being monitored which put them at risk of receiving inconsistent care and their needs not being met.

**Our judgement**

People receive a balanced diet and choices are available to them. People who are at risk do not have their dietary needs monitored in a consistent manner and may put them at risk of harm.

Overall we found that there are areas of non-compliance with this outcome.
Outcome 6: Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
• Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

The provider is compliant with outcome 6: Cooperating with other providers

Our findings

What people who use the service experienced and told us
People living at the home were not able to comment on this so we cannot report what they said.

Other evidence
The relatives we spoke to said that the staff contacted healthcare professionals and doctors as required.

The residents were all registered with the local GP practice and the manager reported that there was a good support system from the local healthcare team. The home relied on the local primary care and the psychiatric team to provide support and guidance in the treatment and meeting of the complex needs of the people accommodated. The residents were supported to access external healthcare and to attend appointments in the community. The manager said that a staff member was always provided to assist people to attend hospital appointments as necessary.

On the day of our visit, the optician from the community was attending the home. They undertook a yearly visit and were available to the residents as required. The residents’ records contained information about recent visits to the dentist.
Healthcare professionals we spoke to said that they visited the home on a regular basis and they had developed a good relationship with the staff.

**Our judgement**

There is a system in place at the home that ensures the residents receive care and support from healthcare professionals as required.

Overall we found that Oak Lodge Nursing Home is compliant with this essential standard.
Outcome 7: 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 moderate concerns with outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
The residents were not able to comment on this outcome area so we cannot report what they said.

Other evidence
The relatives we spoke to said that they felt the residents were safe and that the staff interacted well with the residents. They said that they had no worries and would approach a staff member if they saw or heard anything that caused concerns for them.

Records that we looked at during our visit showed that training was available for the staff in safeguarding adults. This formed part of the company’s induction programme for all new staff. Staff we spoke to were able to tell us about the different types of abuse and said they would report any cases to the manager.

However, we had received information from the adult services team about a number of allegations of poor practice that were being investigated under the safeguarding procedures at the time of our review.
The care practices as described in outcomes 1, 4, 5 and 9 of this report also did not ensure that people were protected from the risks of harm to their welfare and safety and to protect their dignity. The concerns related to lack of a robust system in identifying poor practices, which may cause harm or place the residents at risk of harm. There was little evidence of what action had been put in place following feedback from healthcare professionals in addressing poor practices.

Our judgement
There are processes in place and training in safeguarding is available to the staff. However the care practices do not protect people from risk of harm and this included some poor staff practices.

Overall we found that Oak Lodge Nursing Home is not compliant with this essential standard.
Outcome 8: Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

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<th>Our judgement</th>
<th>There are minor concerns with outcome 8: Cleanliness and infection control</th>
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Our findings

What people who use the service experienced and told us

We did not speak to people about this outcome area so cannot report what people using the service said.

Other evidence

People we spoke to said that the home was always nice and fresh. They said that their relatives' bedrooms were always kept clean including the carpets.

As part of our visit, we looked around some parts of the home including some of the residents' bedrooms. We found that the home was clean with no adverse odours.

The home had a dedicated laundry room and sluice rooms where infected materials could be disposed of safely. We observed that the staff were provided with protective equipment such as aprons and gloves. We saw infection control measures such as alcohol gels were available at reception and in the communal areas for use by visitors.

The manager reported that a recent internal survey of people at the home expressed a high level of satisfaction with the cleanliness of their bedrooms and the home in general.
We saw records that showed the staff had undertaken training in infection control as part of their induction and hand washing training had also been completed by the staff. The home employed domestic staff seven days a week to ensure that the home was kept clean. The home was introducing a cleaning checklist as part of their internal audit at the time of our visit.

The staff said that slings used for hoisting were currently shared between the residents, unless someone was found to have an infection, when they would be provided with their own slings.

The home had accessed the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance and the manager was planning to introduce this at the home. There was currently no one identified as a lead in infection control and the manager confirmed this was being discussed as well as infection training for all the staff.

**Our judgement**

There are some infection control procedures in place, however further development is needed to meet with the current regulation for infection control.

