Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Oakwood Residential Home

192 West End Road, Bitterne, Southampton, SO18 6PN

Tel: 02380466143

Date of Inspections: 24 January 2014
23 January 2014

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✖	Enforcement action taken
Safeguarding people who use services from abuse	✖	Enforcement action taken
Cleanliness and infection control	✖	Enforcement action taken
Management of medicines	✖	Enforcement action taken

Details about this location

Registered Provider	G & A Investments Projects Limited
Registered Manager	Mrs. Karen Perrin
Overview of the service	Oakwood Residential Home is registered to provide accommodation for up to 28 people who require nursing or personal care. It is for people who are 65 or over and many of the people using the service have dementia.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Oakwood Residential Home had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Cleanliness and infection control
- Management of medicines

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 23 January 2014 and 24 January 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with external healthcare professionals.

What people told us and what we found

At our last inspection on 11, 16 and 19 September 2013, we found the provider was failing to meet the nine essential standards we inspected. We also checked on the warning notices set from our inspection in June and July 2013 and found the provider had not taken adequate action to meet the notices. Following the inspection we took enforcement action and imposed a condition to prevent the provider from accepting any new admissions to the home.

During this inspection we used a variety of methods to help us understand the experience of people using the service. We spoke with eight people, three family members, three external healthcare professionals and observed care and support being delivered. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During our SOFI we saw staff interacting positively with people in the lounge. We heard staff using people's preferred names and speaking with them in a calm and respectful way. Some people told us their needs were met and they were satisfied with the care and support they received. One person said, "They look after me pretty good". One family member said the care had improved recently and that their relative was "so much better now". However, two other family members told us they had concerns about the standard of cleanliness at the home and said their relative's health care needs were not always met.

We looked at 15 care plans and associated records and saw a new format had been developed. However, we found the risks of people falling were not managed effectively and care plans did not contain adequate information about how people's complex needs would be met. There were inadequate arrangements in place for the provision of meaningful activities or mental stimulation.

We looked at records of safeguarding training which showed all staff had received refresher training. Staff we spoke with knew how to identify and report abuse. However, the service had not complied with a condition attached to an authorisation for deprivation of liberty safeguards (DoLS) in respect of one person. People were not protected from the risk of abuse by other people using the service who posed a risk to them.

The provider had not taken the steps necessary to meet the requirements of the code of practice on the prevention and control of infections. Personal protective equipment, soap and disposable towels were not available in key places, so staff could not follow the home's procedures.

We looked at 10 bedrooms and found six were not clean. Three bedrooms smelt of urine; three beds were stained with dried urine; and six bedroom carpets were badly stained with dark patches of an unidentified substance. Laundry policies and procedures had not been developed to minimise the risk of cross contamination within the laundry room and staff could not access the hand washing sink.

We looked at a sample of 12 medication administration record (MAR) charts. The arrangements for obtaining medicines were not robust. Appropriate arrangements were not in place to ensure people were able to self-administer inhalers safety. There were inadequate arrangements in place to ensure people received their "as required" medicines safely and consistently.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have taken enforcement action against Oakwood Residential Home to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

People's needs had been assessed and care plans were being developed to meet those needs. Care and treatment was not always planned and delivered in a way that ensured people's safety and welfare. People's risks of falling were not managed effectively. There were inadequate arrangements in place for the provision of meaningful activities.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

At our last inspection on 11, 16 and 19 September 2013, we found the provider was failing to meet this essential standard. Care plans lacked information; people did not always experience care, treatment and support that met their needs. Assessed risks were not managed effectively; noise levels in the lounge were unpleasant; and emergency planning was inadequate.

Following the inspection we took enforcement action and imposed a condition to prevent the provider from accepting any new admissions to the home.

During this inspection we looked at 15 care plans and associated records and saw a new format had been developed. The care plans and assessments were variable and arrangements on how the provider planned to meet people's assessed needs were not clearly stated in people's care records seen. This meant people were at risk of their needs not being met.

We used a variety of methods to help us understand the experience of people using the service. We spoke with eight people and three family members, and observed care and support being delivered. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During our SOFI we saw staff interacting positively with people in the lounge. We heard staff using people's preferred names and speaking with them in a calm and respectful way.

