Mrs Geetah Devi Hulkua

Oakley House

Inspection report

Oakley House
Hampton Court Way
Thames Ditton
Surrey
KT7 0LP

Tel: 02032582052

Date of inspection visit:
10 August 2017

Date of publication:
31 August 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

At the last Care Quality Commission (CQC) comprehensive inspection of Oakley House, which we carried out on 13 March 2017, we rated the service 'Good' overall and for the five key questions 'Is the care home safe', 'effective', 'caring', 'responsive' and 'well-led'. This was because we found the service was meeting the regulations and fundamental standards we checked.

We undertook this focused inspection on 10 August 2017 in response to information of concern we received about the service including, an allegation of abuse that the provider had referred to the relevant local authority, which was currently being investigated, a sudden change in the homes management and outstanding fire safety issues identified in the provider's previous CQC inspection report. The aim of the inspection was to check that the people who still lived at Oakley House remained safe and the service continued to be well-managed.

This report only covers our findings in relation to this inspection. You can read the report from our previous comprehensive and focused inspections, by selecting the 'all reports' link for 'Oakley House' on our website at www.cqc.org.uk.

We have reduced the services last 'Good' rating to 'Requires Improvement' overall because we found the provider to be in breach of the regulations and fundamental standards we looked at during this inspection. Specifically, the provider had failed to assess and review risks relating to people's health and welfare and nor did they establish and operate good governance systems to monitor the quality and safety of the care and support people living at the home received.

Oakley House is a care home which provides personal care, support and accommodation for a maximum of 11 adults. The service specialises in supporting people with mental health needs. At the time of our inspection there were four people aged 40 and over living at the home. Four people who had previously lived at Oakley House had moved out in that last two months and another person was currently in hospital.

The service used to be managed by an individual who was the registered provider. A registered provider is a person who has registered with the Care Quality Commission (CQC). Registered providers are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered provider left the service in July 2017 at which point the deputy manager was appointed interim manager. At the time of this inspection our records showed that the current provider had applied to cancel their registration. A different limited company has applied to become the registered provider of Oakley House. We are waiting to hear the outcome of their registered provider application to the CQC before we process the current provider's application to cancel their registration. This is because we cannot allow a home to operate and provide care without a person or corporate body having legal responsibility for the service. In this report we refer to the current provider as the individual who although, is no longer in day to day control is still legally responsible. Where we mention the proposed provider we are referring to the company who has applied and is still going

through our assessments process. Where we just refer to providers we mean both the current and the proposed providers.

During this focused inspection, we found that the current provider had taken on board the comments made in their previous CQC inspection report about fire safety and had improved these arrangements. People and their relatives told us Oakley House was a safe place to live. There remained robust procedures in place to safeguard people from harm and abuse and staff were still familiar with how to recognise and report abuse. There also remained enough staff deployed in the home to keep people safe.

However, the current and proposed provider's had not ensured risks people might face due to their health care needs or lifestyle choices had been identified and routinely reviewed. Although the interim manager and staff demonstrated a good understanding of how to manage assessed risks, the current provider had not considered all the risks people might face and nor had existing risk assessments been reviewed. This put people living at the home at unnecessary risk of harm or injury because risk assessments either did not exist or the information they contained for staff to follow in order to keep people safe was inaccurate.

In addition, the current and proposed providers did not always operate effective governance system to assess, monitor and improve the quality and safety of the service. Although there were some good systems in place to monitor and review the quality of service delivery, we found limited documentary evidence checks and audits were routinely undertaken and the outcomes formally documented. We also identified a number of issues during our inspection which had not been picked up by the providers around monitoring finances handled on behalf of people living in the home by staff, and the assessing and reviewing of risks people might face. This meant the providers had always sufficiently monitored and improved all aspects of the service so that people experienced good quality, safe care.

These failings represent two breaches of the Health and Social Care (Regulated Activities) Regulations 2014 in relation to safe care and treatment, and good governance. You can see what action we told the providers to take with regards to these breaches at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe. Risk management systems in place to protect people and others from the risk of harm were not always assessed and reviewed appropriately. This meant some people were put at unnecessary risk of harm.

We have therefore changed the rating for this key question from 'Good' to 'Requires Improvement'.

