Review of compliance

Bupa Care Homes (CFHCare) Limited
Oak Lodge Nursing Home

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<th>Region:</th>
<th>South East</th>
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<td>Location address:</td>
<td>45 Freemantle Common Road</td>
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<td>Southampton</td>
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<td>Hampshire</td>
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<td>Type of service:</td>
<td>Care home service with nursing</td>
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<tr>
<td>Date of Publication:</td>
<td>September 2011</td>
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<td>Overview of the service:</td>
<td>Oak Lodge is registered with the Care Quality Commission to provide nursing and personal care to 71 residents 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</td>
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of Southampton city and within a short
distant from the facilities of Bitterne village.
Our current overall judgement

Oak Lodge Nursing Home was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

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 Oak Lodge Nursing Home had made improvements in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 02 - Consent to care and treatment
Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 06 - Cooperating with other providers
Outcome 07 - Safeguarding people who use services from abuse
Outcome 08 - Cleanliness and infection control
Outcome 09 - Management of medicines
Outcome 12 - Requirements relating to workers
Outcome 13 - Staffing
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, observed how people were being cared for, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

Some people told us that they felt their privacy was respected when they received personal care.

One person told us that some of the care staff ‘can be rough’. Another person said that they were on tablets for their chest and the staff administered these to them.

The relatives told us that care was variable depending on which staff were on duty. Some people said that the home was ‘chaotic’ at times and this was due to the high level of agency staff.

Two people said there were problems with staff not knowing the residents.
People told us that the care had deteriorated in the last few months as there had been no manager.

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

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

The care practices at the home did not always take into account the residents' privacy and dignity. People were not always treated with respect

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

People were involved in their care and consent was sought; however this was not well planned to ensure that consent was gained at the appropriate time.

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

The care practices at the home put people's health and welfare at severe risk. The provider was failing to monitor the care provided and the care plans, reviews and assessments were inadequate to meet people's assessed needs.

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

The people living at the home were put at risk of not receiving an adequate amount of food and fluids. People were not always given the support with their diets and this put them at risk of malnutrition and dehydration.

Outcome 06: People should get safe and coordinated care when they move between different services

There were inadequate arrangements in place to ensure that information was shared. This may have a detrimental effect resulting in people not receiving the care that they required.

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

There were processes in place and training in safeguarding was available to the staff. However the care practices did not protect people from risk of harm.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

There were infection control procedures in place; however the staff were failing to follow these. This may put people's health and welfare at risk.

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

The medicines management at the home was poor and people were put at risk of not receiving their prescribed medicines.

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

There was a satisfactory recruitment process for the permanent staff. The necessary checks for other staff employed were inadequate and put people at risk of receiving care from staff without the appropriate skills and qualifications and pre-employment checks.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

There was a lack of processes in place to ensure the appropriate staffing was in place and people were not confident that the staff had the skills to deliver care in a safe and consistent way.

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 was a lack of clear processes in place to monitor the quality and safety of the care provision at the home.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

The records of residents were not always being held securely and there were not always accurate records of care and treatment.

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.

We have taken enforcement action against Bupa Care Homes (CFHCare) Limited.

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.

Other information

Please see previous reports for more information about previous reviews.
What we found
for each essential standard of quality
and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 01: Respecting and involving people who use services

What the outcome says
This is what people who use services should expect.

