HC-One No.1 Limited

Oakhill House Care Home

Inspection report

Eady Close
Horsham
West Sussex
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Oakhill House Care Home is a residential care home providing personal and nursing care to up to 49 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 30 people using the service. The home was set over two floors, however the top floor was not in use.

People's experience of using this service and what we found
People had not always been protected from the risk of harm and abuse. The provider had recently identified safeguarding concerns reported by staff between 2020 and 2021 which had not been investigated at the time of the incidents or reported to the appropriate agencies externally. Once these incidents had been found, investigations and analysis of each incident had been completed as far as possible and measures put into place to minimise the risk to people. Incidents were reported retrospectively to the local authority safeguarding team, CQC, Police and people's relatives.

Risks to people were not always safely managed. The provider had recently found incidents relating to people's safety that had not been investigated or reported. These included incidents of falls, serious injuries and choking events. Although action had been taken in response to finding these incidents, we found that further improvement was needed around managing people's risks. People at risk of choking had not always been safely supported in line with guidance provided by healthcare professionals.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The provider had identified an historic incident in which a person had been unlawfully restrained. This incident had not been reported in a timely way. The provider had investigated the incident and ensured that staff understood their responsibilities around the Mental Capacity Act.

Governance systems had not been effective in identifying recent concerns at the service regarding the reporting of incidents. The provider's response to finding these incidents was not prompt or in line with their safeguarding policy. Some improvements were needed to record keeping to ensure that people at risk of malnutrition, dehydration and skin breakdown were kept safe.

People and their relatives were positive about the support provided by staff at the home. Staff were kind and caring and treated people with dignity and respect. Staff had been safely recruited and trained to support people. People, relatives and staff were given opportunities to feedback on the quality of care at the home. Staff worked with other professionals to provide joined up care for people.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was good (published 03 April 2020).

Why we inspected
We received concerns in relation to safeguarding and safe care and treatment. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.
For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.
You can see what action we have asked the provider to take at the end of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oakhill House Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safeguarding people from abuse, safe care and treatment and governance.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Oakhill House Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors. An Expert by Experience made phone calls to people's relatives after the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Oakhill House Care home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Oakhill House Care home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 11 July 2022 and ended on 18 July 2022. We visited the location's service on 11 July 2022 and 12 July 2022.

What we did before the inspection
We reviewed information we had received from the provider about the incidents and recent issues at the service. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent time with people and observed how staff interacted with people. We spoke with three people that used the service and 11 people's relatives about the care provided. We spoke to ten members of staff including the provider's area director, nursing staff, senior carers, carers and the chef. We reviewed seven people's care plans in relation to people's care and support needs and multiple medicine records. We reviewed a range of documents relating to the quality and monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People had not always been protected from the risk of harm and abuse. The provider had recently identified safeguarding concerns reported by staff between 2020 and 2021 which had not been investigated at the time of the incidents. Safeguarding incidents included allegations of abuse which had not been appropriately reported to the local authority safeguarding team or appropriately investigated by the provider to ensure people's safety.
- Once these historic safeguarding concerns had been found, there was a delay in reporting these to the local authority safeguarding team, the Police and CQC. The provider told us this was because they wanted to investigate first to see if the incidents needed to be reported; this was not in line with the provider's safeguarding policy or with CQC's regulatory requirements.

People were not protected from abuse and improper treatment. This is a breach of regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Once these incidents had been found, investigations and analysis of each incident had been completed as far as possible and measures put into place to minimise risks to people. The provider had changed their processes for reporting incidents, so that all staff could report accidents and incidents directly onto the provider's system which could be viewed promptly by members of the senior management team. Staff had received supervisions in safeguarding.

- People and their relatives told us people felt safe. One person's relative said, "I spend a lot of time in the lounge with [relative] and other residents and am very aware of what is going on. I have no concerns about her safety."
- Staff had received training in safeguarding and understood how to report allegations of abuse. Staff had received safeguarding supervisions and safeguarding concerns were regularly discussed in staff meetings.

Assessing risk, safety monitoring and management

- Risks to people were not always safely managed and people had come to harm or were at risk of harm as a result of this.
- The provider had identified an historic choking incident which, following their investigation, was found to have been avoidable. The person had showed signs of swallowing issues before the choking incident occurred. Effective action had not been taken at the time of the incident to make a referral to the speech and language therapist team or the person's GP.