Overall we found that Oak Lodge Nursing Home is not compliant with this essential standard.
Outcome 9: 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

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<th>Our judgement</th>
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<tbody>
<tr>
<td>There are major concerns with outcome 9: Management of medicines</td>
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<th>Our findings</th>
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<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
</tr>
<tr>
<td>The residents were not able to comment on how they received their medicines so we cannot report what they said.</td>
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<tr>
<td>Other evidence</td>
</tr>
<tr>
<td>The relatives said that they thought the staff were responsible for the residents’ medication.</td>
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<tr>
<td>We looked at the process that the home had in place for the management of the residents’ medicines. The provider stated that clear policies and procedures were in place for the management of medicines. The staff confirmed that only registered nurses were responsible for medicines management at the home. Staff reported that they carried out a monthly audit of medicines.</td>
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<tr>
<td>All medicines were stored securely in a locked cupboard and locked trolleys. The home had a separate fridge for the storage of medicines and the fridge temperature was monitored daily to ensure that medicines were maintained at the correct temperature.</td>
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The staff maintained a record of medicines received and those that were discarded as required. We looked at a sample of the medication administration record (MAR) charts as maintained at the home. Staff stated that there was no one administering their own medicines at the time of the visit. The MAR charts contained records of medicines administered; however this was not consistent as there were some gaps on MAR records, where it was unclear whether people had received their medicines as prescribed.

A random audit of medicines showed that there were, in some instances, extra tablets that could not be accounted for as the MAR records indicated they had been administered. Staff were failing to record variable dosages as required. Although some information was available about the usage of ‘as required’ medicines, this was inadequate to inform staff practice. The staff agreed that as people were unable to communicate their needs, detailed information was needed in order to ensure that people received their medicines in a consistent manner.

On the day of our visit, we observed that people were receiving their morning medicines at 10:45. However the MAR charts did not reflect this. This was brought to the attention of the manager.

We had received concerning information from the adult services team regarding some poor practices in medicines management at the home and this was being investigated under safeguarding protocols at the time of our review.

Other concerns we received included a resident who did not receive their medicines for two days as the home had run out of their medicines. We also received information that a resident was prescribed some antibiotics and the staff failed to ensure this was available for that person. Another concern related to an allegation of poor practice by a registered nurse. The manager said that was being investigated. Staff confirmed that no one was receiving their medicines covertly at the time of this visit.

Our judgement
The home has clear written procedures for the administration of medicines. However, the current practices at the home put people at risk of not receiving their medicines in a safe and consistent way.

Overall we found that Oak Lodge Nursing Home is not compliant with this essential standard.
Outcome 10: Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

The provider is compliant with outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us

People we spoke to said that they liked living at the home. Some said they liked their bedrooms.

Other evidence

The home is a purpose built environment that offers bright and spacious accommodation that people said met their needs. The residents had access to all the communal areas via passenger lifts and wide staircases. All the bedrooms had en-suite facilities. The home was homely and in a good state of repair. Furnishing was of a good standard and appropriate to the needs of people living at the home.

Relatives we spoke to were complimentary about the surroundings and the facilities available. A relative said that they came to visit and ‘knew this would be the right place’ for their relative.

People said that they were encouraged to bring in items of personal belongings. They said that they were supported to personalise their relatives’ bedrooms for example with photos which were a link to their past and enabled conversation and interests for their relatives.
Some parking was available at the front of the home and there was an enclosed and safe garden with level access that the people living there were able to access. Seating was provided in the garden that residents and relatives said they were looking forward to using when the weather improved.

**Our judgement**
People are provided with a clean, safe and homely environment that meets their needs.

Overall we found that Oak Lodge Nursing Home is compliant with this essential standard.
Outcome 11: Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

The provider is compliant with outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us
People living at the home were unable to comment on this outcome area so we cannot report what they said.

Other evidence
Relatives said that they thought equipment around the home, such as wheelchairs, was in good order.

The home had a variety of equipment such as hoists and assisted baths to support and maintain the independence of people living at the home. The manager reported that there was a dedicated maintenance person available and any fault with the equipment was dealt with promptly.

There was an ongoing programme of maintenance that ensured that all equipment was serviced regularly. Policies and procedures were in place for the reporting of adverse occurrences. We observed that equipment was stored safely and was in good working order. A variety of equipment was available to support people to
maintain their independence, such as assisted baths and hoists.

Before we visited the home, we had received concerning information regarding the lack of slide sheets for the safe moving and handling of the residents. During our visit, the manager confirmed that extra slide sheets and slings for the hoists had been purchased.