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

What we found

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<th>Our judgement</th>
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<td>There are moderate concerns with Outcome 01: Respecting and involving people who use services</td>
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<th>Our findings</th>
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<td><strong>What people who use the service experienced and told us</strong></td>
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<td>Most of the residents at the home could not tell us about this outcome due to their mental frailty so we cannot report what they said. Two people said that the 'girls' did close the door when they received personal care. Another person said that the staff treated her 'all right.'</td>
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<td><strong>Other evidence</strong></td>
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<td>We made visits to the home on 5 and 8 August 2011. During our visits, we visited a resident in their bedroom and found that there were photographs of this person that showed them exposed. These photographs related to their personal care and positioning whilst in bed, and impacted on the person's privacy and dignity. There was no evidence to indicate that this person had given permission for the photographs to be displayed in such a way. We brought this to the attention of the regional manager who was in the home at the time and these photographs were removed. Our concerns were that there had been a number of senior people monitoring the home. However this had not been picked up as part of their monitoring.</td>
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<td>We saw that notices regarding people’s personal care had also been displayed on the walls of their bedrooms, for all to see. One of the notices referred to keeping the door locked when the person was not in the room. This was discussed with staff; they could...</td>
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not give an explanation as to why this instruction was written. A member of staff stated perhaps this may be what the person's relative wanted.

We received concerning information from other 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 one of the residents was wearing a 'bib'. We asked a member of staff why they were wearing this, she stated it was to protect their clothes, as they were always dribbling. We looked under the bib and found that her shirt was wet and had not been changed. She also had dried up saliva on their chin; no one had attempted to clean this.

On 8 August 2011, we observed a person being transferred from a wheelchair to an armchair with the use of a hoist. Little attention was paid to the person's dignity and they were left exposed and their continence pad was clearly visible to all in the area.

We also observed one person in a state of undress in the lounge area and visitors were present at the time. Staff were observed to stand this person in a state of undress to assist them without shielding them to maintain their privacy and dignity. We brought this to the senior managers attention at the time.

**Our judgement**
The care practices at the home did not always take into account the residents' privacy and dignity. People were not always treated with respect
Outcome 02:
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
There are minor concerns with Outcome 02: 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 made visit on the 5 and 8 August 2011, we looked at care records and these contained some information about consultation with the family over their relatives' care. A visitor confirmed that they were kept up to date with their relative's care and the staff had explained to them about their care plans.

Prior to our visit, we had received information that the residents had not received their flu vaccines as consent was not gained in time. During our visit we checked upon this and found that there was a lack of processes in place to ensure that this occurred in a timely fashion. This may be to the detriment of the residents.

The care records also contained information about when the staff had contacted the relatives about changes to care. However, this was not consistent as one relative told us that the home had not informed them when their relative had suffered an injury following a fall.

The senior staff confirmed that 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**
People were involved in their care and consent was sought; however this was not well planned to ensure that consent was gained at the appropriate time.
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

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<th>Our judgement</th>
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<tr>
<td>There are major concerns with Outcome 04: Care and welfare of people who use services</td>
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<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 of the residents were unable to tell us about their care arrangements due to their mental frailty so we cannot report what they said.</td>
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A relative told us that he was very happy with the care and the staff were very kind. Two people said they thought the care was all right. One person told us that some of the care staff 'can be rough'.

The relatives told us that care was variable, depending on which staff were on duty.

Other evidence
During the visits, we found that the registered provider was failing to take proper steps to ensure that each resident was protected against the risks of receiving unsafe care and treatment. As a consequence the provider was putting the health, safety and welfare of residents at considerable risk of harm.

During our visit on 5 August 2011, when we arrived on the first floor at 10.15 am we observed a resident was sitting in an armchair. This person was very frail, and was too short for their feet to touch the ground. No one had provided a foot stool in order to ensure that this person was comfortable. This resident was asleep in the chair, and there was a cold beaker of tea on the side table. We spoke with staff in respect of this person and they informed us that, under normal circumstances, this person would be resting in their bed, but that their bed was broken. They informed us that they were waiting for the bed to be repaired. We checked the person's bedroom and found that
the bed was broken.

At 12.15 pm that day, we observed that this resident was still asleep in their chair, and in the same position we had found them in the morning. The cold cup of tea had been replaced with a beaker of orange fluid, and the beaker was full. We also observed that their eyes were sticky.