● Although measures were put into place to ensure staff received training and clear communications regarding people who were at risk of choking, during our inspection we found people were still at risk. One person who needed their fluids prepared to a particular consistency as assessed by the speech and language therapist (SALT), had drinks in their bedroom of two different consistencies. This meant the person's SALT guidance was not being followed by staff, putting the person at risk of choking. We raised this with the provider who discussed this with staff and changed the process for drinks preparation.
● During our inspection, we observed one person was struggling with their drink and coughing after each sip they had. Staff told us this person had been referred to the SALT team for assessment. When we discussed this with the nursing and management team, they told us they had not been made aware that the person was having difficulty with swallowing and no referral had been made. The clinical manager arranged for a referral to be made for the person during our inspection.
● People were not always protected from the risk of falls. The provider had identified several historic incidents in which people had fallen, resulting in injury which had not been investigated or analysed or measures put in place to minimise the risk of the falls occurring again.
● A person who had recently moved into the home as a result of a fall at home had not had a risk assessment completed to minimise the risk of falls or a falls care plan. Although this person had measures in place to protect them from falls when in bed, the person had a fall from their chair resulting in them attending hospital. We saw that a falls risk assessment and care plan had been completed upon their return to the home. As a result of this incident the provider had changed their process for people newly admitted to the home to ensure a full care plan was completed on the person's arrival.

Risks to people's health and safety had not been assessed and action had not been taken to mitigate any such risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When these historic accidents and incidents had been found by staff, the provider investigated as far as possible and reviewed staff practices in relation to the incidents. When we raised issues about the current risks to people around choking management, the provider responded immediately by speaking to staff and reviewing systems in place for drink preparation.

Using medicines safely
● Some people had been prescribed 'as required' (PRN) medicines. They took these only when they needed them, for example, if they were in pain. Not all medicines prescribed as PRN had protocols or guidance to inform staff when these medicines should be given. Some medicines had been prescribed with variable doses. There was not always guidance to determine which dose should be given.
● Some people who were unwell had been prescribed anticipatory / 'just in case' medicines. These medicines are prescribed when it is anticipated that a person may require end of life care or their health condition may change. PRN protocols were in place; however, they did not include information for staff about when to use these medicines. For example, there was no information about the person's current pain management to help staff determine if or when the anticipatory medicines were needed. One person had been prescribed a routine pain relief medicine to take as required. There was no protocol for this. There was a protocol for the anticipatory pain relief medicine, but this did not include any information about the routine pain relief and whether this should be given first. We raised these issues with the provider who made changes.
● Other aspects of medicines were well managed. Medicines were ordered, stored and disposed of appropriately and given to people individually in a way that suited each person. There were checks of medicine stock levels so any shortfalls could be addressed in a timely way.
● Some people had been prescribed medicines to be taken covertly. Covert medicines are medicines given

to a person without their knowledge and often disguised in food or drink. Covert medicines can be given when a person refuses to take their medicine, that is deemed essential to their health and wellbeing, and where a person is assessed not to have the capacity to understand the consequences of their refusal.
● Mental capacity and risk assessments were completed to demonstrate the decisions had been made in the person's best interest. There was information from the pharmacist about how to give the medicine as the efficiency of some medicines are altered when crushed or mixed with food or drink.

Staffing and recruitment
● The provider had struggled with staff recruitment recently but had put incentives in place to promote the recruitment of staff. Recruitment was ongoing and there were enough staff to support people safely. One person's relative told us, "The staff are very, very caring and also look after visitors well. I think there appears to be enough of them."
● Staff were recruited safely. Checks were completed on staff before they started work. This included employment history, references from previous employment, and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Checks ensured staff working as registered nurses had a current registration with the Nursing and Midwifery Council (NMC) which confirmed their right to practice as a registered nurse.
● Checks were made on agency staff before they commenced a shift at the home. This included an overview of completed training and DBS checks. Details of nurses' registrations were also obtained. Staff received an induction to the home, which included the layout of the home and how to report concerns. Agency nurses were asked to read the medicine protocol and shown the medicine system to ensure they were familiar of what was required.

Preventing and controlling infection
● We were somewhat assured that the provider was using PPE effectively and safely. During our inspection we saw three members of staff wearing gloves in the corridor after providing people with personal care. We have also signposted the provider to resources to develop their approach.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

People received visitors to the home when they chose to. There were no restrictions on visiting.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider had found an historic incident in which a person had been unlawfully restrained by staff while supporting them with personal care. This had resulted in minor injury to the person and had not been reported or investigated at the time of the incident. The provider's policy states that people must not be supported with personal care without their consent.

People must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. This is a breach of regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the incident being found, the provider had raised a safeguarding for the person, spoken with staff and ensured staff had completed training around mental capacity and restraint. During our inspection, we found that this risk had been managed well. People told us that staff supported them gently and were never rushed. People's care plan records showed that if people became upset whilst being supported with personal care, staff gave the person time to calm down and tried a different staff member to support the person.

