Mrs P M Eales

Limber Oak

Inspection report

Crookham Common
Newbury
Berkshire
RG19 8BR
Tel: 10635 871213
Website: www.justhomes.info

Date of inspection visit: 20 July 2015
Date of publication: 02/09/2015

Overall summary

We carried out an unannounced comprehensive inspection of this service on the 26 and 27January 2015. A breach of a legal requirement was found at that time. This was because the management and staff had not followed safeguarding and whistleblowing procedures to protect people from abuse.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on the 20 July 2015 to check they had followed their plan and to confirm that they now met the legal requirements.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Limber Oak' on our website at www.cqc.org.uk

Limber Oak provides accommodation for up to seven people with a learning disability who require support with their daily life and personal care. There were six people living in the home at the time of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they 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. However, the registered manager had taken absence of leave following our comprehensive inspection in January 2015. We were informed by the provider that the registered manager would not be returning to their substantive post. In the short-term the provider had taken action to ensure a supportive management team were placed at Limber Oak whilst they recruit a new manager.

At our focused inspection on the 20 July 2015, we found that the provider had followed their plan which they told us would be completed by the 28 April 2015 and that legal requirements had been met.

Staff had received updated training on safeguarding vulnerable adults and knew how to keep people safe by reporting concerns promptly through processes that they understood well.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
People were safe

The provider was now meeting the legal requirements.

Staff knew how to protect people from abuse

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'good' would require a longer period of consistent good practice.

We will review our rating for safe at the next comprehensive inspection.

Limber Oak

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 was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We inspected the service against one of the five questions we ask about services: is the service safe. This is because the breach found at the last inspection was in relation to this question.

The inspection was unannounced and undertaken by two inspectors.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements. We spoke with the local authority commissioning and safeguarding team and with the provider.

At the visit to the home we observed support provided to people and spoke with the trainee proprietor, deputy manager and four staff.

Is the service safe?

Our findings

At our comprehensive inspection of Limber Oak on the 26 and 27 January 2015 we found that people were not protected against the risks associated with safeguarding people from abuse. The registered manager had not followed multi-agency safeguarding procedures by notifying the appropriate authority or Care Quality commission (CQC) when informed by staff of alleged abuse towards people who use the service.

This was a breach of regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse, which corresponds to regulation 13 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection we found that the provider had taken the action they had planned in order to meet this regulation. This involved an evaluation of staff training followed by updated training for all staff on safeguarding vulnerable adults. The provider reviewed their whistle blowing policy to make sure staff were fully aware of what action they should take if they felt they were not being listened to by the provider or by the registered manager.

Staff were able to give a good account of the types of abuse that vulnerable people might be subjected to and were fully aware of safeguarding procedures. Staff were less clear of the distinction between safeguarding and whistle blowing. However, we were confident that any issues of concern that staff raised and were not dealt with appropriately by the management team would be brought to the attention of the appropriate authorities. There were policies and procedures in place for safeguarding people and for whistle blowing. These were understood by staff who knew where to find them if required.