The comments above notwithstanding we found the providers had improved their fire safety arrangements. Staff also knew how to recognise signs that people may be at risk of abuse or harm and the action to take to ensure they were protected. There remained enough staff deployed in the home to keep people safe.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. Although systems were in place to monitor and review the quality of service delivery; these governance systems were not always effectively operated because they had failed to identify a number of concerns we had found during this inspection.

We have therefore changed the rating for this key question from 'Good' to 'Requires Improvement'.

The comments made above notwithstanding people, their relatives and staff spoke positively about the management style of the new interim manager.

Oakley House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This focused inspection took place on 10 August 2017 and was unannounced. The inspection was carried out by a single inspector.

The inspection was carried out to follow up concerns we recently received about the service and to check they continued to meet regulations and fundamental standards. We inspected the service against two of the five key questions we ask about services: Is the service safe? and Is the service well-led?

Before our inspection we reviewed the information we held about the service. This included previous CQC inspection reports and notifications the provider is required by law to send us about events that happen within the service. We also reviewed the provider information return (PIR). The PIR is a document we ask current provider to submit before our inspection about how they are meeting the requirements of the five key questions and what improvements they intend to make.

During our inspection we spoke in person to three people who currently lived at Oakley House, the interim manager (former deputy manager) who was now in day-to-day charge of the service and a support worker. We also made telephone contact with two people's relatives and a member of the Board of Directors of the provider who has applied to register with CQC. Records we looked at included three peoples care plans and associated risk assessments, staff rotas and other documents that related to the overall governance of the service.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt Oakley House was a safe place to live. One person said, "I feel safe living here now, especially since a person I didn't get along with moved out. I can usually take care of myself, but I know the staff are always here for me if I need them." Comments we received from relatives were similar in nature. One relative remarked, "The home has been through a real crisis lately. We were all shocked when the manager left so suddenly like that. The manager [new interim manager] has had a very calming influence on things and my [family member] seems settled and content at the moment." Another relative told us, "I have no idea what's been going on at the home recently, but things seem to have stabilised now. Personally, I remain confident the staff who have stayed will continue to look after my [family member] properly and keep them safe."

At our last inspection of this service in March 2017 when answering the key question 'Is the service safe?' we rated them 'Good'. However, in the last month we have received concerning information about the service that included an allegation of financial abuse. This had been referred to the local authority by the provider and was being investigated at the time of this inspection, the police were also aware of the allegation. There were also outstanding fire safety issues identified in previous CQC inspection report, which related to a lack of risk assessments in place to mitigate risks associated with people smoking at home.

The provider continued to have robust systems in place to identify report and act on signs or allegations of abuse and neglect. Staff had received up to date safeguarding adults at risk training and were familiar with the different signs of abuse and neglect, and the appropriate action they should take immediately to report its occurrence. One member of staff told us, "I completed my safeguarding adults training again this year which reminded me about the difference types of abuse that can happen in care homes. I would tell the manager straight away if I thought anyone here was being abused."

It was clear from records we looked at and discussions we had with a member of the board and the interim manager that the proposed provider had taken appropriate action in response to a recent safeguarding incident concerning the home. This had ensured people who lived there remained as safe as possible and minimised the risk of similar incidents reoccurring. At the time of this inspection the referral made by the proposed provider to the local authority about the aforementioned allegation of abuse was being investigated. The proposed provider was cooperating with the local authority with this on-going investigation.

We saw improvements had been made to the provider's fire safety arrangements. Personal emergency evacuation plans (PEEPs) were in place for everyone who lived at the home, which included risk assessments to mitigate the risks associated with people smoking on the premises. This meant staff had access to all the guidance they needed to evacuate people safety from the premises in the event of fire. Records showed fire alarms and extinguishers were regularly tested and serviced in accordance with the manufacturer's guidelines. The interim manager and staff demonstrated a good understanding of their fire safety roles and responsibilities and told us they had received fire safety refresher training in the last six months.

We saw some measures were in place to help staff keep people safe and reduce identified risks individuals might face due to their specific physical and emotional health care needs. This included assessments to mitigate risks associated with people's mobility, behaviours that might challenge the service, personal hygiene and fire safety. We also saw financial records were well maintained and receipts obtained each time staff handled money on behalf of people living in the home. There were no gaps or omissions on the financial records we looked at. Our checks of the amounts of money held in lockable tins kept in a secure place in the home tallied with balances recorded on people's individual financial records and receipts obtained by staff.