Some people told us their needs were met and they were satisfied with the care and support they received. One person said, "They look after me pretty good". Another person told us they were "quite happy with things". One family member said the care had improved recently and that their relative was "so much better now". Two other family members told us they had concerns about the standard of cleanliness at the home. They said their relative's health care needs were not always met as staff did not recognise changes in the person's condition and seek medical attention in a timely way. Concerns were also raised about the lack of chiropody that impacted on this person's welfare.

We observed three people using our SOFI and found they did not always receive care and attention. They were left for long periods with no staff interaction and spent their time with their eyes closed or staring blankly. One person was agitated and walked up and down the lounge, at times stopping and leaning over another person. We noted that people appeared bored and were sat for long periods staring at the walls or falling asleep. The atmosphere in the lounge was not conducive to creating a relaxed atmosphere due to high levels of noise. As well as the sound of the radio and televisions, there was a constant high-pitched beeping sound from a defective door closure. This was added to by high pitched alarms sounding on a display panel used to monitor people's call bells, which was also situated in the lounge. The home accommodated people with varying degrees of dementia. We observed the people using the service did not pay any attention to the television although this was on all day. We had identified this as a concern at our last inspection and found no improvements had been made.

Staff told us they completed the daily records which should contain information about the care people had received. We looked at daily records of care and saw they were completed for each shift; for example, from 8:00am – 2:00pm, 2:00pm – 8:00pm and 8:00pm onwards. However, we saw these provided only a summary of care and support provided and entries were not timed. The records for two people we looked at were blank for a number of occasions and staff were unable to tell us what care people had received. This was brought to the attention of the manager at the time of the inspection.

The daily care records showed that two people were refusing personal care and had been identified as at risk of self-neglect. In their care plans, we found there were no strategies in place to show what action should be taken in order to ensure these people's personal care needs were met. An external healthcare professional told us they were concerned that one person's needs were not being met as "staff lacked the necessary skills". However, in respect of a person who had been refusing personal care for a month, another external mental health professional told us staff "tried very hard with someone who is difficult to manage". The provider was unable to demonstrate that people received care and support at appropriate times and according to their needs.

We found the risks of people falling were not managed effectively. People were assessed according to their level of risk, from 'low' to 'high'. However, there was no evidence that regard had been paid to relevant research or guidance in the way these risks had been assessed. At our last inspection, in September 2013, there was no risk assessment tool in place and the manager told us they would introduce a tool given to them by the local authority team. We found this had not been introduced and reviews were not always conducted when people had suffered falls. For example, accident records showed that one person had suffered two falls in the month of our inspection and three falls in the previous month. This information was not included in their care plan and no changes had been made to reflect the current risk and any preventative measures that may be needed to protect this person from further harm.

We saw a care staff member assisting this person to mobilise from a chair to their walking frame; they did not follow the instructions contained within the care plan to ensure the person did not fall during this process. A care plan for another person, whose care had been reviewed, identified they had "difficulty walking with their frame". However, no action had been taken to address this concern, such as referral to a specialist for advice. Failure to assess and manage risks appropriately put people at risk of serious injury.

There were inadequate arrangements in place to ensure the planning of care took into account the welfare and safety of people accommodated. We looked at the body maps and skin integrity charts for five people. Each showed a high number of unexplained cuts, bruises and skin flaps. For example, one person's records showed they had seven bruises to their arm. Although care staff recorded these incidents, there were no risk assessments or analysis to establish the root causes of these injuries; measures were not put in place to prevent further injury. We discussed the management of falls with the manager, who accepted the care plans and risk assessments required further development in order to ensure the safety of people using the service.

People who were diabetic did not have adequate arrangements in place to manage their condition effectively. The care records of one person showed they were diabetic. Their care plan did not contain information about their diabetic needs and how these would be met. Following a change in their treatment, the GP had required staff to monitor their blood sugar levels regularly, but we saw this had not been done. Their records showed their blood sugar levels had varied considerably; an external health care professional confirmed to us these readings were high and felt the GP should have been informed. A senior staff member agreed action should have been taken. This person was put at risk as their sugar levels were not monitored effectively.