At 14.40 pm, we checked this resident again. We found that they were still in the armchair in the position we had found them in earlier in the day. The full beaker of orange fluid was still on the side table. This resident's eyes were still sticky. We spoke with the one of the senior members of staff regarding this, and we asked why they had not been put back into bed. They informed us that this resident's bed was not going to be repaired that day. This person also told us that care staff were aware of this, and that they had been instructed to put this person into a bed in one of the vacant rooms. Clearly this had not happened, and, as a consequence, this resident had been left in the arm chair for a considerable amount of time. No one came to move them until 14.54 pm. This meant that this resident was put at risk of harm to their health, safety and welfare.

During our visit on 8 August 2011, we observed that a resident was asleep in their bed at 08.40 am. They were lying on their right hand side. We returned to the bedroom at 11.20 am and found that this person was in the same position. We spoke with a senior member of staff who confirmed that this resident should have been turned in bed every two hours. Clearly, this had not happened and immediate action was required to ensure this person's position was changed. This was a serious cause for concern because this person was a highly vulnerable person at considerable risk of developing pressure ulcers.

At 12.15 pm on the 5 August 2011, we observed that a member of agency staff had been deployed to look after an extremely vulnerable resident whilst they were sitting outside in the garden. We observed that the member of staff was sitting with their eyes shut for a period of two minutes. This was not observed by other staff at the home. This was a serious concern and it had to be brought to the attention of the deputy manager.

We observed the lunch time activity on 5 August 2011. During this period, one person asked a number of times to visit the toilet. Staff did not hear their request. This had to be brought to the attention of the staff. One resident was sitting asleep not eating their food, this was not noticed by staff. The person's plate was taken away without them eating any of the food. One resident tried to drink another resident's drink, staff did not notice, and the person's relative had to intervene. We observed a resident returning from the toilet in a wheelchair, for which there were no footplates in place and the person had to hold their legs up to prevent their feet from dragging on the floor.

On 5 August 2011, we looked at a number of care records and found that assessments were not being carried out properly. A resident's care records showed us that, on 15 July 2011, this person's weight was recorded at 59.1kgs. On 2 August 2011, their weight was recorded as 55kgs. There was no evidence of any action taken to monitor this person's weight loss.

On 8 August 2011, we observed that a resident was left in the lounge on the lower ground floor for a period of 25 minutes. During this time, no member of staff was
observed coming into this room to check if this person was safe. This was brought to the attention of a senior member of staff and they confirmed that this person should have been monitored more closely.

On both visits, we observed that care records were not being reviewed and updated to reflect the current care needs of people. For example, one resident's records showed that they were at high risk of pressure ulcers. We observed that their Waterlow score was recorded at 19 (high risk). This is a pressure ulcer risk assessment tool. This person's Waterlow risk assessment was not reviewed in June 2011 despite the high risk although the assessment was reviewed in July 2011.

The records we saw during our visits also showed that one of the residents had 3 falls recorded in June 2011, and three falls in July 2011. The falls risk assessment was not reviewed in June 2011, despite the increased number of falls. The risk assessments were contradictory and stated ‘running putting them at greater risk of falling’ and ‘gait steady’. We discussed this with staff; they confirmed that the risk assessment was incorrect.

We saw that on 5 August 2011, the Waterlow risk assessment for another resident was also incorrect. On the 4 June 2011, the score was recorded as 19 (high risk). However, on 14 July 2011, the score was recorded as 17, despite records showing that her weight on 18 June 2011 was 33kgs and on 4 July 2011 was 31.8kgs. The reduction in their weight, reduced intake of food and the lack of mobility should have indicated that this resident was at higher risk of developing pressure ulcers.

On 5 August 2011, we observed a resident being transferred from their armchair into a wheelchair. The moving and handling assessment record for this resident showed that a brown sling should have been used to transfer this person. We observed that a red sling was used. The record had not been updated to reflect this change.

On 8 August 2011, we observed that a resident had an indwelling catheter to manage their urine output. We looked at their care records and found that on 19 June 2011 this person had a new catheter inserted by the GP. Instructions were left to ensure that this resident was encouraged to take fluids as they were dehydrated; this showed that they had not been receiving adequate fluids. There were no records kept of the batch number in respect of the particular catheter used. This was an issue that had been previously identified, in order to ensure that accurate records of the type, size of catheter used were maintained.

