### Bupa Care Homes (CFHCare) Limited
### Oak Lodge Nursing Home

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<th>Region:</th>
<th>South East</th>
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| **Location address:** | 45 Freemantle Common Road  
                      | Southampton           
                      | Hampshire             
                      | SO19 7NG              |
| **Type of service:** | Care home service with nursing |
| **Date of Publication:** | November 2011         |
| **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 person category, including 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.
Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

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

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

Why we carried out this review

We carried out this review to check whether Oak Lodge Nursing Home had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 09 - Management of medicines
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider and carried out a visit on 23 September 2011.

What people told us

Most of the people living at the home were not able to tell us about their care due to their mental frailty. Some said that they were ‘all right’ and that the food was nice. Another person said that the staff did help them and they preferred to remain in their rooms and that this was all right.

Relatives told us that the home had a large number of agency staff and that at weekends this ‘was worse’. They said that they felt their relatives’ needs were not always met as the staff did not know the residents.

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

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

Some assessment of peoples care needs have been undertaken. Though this information has been used to develop care plans, care practices do not always ensure that people receive appropriate care to meet their needs.
Outcome 05: Food and drink should meet people's individual dietary needs

People are supported with their food and fluids. Though records are maintained and care plans developed these do not consistently reflect the needs of the individual.

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

The home has a system in place for the management of people's medicines. People who require as required medicines and thickening agents needs are not always met in a 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 are some systems to assess the quality of the service. These systems are not fully embedded. Action plans are not consistently developed and monitored to ensure these have a positive outcome for the residents

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

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

Other information

In a previous review, we found that improvements were needed for the following essential standards:

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

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

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

In a previous review, we suggested that some improvements were made for the following essential standards:

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

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

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

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

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

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

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

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

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

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

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

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

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 04:
Care and welfare of people who use services

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

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

What we found

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<th>Our judgement</th>
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<td>There are moderate 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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What people who use the service experienced and told us
Most of the residents were unable to tell us about their care due to their mental frailty.
Two of the residents told us that they were supported by the staff and the staff were 'all right.'
Other people told us that they felt that their relatives' needs were not always met due to the large number of agency staff. They said that there was a lack of continuity in care as the agency staff did not know the residents.

Other evidence
We issued a warning notice on the provider on 19 August 2011. We carried out this visit to check on the improvement implemented.

We found that the home had introduced an interim care plan. We were told that this was to assist the staff in providing information about the residents needs. The turn charts that we looked at indicated that people were being supported to change their positions at a more regular interval. One of the residents' care plan showed that they should not be up for longer that two hours. We observed that the staff assisted them back to bed although they had been up longer that their care plan indicated.

A resident's care record showed that they had been assessed as high risk to their pressure areas and pressure relieving equipment was needed. We checked their bed and found that this was in place and was set to the setting as stated in their care plan. This person's care plan showed that they needed a pressure cushion when they were sat out. This was not in place, we noted that a different cushion was available. The
nurse in charge confirmed that the staff had not used the correct equipment on their chair.

At different times during our visits we checked and found that the care staff were available in the lounges on different floors to assist people as needed.

We found that the care plans and assessments had been reviewed since our visit in August 2011. The senior staff told us that the care plans were being looked at as the care staff were finding the care plans 'cumbersome'.

The care record showed that the moving and handling assessment for a resident had been reviewed in August and September 2011 and there was no change made and to continue using red sling for hoist transfer. We observed this person being hoisted in the lounge and the staff did not use the correct sling, as assessed in their care plan. This was brought to the attention of the person in charge.

We found that some of the residents had observation charts to monitor their movements and staff told us this was to ensure that they were safe. One person who was known to 'wander' and had been placed on an hourly observation of their whereabouts. The staff could not tell us the whereabouts of that person and we found that their records had not been completed for the last four hours. We observed that this person was walking in the corridor and on one occasion entering another person's bedroom. We later found that the observation record had been fully completed with actual times inserted, which gave us concerns about the reliability of some records.

The care records contained continence assessments and the type of pads to be used. We found that although it contained some information, this was not clear. One record stated to refer to plan A. We spoke to the care staff and they were unable to find this information in the care plan and they were unable to tell us about it.

We also observed that some of the records of care were inadequate as they did not show that people had been supported with mouth care. The staff confirmed that people were unable to maintain these for themselves. Other records showed that personal care had been provided by the night staff and it was unclear what care had been provided.

We found that one person's pain management was not managed appropriately. We brought this to the attention of the nurse in charge as there was no evidence of a pain assessment in place to ensure that their pain was dealt with appropriately.

Our judgement

Some assessment of peoples care needs have been undertaken. Though this information has been used to develop care plans, care practices do not always ensure that people receive appropriate care to meet their 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 minor concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
Some of the people we spoke to said that they liked the meals and two comments were 'nice food.' Most of the residents could not tell us about their nutritional needs due to their mental fragility.

Other evidence
We issued a warning notice on the provider on 19 August 2011. We carried out this visit to check on the improvement implemented.

At our previous visit we had concerns about the management of thickened fluids as this was not being managed safely. We looked at the records of four people who were receiving thickened fluids. The home had introduced a new recording system for those people who required thickened fluids. We found in two care records that swallowing assessments had been completed. However the assessment could not be found for another person who was receiving grade 3 fluids. This is the consistency of fluid that had been assessed as safe for this person.

A resident's fluid chart showed that they were receiving grade 2 thickened fluids and the staff told us that they added 1 spoonful of powder to their drinks. The care and support record indicated that this person was not receiving thickened fluids. This was brought to the attention of the person in charge who stated that the records had not been updated as required.