However, although staff demonstrated a good understanding of how to prevent or minimise identified risks, such as ensuring a person had access to a mobility aid to mitigate the risk of them falling when they walked; we found the providers had not considered all the risks people might face. For example, care plans we looked at indicated some people travelled independently in the wider community, managed their own finances, and sometimes experienced difficulty swallowing food and/or breathing. We found no risk assessments or associated risk management plans had been developed for staff to follow and take appropriate action to prevent or manage these potential risks. This put people at unnecessary risk of harm or injury.

In addition, none of the risk assessments and associated risk management plans we looked at had been reviewed or up dated for over a year. This was confirmed by discussions we had with the new interim manager. This also put people living at the home at unnecessary risk of harm or injury because the information these risk assessments contained for staff to follow or in order to keep people safe might be inaccurate.

The failure to identify and take action to mitigate risk is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were enough staff to support people. People and their relatives told us they felt there continued to be sufficient numbers of staff working at Oakley House. One person told us, "There's always one member of staff in the house during the day and at night. [Name of interim manager] is here quite a bit these days." A relative remarked, "As far as I'm aware only a few staff left when people started moving out and the manager went. There's always someone on duty whenever I call or visit the home."

During our inspection we saw two staff were on duty which included the interim manager and a support worker. We saw the support worker was visible in the main communal area where people congregated and observed several examples of them attending immediately to people's requests for a drink or assistance to stand. We saw the staff rota for the service was planned in advance and took account of the level of care and support people required in the home. Staff told us now there was only three people living in the home and another person currently in hospital one member of staff would often be the sole person on duty. This was confirmed by discussions we had with the interim manager who told us the home operated an on-call system, which enabled a lone working member of staff to contact either themselves or a designated member of staff who lived nearby who could provide additional support in the event of an emergency. Records showed the service had three staff vacancies following the departure of the former provider/manager and two support workers in the past month, whose shifts the interim manager told us had been covered between the services existing ten permanent members of staff. The interim manager also told us they worked in the home three or four times a week.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of this service in March 2017 when answering the key question 'Is the service well-led?' we rated them 'Good'. However, in the last month we have received information about changes in the management of the service.

The service had a new interim manager in post. Following the departure of the registered provider in July 2017 the former deputy manager of the home was immediately appointed interim manager. People, their relatives and staff told us they liked the leadership style of the new interim manager. Typical feedback we received included, "I like [name of interim manager). He's good to me and easy to talk too", "I think [name of interim manager] has steadied the ship as best he could in the circumstances and hopefully things will get back to normal around here soon" and "The future is looking at lot brighter now the former manager has left and no more of the people who lived here or staff will leave."

The interim manager told us they were a registered mental health nurse with over 25 years' experience working with and managing services for people with mental health problems. At the time of this inspection our records showed a limited company had applied to become the new registered provider of Oakley House. We were waiting to hear the outcome of their registered provider application to the CQC. The interim manager demonstrated a good understanding of their new managerial role and responsibilities, the needs of the people they supported, the staff and their legal obligations to submit statutory notifications of incidents and events involving people using the service.

However, the providers did not have effective systems in place to assess and monitor the quality and safety of care and support people experienced. We found limited documentary evidence of checks and audits undertaken at the home. For example, the interim manager told us the former manager/registered provider used to regularly carry out audits of finances they managed on behalf of people living in the home and observational checks of the environment and the support provided by staff. However, it was evident from records we looked at and discussions we had with the interim manager that these were done on an ad-hoc basis and not formally documented. The interim manager also told us they had recently undertaken an audit of all monies, financial records and receipts staff managed on behalf of people living at the home, but confirmed they had not kept an accurate record of this quality monitoring check.

We also identified a number of issues during our inspection which had not been picked up by the providers regarding the assessing, managing and reviewing of risks people might face due to their health conditions or lifestyle choices. These shortfalls indicated the providers were not sufficiently monitoring and improving all aspects of the service so that people experienced good quality, safe care.

The failure to operate an effective quality assurance system leading to improvements is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always complete risk assessments and plans for managing risks relating to the health, safety and welfare of people using the service. In addition, risk assessments and plans for managing identified risks that were in place were also not regularly reviewed and kept up to date by the provider. Regulation 12 (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems to assess, monitor and improve the quality and safety of the service people living at the home received. Regulation 17(2) (a).