On both visits the care records we looked at showed that a number of people required continence management. We found there was no clear guidance as to how this was being managed, such as regarding the frequency of changing their continence pads. This meant that people were put at risk of not having their continence needs fully met.

On 8 August 2011, a resident's relative raised concerns in respect of his relative's care and them being sent to hospital for non-emergency treatment. We observed a discussion between the relative and a registered nurse. The nurse was unable to take a decision in respect of his relative's care and welfare and advise him.

On both visits we looked at the daily person care records for a number of people and, on a number of occasions, the records showed that they had not received any personal
care. For example, the personal care records for one of the residents showed that on 25, 26 and 28 July 2011 no entries were made. The records for another resident were also blank on 21 July, 2, 4 and 5 August 2011. From the records, it was not clear as to whether or not these people had received any personal care.

When we looked at care records on 5 August 2011, we also spoke with staff about people's assessments and care plans. A number of the staff were not able to tell us what the content of the care plans were, nor were they able to locate particular records we requested. Clearly, this showed, that staff were not familiar with nor using the care plans, and, as a consequence, people were at risk of not receiving the appropriate care and support according to their assessed needs.

From the evidence that we gathered during our visits, this clearly showed that the provider was failing to take appropriate steps to ensure that people's needs were appropriately met. They were not protected against the risk to their health and welfare.

We raised our concerns with senior management who were monitoring the service. There was a lack of an effective plan to ensure that people's care needs were met.

In view of the major concerns identified in this outcome area the Care Quality Commission served a Warning Notice on the Registered Provider on 19 August 2011.

**Our judgement**
The care practices at the home put people's health and welfare at severe risk. The provider was failing to monitor the care provided and the care plans, reviews and assessments were inadequate to meet people's assessed needs.
Outcome 05: Meeting nutritional needs

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
There are major concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
Most people were not able to comment on the choices regarding food and fluids so we cannot report what they said. However, three people told us that the food was nice. One person said that the lunch was 'very good.'

Other evidence
We found, during our visits, that the provider was failing to make appropriate arrangements to ensure that people received adequate nutrition and hydration and as a consequence was putting their health, safety and welfare at risk.

On 8 August 2011, we observed a resident was asleep at 09:30 am and their food record showed that they had refused their breakfast. We returned at 11:20 am and found them lying in the same position and their food record showed that they had not received any food or fluids. The last recorded fluid according to their record was 23:30 pm on the 7 August 2011 when they drank 50 mls of juice. Their record showed that the last meal was taken at 13:40 pm on the 7 August 2011. As a result, this person was not being protected from the risks of inadequate nutrition and dehydration.

On 8 August 2011, we observed at 08:50 am another resident had been served their breakfast of tea and toast and this person was asleep. This person was an insulin dependant diabetic. When we returned at 11:20 am, we found that their breakfast including their tea was untouched and this person had not been assisted with taking their food and fluids. This lack of action placed a very vulnerable person at high risk of dehydration, malnutrition and associated complications from their diabetes.
On the 8 August 2011, we found that a resident was sat in the lounge. Their food and fluid records for 7 August 2011 showed that they had not received any nutrition from 12:30 pm until 22:00 pm. The staff we spoke to confirmed that this person was chair bound and totally dependent on the staff to meet all their care needs. We observed that this person was also receiving a fortified drink which indicated that they were at risk of not maintaining normal adequate dietary intake to sustain them.

On the 5 August 2011, we found that another resident, according to their care records, was prescribed thickened fluids to be administered at stage 2 consistencies which related to the thickness of fluids to be administered. We observed that this person had been given a beaker of juice that did not contain any thickener as prescribed. The staff confirmed that they should be receiving fluids at stage 2 consistencies. However, the staff we spoke to could not explain why this had not occurred. This lack of action put this resident at high risk of aspiration by not receiving the correct consistency of fluids. We noticed that this person was also very chesty. The evidence that we gathered during our visits demonstrated that the provider was not protecting residents against the risks associated with poor nutrition and dehydration.