People who were at risk of weight loss were not always identified or managed appropriately. A system was in place to monitor people's weights on a monthly basis. Records for one person, who had lost weight, showed they had been referred to a dietician, prescribed fortified drinks and had gained weight. However, records for another person showed they had lost four kilograms of weight during the course of a month. We saw no action had been taken to address this concern.

The records for a third person showed they had lost 10 kilograms during the course of a month. Staff had not identified this as a cause for concern. Action was not taken until the weight loss was highlighted to the community nurse after approximately three weeks. The district nurse asked staff to weigh this person at the time of our inspection; it transpired that the original recording was inaccurate and the person had not lost weight. However, the lack of action and delay in reporting the apparent weight loss meant the person may have been put at risk. The manager said she was not aware of this issue, we saw the weight record was displayed in the office.

At our last inspection we identified one person with behaviour that could challenge, who used alcohol. Their care plan did not adequately support the person to manage these risks. At this inspection we found their care plan had been updated in November 2013, but did not contain sufficient information to enable staff to support them appropriately. This person suffered from dementia and was unable to make an informed decision on alcohol consumption. Their care plan said the person's alcohol was "best kept in fridge in bedroom where he has control" and added, "staff to ensure only enough cans for him not to become intoxicated". It did not specify how many cans would be appropriate without causing them harm. At the time of the inspection there were four cans in the bedroom's fridge. Staff told us there were bottles of spirits and wine kept in the kitchen, from where they controlled the

amount the person consumed. The care plan made no reference to this additional alcohol, or how it should be managed.

Their care records showed this person had an underlying medical condition which could be triggered by alcohol. However, their care and support needs had not been planned effectively to manage this condition, which put their health and welfare at risk.

We saw records were maintained of the person's behaviour when they showed signs of aggression. However, it was not clear if this was linked to their consumption of alcohol or was part of their dementia. It was, therefore, not possible for the provider, or external healthcare professionals, to analyse the causes of the person's behaviours and identify strategies for managing them in order to meet the person's needs.

The care plan for another person who also exhibited behaviour that could challenge contained an account, which they had been supported to provide, about the causes of their aggression. The care plan included information about steps staff could take to manage the early signs of aggression by "talking to him". The care plan also said, "becomes frustrated if staff refuse cigarettes". However, the person's smoking needs were not mentioned in their care plan. We observed the person using an electronic cigarette on occasions, and staff told us the person also had access to a nicotine spray; however, support to use these items was not mentioned in their care plan. This person's care and support needs had not been planned effectively. This put them at risk of receiving care which was inconsistent and not in accordance with their needs.

People who were at risk of skin breakdown did not have a robust assessment in place using a recognised tool to ensure appropriate care and treatment was available to them. We saw the records for two people contained conflicting information about their skin integrity such as whether skin was broken and dressing needed. The care staff told us this was the domain of the district nurses. However staff were providing care and support and did not understand the district nurses records should be used to support people. The health care professionals told us they had provided pressure relieving equipment which we saw were in use for two people we case tracked.

We looked at the process in place for monitoring food and fluids intakes for people who were identified as at risk of weight loss. Monitoring of people's food and fluid intakes was conducted for all people using the service, irrespective of their individual risks of malnutrition or dehydration. However staff did not accurately record the amount of food and fluids consumed and could not be assured people it was adequate to people's needs. We observed in people's bedrooms they did not have any jugs of fluids until the afternoon. The records for one person showed the 'input' and 'output' quantities were identical on four occasions during the day, although staff told us they did not monitor the output of this person. In respect of fluid intake, previous records showed the amount of fluid offered and consumed, and included daily totals. However, current records only showed the amount offered. Fluid monitoring was, therefore, not effective in ensuring people received adequate hydration.

We saw care plans included details of equipment needed to support people's continence. However, care plans did not include individual continence assessments. Where people were shown as incontinent, records did not say whether they were singly or doubly incontinent. The care plans did not contain information about how the individual's continence needs would be met. This meant staff would not be able to support people appropriately and according to their individual needs.