A sample of food and fluid balance charts showed that staff were recording these and there were fewer gaps in the records than seen at our last visit. We observed that at
different times during our visits that the staff were supporting the residents with fluids.

During our visit we found that some of the staff were unsure about the quantity of fluid
given which could lead to discrepancy in the fluid records and the amount of fluids that
people had received. This was brought to the attention of the person in charge.

Our judgement
People are supported with their food and fluids. Though records are maintained and
care plans developed these do not consistently reflect the needs of the individual.
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

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<td><strong>What people who use the service experienced and told us</strong></td>
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<tr>
<td>We did not speak to people about their medicine on this occasion.</td>
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**Other evidence**
We issued a warning notice on the provider on 19 August 2011. We carried out this visit to check on the improvement implemented.

We saw that some systems had been put in place following to allow for records to be kept for audit purposes. We noted that when a variable dose was prescribed, the actual amount given was recorded. The home had reduced excess stock to a minimum level and had counted and recorded all medicines in the home as a base line.

Any subsequent receipts, administration and disposal were recorded. Check was done at each shift change by staff to ensure all records were completed and accurate.

A monthly medication audit was done as per company policy and was carried out on 8 September 2011. This was done to highlight any shortfalls in safe medicine management.

With regards to regular medicines in tablet, liquid and injection form, we noted that these were given as prescribed.

The care plans for medicines to be taken only when needed, which had been
prescribed four days previously and were not available. For another person, who was on four medicines prescribed to be taken only when needed, two medicines had a care plan and two did not.

One care plan for pain management stated that staff must give this medicine when the person 'shows discomfort, cries loudly and refuses food and drink'. In practice the staff informed us that they then performed an 'Abbey pain assessment' to see if pain medicine is required. This information was not included in the care plan.

During our visit we found that this person was in discomfort while receiving care. Their record showed that they had not received any pain killers, although this was prescribed for 'as required'. There was no pain assessment in place to ensure that their pain was managed effectively. We brought this to the attention of the nurse in charge and a pain assessment was then carried out.

Two people were refusing medicines and there were reminders in the diary to inform the doctor so that he can come and review this. In one case the doctor had been contacted and they were awaiting their visit.

A resident who was a diabetic had been refusing their medicines. The person in charge stated that this had been reported to their doctor two weeks ago. There was no evidence of what action had been taken since that time.

We found that following an assessment; one of the residents had been prescribed a thickening agent to be added to their fluids. The staff confirmed that the home's procedure was for this to be prescribed by their doctor and recorded on their medication administration record (MAR) chart. The staff confirmed and their fluid record showed that they had been receiving this thickener. There was no record of this prescription on their MAR chart. The care staff member that we spoke to could not find the thickening agent for that person. The staff told us that they did not know what was being used, although we did see there was some available for another person.

**Our judgement**
The home has a system in place for the management of people's medicines. People who require as required medicines and thickening agents needs are not always met in a 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

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<td><strong>What people who use the service experienced and told us</strong></td>
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<tr>
<td>People were not able to tell us about this due to their mental frailty.</td>
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The provider had started the process of seeking the views of the residents/relatives. A relatives' meeting was held in September and minutes of this meeting were recorded. The senior staff from the company had confirmed that they had started seeking formal feedback from the relatives and questionnaires had been sent out.

One visit had been completed as part of the home's internal audit. The staff confirmed that this had been undertaken by a staff external to the home.

We had received some whistleblowing concerns that showed that staff were still not fully confident in raising their concerns with the management. These were confirmed by staff we spoke to.

We looked at the home's safeguarding tracker, as a number of concerns had been identified in respect to care and welfare of people. Action plans to look at the identified issues were not developed in a timely manner.

There was no evidence of audits for falls and pressure ulcers auditing and the person in
charge confirmed that this was being developed.

The person in charge told us that they were aware of the shortfalls in the home. The provider had told us that this was being addressed through staff competency's assessment and staff we spoke to confirmed that this was ongoing.

There was a record for logging complaints in place. We found that there were a number of concerns that the service was in the process of investigating. We found that there was concern relating to an old complaint that was not fully investigated. We could not find any record of what investigation was carried out. The person in charge said that this would be looked into.

We received concerns from another service user who alleged that a complaint raised with the home in July 2011 had not been responded to. During our visit we were informed that there had been a misunderstanding and the complaint will be looked at.

The person in charge told us that they had introduced daily 'walking the floor'; there was no evidence of what action plan was in place following these audits to address any issues identified.

The home did not have a registered manager and there was a management team supporting the manager in her role.

**Our judgement**

There are some systems to assess the quality of the service. These systems are not fully embedded. Action plans are not consistently developed and monitored to ensure these have a positive outcome for the residents.
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.

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<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<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>
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</table>

**Why we have concerns:**
People are supported with their food and fluids. Though records are maintained and care plans developed these do not consistently reflect the needs of the individual.

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

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

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

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

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

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<tr>
<th>Regulated activity</th>
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<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>
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<td><strong>How the regulation is not being met:</strong></td>
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<td>Some assessment of peoples care needs have been undertaken. Though this information has been used to develop care plans, care practices do not always ensure that people receive appropriate care to meet their needs.</td>
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<td>Outcome 09: Management of medicines</td>
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</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 the date that the final review of compliance report is sent to them.

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

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

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

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

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

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

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

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

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

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

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<th>Document purpose</th>
<th>Review of compliance report</th>
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