In view of the major concerns identified in this outcome area the Care Quality Commission served a Warning Notice on the Registered Provider on 19 August 2011.

**Our judgement**

The people living at the home were put at risk of not receiving an adequate amount of food and fluids. People were not always given the support with their diets and this put them at risk of malnutrition and dehydration.
Outcome 06: 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

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| **What people who use the service experienced and told us**  
The people living at the home were not able to tell us about access to healthcare services so we cannot report what they said. Two relatives aid that they were sure that the staff would call in the doctor if their relatives needed one. Another relative told us about the recent outpatient appointment that their relative attended with the support of the staff.  

**Other evidence**  
The care records that we looked at showed that the residents were supported to access their doctors and other healthcare professionals as required.  
The staff said that they contacted the local doctor’s surgery and they always received a home visit when they requested it.  
The care records contained some information about visits from doctors and other professionals.  
We had received some concerns about the staff not following the doctors' instructions that impacted on the care and welfare of people. We also found that the agency staff were ill equipped to share information with the doctors when they visited the home following a request to see the resident. Concerns were raised by healthcare professionals that the agency staff did not know enough about the residents in order to assist the healthcare professionals.  

**Our judgement**
There were inadequate arrangements in place to ensure that information was shared. This may have a detrimental effect resulting in people not receiving the care that they required.
Outcome 07: Safeguarding people who use services from abuse

What the outcome says
This is what people who use services should expect.

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

What we found

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

**Our findings**

**What people who use the service experienced and told us**
The residents were unable to comment on this outcome area due to their mental frailty so we cannot report what they said.

**Other evidence**
We spoke to the staff during our visits on the 5 and 8 August 2011. The staff said that they had received training in safeguarding adults. This training was completed as part of the home’s induction.

Although there was a safeguarding policy in place, the staff were not confident to raise their concerns with the management at the home. We received concerns about allegations of ill treatment of a vulnerable person. This concern had been raised by a staff member to the resident’s relative, and not to the manager.

There were a number of safeguarding investigations that were ongoing at the time of our visits. There were 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 these concerns.

**Our judgement**
There were processes in place and training in safeguarding was available to the staff. However the care practices did not protect people from risk of harm.
Outcome 08:
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

Our judgement
There are minor concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
Two of the residents told us that they liked living at the home. They said that they liked their bedrooms and the 'girls did a good job' cleaning the home.

People we spoke to said that the home was always nice and fresh. They said that their relatives' bedrooms were always kept clean and there was no problem.

Other evidence
All parts of the home that we looked at on both visits were clean. The cleaning staff told us that they had a cleaning roster that included cleaning the carpets.

The home had put in place the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance. Staff reported that they had received training in infection control.

During our visits, we observed on three separate occasions where staff demonstrated poor infection control practices. On two occasions, we saw staff carrying soiled laundry that was pressed against their clothing. The person in charge agreed that they should have worn aprons. We were also told that the staff should bring the linen trolley with them to the bedrooms to dispose of the soiled laundry. We also noted that in one bedroom the staff had discarded the soiled bedding onto the carpet.

Our judgement
There were infection control procedures in place; however the staff were failing to follow these. This may put people's health and welfare at risk.
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 major concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
Most of the people were not able to tell us about their medicines management due to their mental frailty so we cannot report what they said. However, one person said that they were on tablets for their chest and the staff administered these to them.

Other evidence
We found during our visits that the provider was failing to make appropriate arrangements to ensure that people received their prescribed medication and appropriate pain control, as and when prescribed or required and as a consequence were putting their health and safety at risk.