There were inadequate arrangements in place for the provision of meaningful activities or mental stimulation. The only activity we observed during the two days of our inspection was one person having their nails painted. Two televisions and a radio were used to provide entertainment for people. However, two of these were often on at any one time, making it difficult for people to concentrate on either properly. A person told us they were "incarcerated "at the home and was "not allowed" to go out although they went out with their relative. Another person commented, "There are never enough people [staff] here to go out". Staff told us they did not take people out, although they said some people sat in the garden in the summer. We saw a programme of activities had been prepared, but staff said this was not current. They told us of plans to appoint an activities coordinator, but said the only current provision was by three care workers who occasionally arranged activities in between providing care. Records of activities people engaged in were maintained and showed only two activity sessions had been run since the end of October 2013. This meant people's welfare needs were not being met.

Our previous inspections in March 2013 and June/July 2013 identified the absence of an emergency or business continuity plan, apart from an emergency contact list for the staff to call to seek help. At this inspection we found arrangements for dealing with foreseeable emergencies were being progressed and personal evacuation plans were being developed.

The people accommodated had varying degrees of dementia. Staff told us that people would require full assistance in the event of an emergency and said there were no risk assessments or action plans in place for this. This meant if people needed to be moved out in an emergency, their welfare and safety was at risk, as their needs would not be known to other providers.

Safeguarding people who use services from abuse ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

People who use the service were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. The provider did not always respond appropriately to allegations of abuse.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

At our last inspection on 11, 16 and 19 September 2013, we found the provider was failing to meet this essential standard. There were inadequate arrangements in place to monitor incidents of abuse and to develop appropriate action plans to support people, prevent risks and improve practices.

Following the inspection we took enforcement action and imposed a condition to prevent the provider from accepting any new admissions to the home.

During this inspection we spoke with three members of staff about safeguarding. We found they had an understanding of what constituted abuse and knew how to report it internally and externally. One member of staff showed us a file containing contact details for the local safeguarding team and we saw a notice about safeguarding displayed in the staff office.

We looked at records of safeguarding training. These showed all staff had received refresher training in safeguarding since our last inspection. Staff had the knowledge required to identify and report abuse.

We asked the manager if any of the people using the service were subject to deprivation of liberty safeguards (DoLS). These were required if a person was prevented from leaving a home due to them being at risk of harm if they did. The manager said two people were subject to such authorisations. However, after checking a file they told us only one of the authorisations was current, the other having expired three years ago. The person whose authorisation had expired was at risk of unlawful restraint by staff who lacked up to date knowledge on the status of their DoLS.

We looked at the documentation for the DoLS that was current and saw it had been authorised on 30 September 2013. A condition had been attached to the authorisation which required "Consultation with the GP regarding a referral to appropriate OPMH [Older People Mental Health] services locally". The manager told us she was not aware of this requirement as the authorisation had been completed in her absence. She said such a referral had not been made. This legal requirement had not been complied with, which meant the person was at risk of unlawful restraint.

We spoke with one person using the service and one of their relatives. The person told us they used alcohol which the relative brought in for them. One member of staff said the person also had a bottle of spirits in the kitchen, which they administered in the evening. Another member of staff told us there were bottles of wine in the kitchen which belonged to the person. An inventory of this alcohol was not recorded in the person's records and the use of the alcohol was not accounted for by the home. This put the person at risk of their alcohol being misappropriated.

We looked at the person's care plan and saw it did not contain information about how their alcohol should be supplied to them. Staff told us the person was able to consume the alcohol in their room freely, but that they controlled the supply of alcohol kept in the kitchen. Care records showed the person could become aggressive and displayed behaviour that could challenge. Information about the quantity and frequency of alcohol used by this person was not recorded in the person's care plan; no link had been made between their consumption of alcohol and their behaviour. This put them and other people using the service at risk of physical abuse.

Another person had also been identified as at risk of becoming anxious. Their 'behaviour record chart' showed they had been aggressive towards staff and other people using the service. The actions detailed in the person's risk assessment, for supporting them when they became anxious, was to "talk to them" and if that didn't work to "call the manager or deputy manager". There was no plan in place to safeguard other people from the risk of harm. The plan was not robust and did not provide alternative strategies if the manager or deputy manager were unavailable. This put other people at risk of harm.