**Our judgement**
There is a programme to ensure that equipment is safe and available to people as required.

Overall we found that Oak Lodge Nursing Home is compliant with this essential standard.
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 living at the home said that the staff were nice.

Other evidence
Relatives said that they would expect that people would have the necessary checks in place as this was high profile in the media.

The service had procedures in place regarding the recruitment of workers.

Staff we spoke to said that they had completed an application form and references were required as part of their application. The manager stated that the company had a robust recruitment process in place and all checks were completed prior to staff starting work.

We looked at three staff records as part of this visit. We found that they had all completed an application form and references were sought as part of the recruitment process. Other checks such as criminal record bureau (CRB) and independent safeguarding authority (ISA) checks were completed prior to them starting work.
Our judgement

There is an effective recruitment process in place and necessary staff checks are carried out to protect people living at the home.

Overall we found that Oak Lodge Nursing Home is compliant with this essential standard.
Outcome 13:
Staffing

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 sufficient numbers of appropriate staff.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
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</thead>
<tbody>
<tr>
<td>There are minor concerns with outcome 13: Staffing</td>
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<table>
<thead>
<tr>
<th>Our findings</th>
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</table>

**What people who use the service experienced and told us**
The people living at the service were unable to comment on staffing levels so we cannot report what they said.

**Other evidence**
The relatives told us that they thought that there were enough staff as they were usually around when they visited. People said that the staff were very kind and they had developed good relationships with them and the manager was supportive and ‘listened’ to them.

At the time of the visit, the manager said that they had 10 empty beds. We had been told that there were three registered nurses on the day shifts who were supported by care staff members and activity coordinators. There were also dedicated domestic and catering staff who provided cover seven days a week. The home had two registered nurses and seven care staff on night duty. We observed that staff were available in the communal areas throughout the day.

Staff we spoke to told us that this was a very busy home and sometimes it was not easy to catch up as they moved from different floors of the home. This meant that they did not always have the information they needed and this posed a risk of inconsistent care. Staff told us that they often had to wait for a long time to get help
with a person who required one to one support. On the day of the visit, the staff told
us that they had been waiting for a while for help to put a resident to bed and that
this person had become agitated.

Information from the home’s internal audit of the residents’ meetings also
highlighted similar concerns about movement of staff and the risk of a lack of
continuity of care for the residents.

**Our judgement**
The home has a planned duty roster with domestic and catering support for the
staff. People’s support needs are not always met in an effective manner with long
delays at times in receiving help.

Overall, therefore, we found that there are areas of non-compliance with this
outcome and improvements are needed.
Outcome 14: Supporting 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 competent staff.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
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</thead>
<tbody>
<tr>
<td>The provider is compliant with outcome 14: Supporting workers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
</table>

What people who use the service experienced and told us
The people living at the service were unable to comment on the staff training so we cannot report what they said.

Other evidence
People we spoke to said that the staff were caring and kind and they thought that the company would have some sort of training for the staff.

Staff told us they received induction. They also told us they felt well supported, received supervision and attended staff meetings.

As part of our visit, we observed the staff practices and we saw good interactions between the residents, relatives and staff.

There was a planned training programme in place to support the staff. A sample of the staff’s training records that we looked at showed that they completed training in health and safety, infection control, prevention of abuse, moving and handling, basic food hygiene and dementia care.

There was also an induction programme that the staff completed at the start of their employment at the home. A staff member was completing their induction on the day of the visit and they told us that they were working as an extra for the shift and this
meant that they were shadowing an experienced staff member. The manager reported that the home had planned supervision for the staff and this helped to identify any training needs.

**Our judgement**
There are planned training and supervision arrangements to support the staff in their role.

Overall we found that Oak Lodge Nursing Home is compliant with 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 minor 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 they were happy living at the home.

Other evidence
The manager said that the home had some systems in place that they used as part of their internal audit. They carried out audits of care plans and medicines management. An action plan was put in place to look at medication shortfalls, such as planning some training for senior staff that would be cascaded to the other staff.

There were regular residents’ and relatives’ meetings on a three monthly basis. Relatives told us that they had attended residents’ meetings and they thought this was a good thing as they ‘could bring up any worries.’

Staff told us that they had regular staff meetings. The activity coordinator held activity committee meetings and, following these meetings, a knitting club had been developed. We spoke to a relative who was attending the knitting club on the day of our visit and we received positive feedback about it.