During our visits on 5 and 8 August 2011, we found that a resident was receiving end of life care and had been prescribed Oramorph for their pain control. The staff confirmed that they had an increased need for this pain control. The pain assessment chart was not used effectively to monitor their needs for pain control and ensuring that this person was not left in unnecessary pain. This may have led to inconsistency in how this person’s pain was being managed.

The record also showed that, following administration of this medicine, staff should monitor the effect to ensure that the pain control was effective. We found that this was inconsistent; some staff were completing this record at the point of administration,
others after half an hour. However the record showed that some staff did not monitor the resident until nearly three hours later. For example, on 5 August 2011, the resident was given Oramorph at 22:20 and was not checked until 01:00.

During our visit on 8 August 2011, we found that one resident was prescribed Digoxin and their care record showed that there was a gap on the Medication Administration Record (MAR) chart and staff we spoke to could not confirm whether they had received this medication.

On 8 August 2011, we found that another resident had refused their medicines on 17 occasions. One of these medicines was for the treatment of this person’s arthritis. There was no evidence of any action taken by staff to inform the doctor and put in place an action plan.

On 8 August 2011, when we looked at the record of the MAR chart for another resident, it showed that they had received their medicines and their MAR chart had been signed to confirm this. We found that there was another record where staff had recorded that this person had refused their medicines on a number of days. The MAR chart records were inaccurate and contradicted the information on the second record. As a result, this resident was at risk of not receiving their medicines safely as prescribed.

On 8 August 2011, we saw that a number of the residents were receiving thickened fluids and their MAR chart records showed that they had only received this once a day. Staff confirmed that people should be receiving these in all their fluids as prescribed and that the records were inaccurate.

On 8 August 2011, we saw that the records for a resident showed that 86 Paracetamol had been consigned for destruction on the 31 May 2011. The current MAR chart showed that 86 tablets were carried forward and these were in stock when we checked. Staff we spoke to were unable to explain the various discrepancies in the records.

During our visit on 8 August 2011, we found that the residents did not receive their medicines until after 10:20 in the morning. However, the MAR charts had been signed to show they had received them at 08:00 am.

On 8 August 2011, we saw that the MAR chart records for the administration of creams for a number of the residents were inadequate with numerous gaps that showed people had not had their creams or ointments applied. The staff told us that the care staff were applying the creams and the registered nurses were signing for them during the medicines round.

On 8 August 2011, we saw that the record of the MAR chart for a resident showed that they had been prescribed Co- Codamol to be given 1-2 tablets four times a day. The MAR records contained gaps which showed that they had not received their medicines as prescribed. Due to a failure of recording the variable dosages, an audit of this medicine could not be carried out.

During our visit on 8 August 2011, we saw that the record for another resident showed that they were prescribed a medicine for treatment of loose stools. The record showed...
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 July 2011</td>
<td>The MAR record indicated that they had received 3 tablets; however there were only 22 tablets left in stock and the missing tablets could not be accounted for.</td>
</tr>
<tr>
<td>5 and 8 August 2011</td>
<td>The staff told us that they were carrying out an internal audit of medicines at the home; however none of the shortfalls referred to above had been identified through this audit.</td>
</tr>
</tbody>
</table>

In view of the major concerns identified in this outcome area the Care Quality Commission served a Warning Notice on the Registered Provider on 19 August 2011.

**Our judgement**
The medicines management at the home was poor and people were put at risk of not receiving their prescribed medicines.
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

<table>
<thead>
<tr>
<th>Our judgement</th>
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</thead>
<tbody>
<tr>
<td>There are moderate concerns with Outcome 12: Requirements relating to 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 home were not able to tell us about this outcome area due to their mental frailty so we cannot report what they said.

Other evidence
During our visits, the staff we spoke to said that they had completed an application form and references were sought, as part of their application to work at the home. The staff confirmed that the provider had a robust recruitment process in place and all checks were completed prior to them starting work.