The provider did not always respond appropriately to allegations of abuse.
We saw a 'behaviour record chart' was being used to record incidents of aggressive behaviour by another person. These included, on one occasion being "very aggressive, confused, angry, rude with staff and residents, swearing at them, putting stuff on floor, try to kick staff" On another occasion they were "very aggressive – rude, angry, aggressive with [another person], hit her on her right arm, shouting at staff".

We looked at the care plan and risk assessments for this person and saw these did not include any information about how the risks to other people would be managed. The incidents of abuse had not been reported to the local safeguarding authority so that the causes could be investigated in order to safeguard people from further abuse.

Cleanliness and infection control ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risk of infection because appropriate guidance had not been followed. People were not cared for in a clean, hygienic environment.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

At our last inspection on 11, 16 and 19 September 2013, we found the provider was failing to meet this essential standard. Procedures for infection control were not robust and staff practices put people at risk of cross infection. Appropriate guidance was not followed and people were not always cared for in a clean, hygienic environment.

Following the inspection we took enforcement action and imposed a condition to prevent the provider from accepting any new admissions to the home.

At this inspection we found staff had received refresher training in infection control. Some beds had been replaced and a wet room had been refurbished to provide a suitable shower facility.

We looked at the provider's policies and procedures relating to infection control. We saw these had been reviewed since our last inspection and were up to date. Infection control risk assessments, for most areas of the home, had been completed, together with an annual statement of infection control and an audit.

However, we found the audit was not comprehensive; it did not examine the arrangements for waste disposal, the effectiveness of cleaning, the availability of equipment for hand washing or the effectiveness of infection control risk assessments.

Providers are required to have regard to the Department of Health's 'Code of Practice on the prevention and control of infections and related guidance'. The Code of Practice sets out the basic steps to ensure compliance with the infection control requirements of the Health and Social Care Act, 2008. The provider had not taken the steps necessary to meet the requirements of this standard.

We found the home's policies were not being followed by staff. For example, the policy

required staff to wash their hands before and after delivering personal care and to wear disposable aprons and gloves when there was a risk of contact with body fluids. We found this was not always possible.

Staff told us the wet room was frequently used to deliver personal care such as changing people's incontinence pads. We saw the room contained no disposable aprons or gloves to protect staff and no soap or hand towels to enable them to wash their hands before or after changing pads.

Staff told us disposable aprons and gloves were available elsewhere in the home. However, the lack of readily available personal protective equipment (PPE) in places frequently used to deliver personal care meant staff may not be able to access protective equipment when they required it.

We looked at the 'sluice room', which staff told us was used to clean commode pots. This room contained disposable hand towels but no soap. We spoke with three members of staff, who told us they used the sink in the staff toilet to wash their hands after using the wet room and the sluice room. However, to access this toilet staff needed to pass through other areas of the home. This posed a risk that microorganisms could be transferred to these areas en route.

Care practices put people at risk of cross infection. In the wet room, the sluice room and the ground floor bathroom, there were bins for disposing of clinical waste. The bins did not have lids. We saw used incontinence pads and used PPE inside the bins, which were exposed and readily accessible to people using the service. People were not protected from the risk of cross infection from these items as waste disposal arrangements were not adequate.

We spoke with three members of staff about arrangements for emptying and cleaning commode pots. Each described a different method for processing used commode pots. One member of staff told us they used an upstairs bathroom, which we found was locked and not in use; another member of staff told us they emptied the pots in the toilet in the wet room and took them through the lounge to the sluice room for cleaning; and a third member of staff told us they used the sluice room to empty and clean the pots. There were no procedures in place to ensure staff followed appropriate and consistent practices to minimise the risk of infection. This was a concern we had raised at our inspection in June/July 2013 and had not been resolved.

We saw clinical waste produced by the home was placed in yellow bags, and stored in a bulk storage container at the front of the home, prior to collection by an approved waste disposal contractor. The storage container was adjacent to the pavement, insecure and accessible to the public. On the first day of our inspection we saw the container was overflowing; the lid could not be closed due to the number of bags piled inside it and there were three bags on the floor in front of it. The provider had not taken adequate precautions to ensure waste was stored securely.