We found that a senior person from the company undertook monthly visits to the
home as part of their audits.

We found that, although there was some auditing in place, there were a lack of clear action plans to resolve issues once they had been identified. We had received information regarding ongoing issues with moving and handling of residents, medicines management and care plans. We found that the result of the audits had not been used to ensure that action was taken to protect people who use services from risks associated with unsafe care, treatment and support.

**Our judgement**

There are some systems for the auditing of care at the home, however these are not adequate and action plans are lacking to ensure that issues identified are resolved.

Overall, therefore, we found that there are areas of non-compliance with this outcome and improvements are needed.
Outcome 17: Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:
- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

The provider is compliant with outcome 17: Complaints

Our findings

What people who use the service experienced and told us
People we spoke to said that they were happy living at the home.

Other evidence
Information about how to raise a complaint was available to the residents and their families. The manager reported that the complaints procedure would be available in other formats if required. The manager had an open door policy and people we spoke to confirmed that they could go and see the manager if they had any concerns.

A random sample of the complaint records at the home showed that concerns raised were investigated and a response was sent. The manager said that she dealt with all concerns and referred them to a senior person from the company as required.

The relatives said that they were content with the care that the residents were receiving. They told us that they knew who to approach if they were not happy. They said that they had no 'worries' and thought that their relatives were well looked after and the staff were good.
Our judgement
There is a complaints process in place and people are confident to use it. People are confident that their concerns are addressed.

Overall we found that Oak Lodge Nursing Home is compliant with this essential standard.
Outcome 21: Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is compliant with outcome 21: Records

Our findings

What people who use the service experienced and told us
People living at the home were not able to comment about records so we cannot report what they said.

Other evidence
During our visit, we observed that all personal records were stored securely and safely. Relatives said that they thought the care records were kept at the nurse’s station.

The manager confirmed that the staff records were kept locked and could only be accessed by designated staff.

Our judgement
The personal records at the home are all held individually and securely.

Overall we found that Oak Lodge Nursing Home is compliant with 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.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic or screening procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Why we have concerns:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People acting on the residents’ behalf are encouraged to express their views and support the residents. However, some of the care practices do not always ensure that people’s privacy and dignity are respected while receiving care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic or screening procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Why we have concerns:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People receive a balanced diet and choices are available to them. People who are at risk do not have their dietary needs monitored in a consistent manner and may put them at risk of harm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic or screening procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Why we have concerns:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are some infection control procedures in place, however further development is needed to meet with the current regulation for infection control.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>22</td>
<td>13</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic or screening procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Why we have concerns:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The home has a planned duty roster with domestic and catering support for the staff. However, people’s support needs are not always met in an effective manner with long delays at times in receiving help.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury.</td>
<td></td>
<td></td>
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<tr>
<td>Diagnostic or screening procedures</td>
<td></td>
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</tbody>
</table>

**Why we have concerns:**
There are some systems for the auditing of care at the home, however these are not adequate and action plans are lacking to ensure that issues identified are resolved.

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 within 14 days of this report being received.

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.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic or screening procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People’s care needs are not always managed in a safe and consistent manner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a lack of assessments of residents and monitoring when people’s conditions deteriorate and care plans are not reviewed to reflect the current needs of people.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic or screening procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are processes in place and training in safeguarding is available to the staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>However, the care practices do not protect people from risk of harm and this includes some poor staff practices.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic or screening procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The home has clear written procedures for the administration of medicines. However, the current practices at the home put people at risk of not receiving their medicines in a safe and consistent way.</td>
<td></td>
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</tr>
</tbody>
</table>

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 14 days of this report being received.
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 Adult 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

<table>
<thead>
<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
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<tbody>
<tr>
<td>Author</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>Audience</td>
<td>The general public</td>
</tr>
<tr>
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## Care Quality Commission

<table>
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<th><a href="http://www.cqc.org.uk">www.cqc.org.uk</a></th>
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<tr>
<td>Telephone</td>
<td>03000 616161</td>
</tr>
<tr>
<td>Email address</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
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</tbody>
</table>
| Postal address   | Care Quality Commission  
                     Citygate  
                     Gallowgate  
                     Newcastle upon Tyne  
                     NE1 4PA |