However, the home was using a number of agency staff to support the residents at the time of our visit. We looked at the records for these staff and found that these were lacking. For example, there was no evidence that these staff had completed the relevant checks such as criminal record bureau (CRB) and independent safeguarding agency (ISA). There was no evidence that the temporary staff had the skills and qualifications in order to deliver care safely. We also found that some of the agency staff had only their first name recorded, and staff could not tell us their full names.

Our judgement
There was a satisfactory recruitment process for the permanent staff. The necessary checks for other staff employed were inadequate and put people at risk of receiving care from staff without the appropriate skills and qualifications and pre-employment checks.
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

Our judgement
There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
The people living at the home were unable to tell us about the staffing levels due to their mental frailty so we cannot report what they said.

Other people told us that the home was variable depending on the staffing. They said that the home was 'chaotic' at times and this was due to the high level of agency staff. Also there were problems with staff not knowing the residents.

One person told us that some of the care staff 'can be rough'

Other evidence
During our visits we observed that there were adequate staff on duty for the daytime shifts. The lower ground floor had four residents and there were two care staff allocated to them. The registered nurse provided support to them and was responsible for the ground floor. However, on night duty there were seven care workers with two registered nurses to support people on four floors.

There had been concerns raised by relatives and other healthcare professionals about the high level of agency staff prior to our visits. The agency staff told us that they worked on different areas at the home and did not know the residents. We observed that, although the staff were present, some of them stood around and did not interact with the residents.

We found that the staff left the residents without any support or supervision and went
on their breaks together. Healthcare professionals had raised serious concerns about the staff who were left in charge as they were unable to assist them with information about people's needs and treatments.

There was no evidence of what type of support the staff were receiving. The staff we spoke to said that there were not enough senior care workers in order to provide continuity of care and support. Other staff at the home told us that some of the staff were 'lazy' and did not always help when it was needed. They said that the management were not proactive in providing cover for shifts, although they knew that some people would be off sick.

Our judgement
There was a lack of processes in place to ensure the appropriate staffing was in place and people were not confident that the staff had the skills to deliver care in a safe and consistent way.
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 major concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
The people living at the home were unable to tell us about this due to their mental frailty so we cannot report what they said.

Other evidence
We found that the registered provider was failing to protect residents, and others who may be at risk of inappropriate or unsafe care or treatment.

During our compliance visits on 5 and 8 August 2011, we found a number of concerns in relation to the care provided at the home. These concerns had not been identified and managed by the provider in accordance with this outcome and Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On 8 August 2011, we looked at the home’s safeguarding tracker form. This document identified a considerable number of concerns in respect of the care, welfare and safety of people living at the home. Whilst the document showed that a number of the investigations had been completed, it was not specific as to what systems were put in place to ensure the areas of concern were being monitored on an ongoing basis to protect residents against the risks of inappropriate or unsafe care.

On the same day, we looked at the records in respect of the visits on behalf of the registered provider to the home to monitor the provision of care and quality of service people received. The only records that were available were dated 21 April, 31 June and 25 July 2011 respectively.
The records of visits did not identify any of the ongoing concerns regarding the home. The visits were undertaken by the same individual who was also managing the home at the time.

Due to the considerable number of shortfalls in the delivery of care that we found, it was clear that the arrangements in place for monitoring the service at the home were ineffective. As a consequence residents were placed at considerable risk of harm to their health, safety and welfare.

We were told that staff did not feel confident in reporting poor practices to management. For example, an allegation of ill treatment was reported to a person's family and not to the manager. As a result, incidents were not analysed and any necessary changes made.

Contrary to Regulation 10(2)(e), we found no evidence to indicate that people's views had been sought as part of the quality monitoring at the home. This was confirmed by staff and relatives.

In view of the major concerns identified in this outcome area the Care Quality Commission served a Warning Notice on the Registered Provider on 19 August 2011.

**Our judgement**
There was a lack of clear processes in place to monitor the quality and safety of the care provision at the home.
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
There are minor concerns 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 on this outcome area due to their mental frailty, so we cannot report what they said.