The bin was emptied on the afternoon of the second day of our inspection. This had presented a risk of infection to staff and members of the public walking past it. Arrangements for the disposal of clinical waste were not effective and did not comply with current guidance.

People were not cared for in a clean and hygienic environment. We looked at 10 bedrooms and found six were not clean. Three bedrooms smelt of urine; three beds were

stained with dried urine; six bedroom carpets were badly stained with dark patches of an unidentified substance. In one room, a pressure relieving cushion, the chair cushion and the frame of the chair beneath it, were impregnated with offensive brown liquid; three doors to rooms were splashed with dark brown liquid.

There was one assisted bathroom in use at the home. We looked at the underside of the hoist seat used to transfer people into and out of the bath. We found it was rusty and stained with yellow deposits of an unknown substance. Cleaning arrangements were not effective in ensuring appropriate standards of cleanliness were maintained. This put people at risk of acquiring health care associated infections as this bath hoist was used as communal. This had been raised as a concern at our previous inspection and had not been addressed.

The Department of Health publishes the "Choice Framework for Local Policy and Procedures 01-04 – Decontamination of linen for health and social care: Social care" ("CFPP 01-04"). CFPP 01-04 is designed to help social care professionals to procure and deliver the level of decontamination that people have a right to expect, by building on existing practice.

We found laundry policies and procedures had not been developed to minimise the risk of cross contamination within the laundry room, as required by this guidance. On the first day of our inspection we saw there were two laundry bags on wheeled frames directly in front of the hand washing sink. The laundry room floor was covered in bags of unprocessed linen, making it impossible for staff to move the wheeled frames and gain access to the sink.

On the second day of our inspection we saw the laundry room floor was again covered in bags of unprocessed linen; two open baskets containing cleaned linen were found on top of the washing machines; and the hand washing sink contained three red bags full of soiled clothing. Staff told us the red bags were soluble and were used to process contaminated or infected linen and clothing. This meant staff could not access the sink to decontaminate their hands after handling soiled linen. We spoke with three members of staff, who told us they used the sink in a nearby staff toilet to wash their hands after handling soiled items. This practice posed a risk that microorganisms could be transferred from the laundry to the door, handle and furniture of the staff toilet.

Management of medicines ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

People were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Information was not available for the use of all "as required" medicines.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

At our last inspection on 11, 16 and 19 September 2013, we found the provider was failing to meet this essential standard. We found medicines were not stored safely and appropriately; people were not receiving their medicines as prescribed; the arrangements for obtaining medicines were not robust and put people at risk of not receiving their prescribed medicines.

Following the inspection we took enforcement action and imposed a condition to prevent the provider from accepting any new admissions to the home.

At this inspection we found medicines were stored securely and the controlled drug cabinet was locked. However, people were at risk of not receiving their medicines safely and when they required them.

We looked at a sample of 12 medication administration record (MAR) charts. The printed MAR chart for one person showed they were prescribed an eye drop to be administered once at night. We saw changes had been made to the handwritten MAR chart, for the person to receive this eye drop twice a day. Staff told us they did not have a copy of this person's prescription and they could not tell us who had changed the MAR chart or when this had occurred. This meant the person was at risk of receiving medicines inappropriately and not according to their prescription. Guidance issued by the Royal Pharmaceutical Society "The handling of medicines in social care" had not been followed. If a new prescription had been issued, this should have been available; if a verbal instruction had been given by the GP, then a record of the changes should have been made, including details of the staff member who received the new instructions.

Another person's medication, which was an "as required" sedation, was found in the medicines trolley. However, the person's MAR chart record did not include this medicine.

We received conflicting reports from staff as to whether this person was currently prescribed this medicine. We asked to see the prescription for it, but this was not available. The arrangements for obtaining medicines were not robust. And put this person at risk of not receiving their medicines when they required them. A senior staff member told us they would seek advice to resolve the issue.

Staff had been asked by the community mental health team to monitor and record the effect of medication prescribed to a person to manage their agitation/behaviour issues. Records for January 2014 showed the person's behaviour had only been recorded on two days. This meant mental health specialists would not be able to monitor the effectiveness of this medication, and adjust the dose appropriately, in order to meet this person's needs.

We found there were three people who were self-administering their prescribed inhalers. A staff member told us this required a certain level of dexterity and cognition to be able to administer them safely. However, they said no assessments had been carried out to ensure these people were able to manage their medicines safely and effectively. There were no care plans in place to identify the level of support and monitoring required; there were no records to show the date or quantity of inhalers dispensed; and staff told us they did not carry out checks to ascertain the frequency with which people were using the inhalers. Appropriate arrangements were not in place to ensure people were able to self-administer this medication safety.

The records for the administration of creams and ointments were not adequate and the provider could not be assured people were receiving their creams as prescribed. Most of the people using the service were prescribed Cavilon cream, which acted as a barrier against body fluids for the prevention of skin irritation from incontinence. The MAR charts showed there were numerous gaps and staff could not tell us whether people had had their creams applied. One person was prescribed a cortisone based cream, but their MAR chart showed they did not receive this cream for two consecutive days. Another person's record showed they had cream applied for soreness, but staff could not tell us what cream they had applied.

The MAR chart for another person showed a cream should have been applied each time the person's incontinence pad was changed. However, it was shown as having been applied at routine times once and twice daily, which did not correlate with times they had had their pads changed. A staff member told us this was a mistake as staff had not followed the instructions for the application. This meant this person did not receive appropriate treatment as prescribed.

We found the dates of opening of creams and ointments were not always recorded; this meant the provider could not be assured these had not passed their 'use by' dates. This had been identified as a concern at our last inspection and had not been resolved.

There were inadequate arrangements in place to ensure people received their "as required" medicines safely and consistently. For some people, information was available about the use of "as required" bowel medicines. However, information was not available for the use of other "as required" medicines. These included pain relief medicines. Staff told us people who had cognitive difficulties may not be able to communicate their needs for pain relief. Care plans had not been developed to identify when these people required pain relief. They were, therefore, at risk of not receiving pain relief when they required it.

For people who received "as required" pain relief, this was not always managed safely. The MAR charts had set times for these medicines to be administered, as part of the set

medicines round. Staff did not record the exact time people received their pain tablets. This meant they were unable to assure themselves that the appropriate time had elapsed before administering a further dose. This put people at risk of overdose.

At the last inspection we found there was inadequate auditing of people's medicines and the provider could not demonstrate they maintained a record of all medicines received. A senior member of staff told us they had developed a stock checking system to ensure records were maintained of all medicines received. However, we found stocks of Warfarin tablets for one person were not recorded as having been received into the home. The staff member told us these tablets should have been recorded as received and did not know how they had been missed. The provider was unable to conduct an effective audit of medication as all the medicines received into the home had not been recorded. We checked the stock level of medicines for two people and found they did not agree with the quantities shown in the MAR charts, as there were extra tablets present. Staff could not explain the discrepancy. Although MAR charts showed people had received their medicines, this may not have been accurate.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 14 March 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Each service user was not protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of carrying out an assessment of service users' needs; planning and delivering care to meet service users' needs; and ensuring the welfare and safety of service users. Published guidance was not being followed. Regulation 9(1)(a) and (b)(i), (ii) and (iii)) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
We have served a warning notice to be met by 14 March 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met:

This section is primarily information for the provider

	There were inadequate arrangements in place to service users were safeguarded against the risk of abuse by taking reasonable steps to identify the possibility of abuse and prevent it before it occurs. Service users were not protected against the risk of unlawful control or restraint. Allegations of abuse were not responded to appropriately. Regulation 11(1)(a),(b) and 11(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
We have served a warning notice to be met by 14 March 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: There was a failure to ensure that service users, persons employed for the purpose of carrying on the regulated activity and others who may be at risk of exposure to a health care associated were protected against identifiable risks of acquiring a health care associated infection by means of the effective operation of systems designed to assess the risk of and to prevent and control the spread of health care associated infection. Appropriate standards of cleanliness and hygiene in relation to the premises were not maintained. Regulation 12(1)(a),(b),(c), 12(2)(a) and 12(2)(c)(i),(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
We have served a warning notice to be met by 14 March 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met:

This section is primarily information for the provider

	Appropriate arrangements are not in place to protect the service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, using, safe keeping and safe administration of medicines. Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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

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

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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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