Other evidence
We found that the records in relation to the care and welfare of the residents were not adequate in order to provide consistent and effective care. This was mainly due to poor recording and the staff were not able to tell us about people’s care plans and assessments.

Some records were maintained safely and securely. However, on the 5 August 2011, we found boxes of records of the residents’ personal care, treatment and support in the home’s hairdressing salon. This room was not locked and put the residents at risk of their confidentiality being breached. We also found that some records such as food and fluids charts, and care plans were not easily accessible, when we asked for them.

There were also concerns raised due to the lack of appropriate records where a person did not have their health monitored. The records did not always reflect accurately the care given, such as medication administration and the time this was administered.

Our judgement
The records of residents were not always being held securely and there were not
always accurate records of care and treatment.
**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>Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 02: Consent to care and treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Why we have concerns:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>People were involved in their care and consent was sought; however this was not well planned to ensure that consent was gained at the appropriate time.</td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 06: Cooperating with other providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Why we have concerns:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>There were inadequate arrangements in place to ensure that information was shared. This may have a detrimental effect resulting in people not receiving the care that they required.</td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 07: Safeguarding people who use services from abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Why we have concerns:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>There were processes in place and training in safeguarding was available to the staff. However the care practices did not protect people from risk of harm.</td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 08: Cleanliness and infection control</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Why we have concerns:</strong></td>
</tr>
</tbody>
</table>
There were infection control procedures in place; however the staff were failing to follow these. This may put people’s health and welfare at risk.

| Accommodation for persons who require nursing or personal care | Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 | Outcome 21: Records

**Why we have concerns:**
The records of residents were not always being held securely and there were not always accurate records of care and treatment.

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>
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</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 01: Respecting and involving people who use services</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>How the regulation is not being met:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The care practices at the home did not always take into account the residents' privacy and dignity. People were not always treated with respect.</td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 12: Requirements relating to workers</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>How the regulation is not being met:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>There was a satisfactory recruitment process for the permanent staff. The necessary checks for other staff employed were inadequate and put people at risk of receiving care from staff without the appropriate skills and qualifications and pre-employment checks.</td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 13: Staffing</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>How the regulation is not being met:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>There was a lack of processes in place to ensure the appropriate staffing was in place and people were not confident that the staff had the skills to deliver care in a safe and consistent way.</td>
</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.
Enforcement action we have taken

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation or section of the Act</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 04: Care and welfare of people who use services</td>
</tr>
</tbody>
</table>

How the regulation or section is not being met:

The care practices at the home put people's health and welfare at severe risk. The provider was failing to monitor the care provided and the care plans, reviews and assessments were inadequate to meet people's assessed needs.

To be met by: 24 August 2011

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation or section of the Act</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 05: Meeting nutritional needs</td>
</tr>
</tbody>
</table>

How the regulation or section is not being met:

To be met by:
The people living at the home were put at risk of not receiving an adequate amount of food and fluids. People were not always given the support with their diets and this put them at risk of malnutrition and dehydration.

### Enforcement action taken

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation or section of the Act</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 09: Management of medicines</td>
</tr>
<tr>
<td>How the regulation or section is not being met:</td>
<td>Registered manager:</td>
<td>To be met by:</td>
</tr>
<tr>
<td>The medicines management at the home was poor and people were put at risk of not receiving their prescribed medicines.</td>
<td></td>
<td>24 August 2011</td>
</tr>
</tbody>
</table>

### Enforcement action taken

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation or section of the Act</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 16: Assessing and monitoring the quality of service provision</td>
</tr>
<tr>
<td>How the regulation or section is not being met:</td>
<td>Registered manager:</td>
<td>To be met by:</td>
</tr>
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| | | |
| There was a lack of clear processes in place to monitor the quality and safety of the care provision at the home. | 24 August 2011 |
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

<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>
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<td>Audience</td>
<td>The general public</td>
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<td>Email address</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
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<td>Care Quality Commission</td>
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