● Mental capacity assessments had been completed by staff to assess whether people could make their own decisions with the care and support they received. Where people lacked the capacity to make certain

decisions, decisions had been made in the person's best interests. However, it was not always clear what consultation had happened with people's representatives. More detail was needed to evidence that conversations with people and their relatives had taken place. We addressed this with the provider who told us they would work on this.
● DoLS applications had been completed where required.
● People's relatives told us that staff asked people for choices about how they wanted to spend their time. One person's relative told us, "Staff try and involve [relative] in decisions and choices in spite of her condition."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were holistically assessed and considered each person's individual needs and preferences and how people wanted to have their needs met by staff. Care plans were regularly reviewed with people and their relatives.
● Staff used nationally recognised tools to help assess people's needs. This included malnutrition tools to check people's risk of weight loss and tools to assess the risk of skin damage for people.
● Assessments of people's oral health were clear and detailed specific guidance for staff to support people to maintain good oral hygiene.

Staff support: induction, training, skills and experience
● Staff received a thorough induction when they started working at the home. Staff were given time to read through people's care plans and spend time getting to know people. New staff shadowed experienced members of staff until they felt confident to support people on their own.
● Staff received training in areas that were relevant to the people they supported.
● People's relatives told us they felt staff were experienced. One person's relative told us, "They have a procedure in place if a new person comes in, and they have to shadow one of the more experienced nurses. Every resident there is different and they are treated in accordance with that. The carers there know [relative] well and understand her and can have a laugh with her." Another person's relative told us, "I am confident that there are very experienced staff who are capable of managing [relative's] needs and are friendly and professional at all times."

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink. Choices of drinks were provided for people throughout the day and night. People told us they enjoyed the food and had a choice of what they wanted. Staff received people's feedback on meals and made changes accordingly.
● Although the menu was decided by the provider, people were offered a choice of meals and the chef was happy to prepare off-menu meals for people if they did not like the choices. One person told us, "I don't normally like the meals on the menu so the chef comes and asks me what I'd like instead and is always able to accommodate what I ask for."
● People received specialised meals where needed, this included for people who were diabetic or had modified consistency diets. The chef told us that they worked in partnership with the nursing staff to check blood sugar levels of people living with diabetes to ensure their diet met their health needs each day.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Adapting service, design, decoration to meet people's needs
● Staff worked in partnership with external health professionals. Records showed that staff contacted the GP in a timely way when people were feeling unwell. Staff recorded and followed the advice the GP had given.

● There had been issues with the home not receiving people's monthly medicines in a timely way. Therefore, the clinical staff had met with the pharmacy to try and resolve the issues. This had resulted in medicines being delivered a day earlier which would allow staff extra time to follow up short falls, for example, missing medicines.
● People's relatives told us they were informed when their loved one had involvement from external professionals. One person's relative told us, "When [relative] has had a [medical issue], they will contact me to inform me that they are getting a doctor in or have had one in to see her. The communication with me about this is very good."
● People's bedrooms had been personalised and people told us they liked their rooms. One person told us, "My room is really nice, there's lots of space and I have everything I need."
● The home had recently undergone some renovations. People's bedroom doors had recently been painted in eye-catching colours and plans were in place to personalise these further by having items relating to people's hobbies and interests to help them recognise their bedrooms.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider's systems and processes had not been effective in ensuring that safeguarding concerns, accidents and incidents were always appropriately recorded and reported. Although staff had recorded the historic incidents and reported to the management team at the time, further action had not been taken to minimise the risk of abuse. This had not been identified by the provider's monitoring of the service.
- Information about risks to people was not always communicated effectively between staff. During our inspection we identified one person was coughing when drinking and another person had drinks of two different consistencies in their bedroom. Information relating to the risk of choking for these two people had not been communicated to the nursing or management team by staff. The provider could not be sure that people were safe from the risk of choking.
- Some improvements were needed to record keeping. For example, food and fluids charts to record people's intake did not have the person's fluid target written on them, that is, how much they should drink each day in order to be hydrated. It was not clear from these charts whether the person had had enough to drink or if action had been taken if the person had not had enough to drink. Another person's food chart did not give enough detail about what the person had eaten. For example, staff had recorded 'lunch' rather than the food the person had eaten or been offered. This meant the provider could not be assured people had maintained adequate food or fluid intake or identified when people were at risk of malnourishment.
- Mattress checks were in place for people with airflow mattresses. However, we saw some charts had not recorded what the person's mattress setting should be. This meant staff were not able to check the current mattress setting against what had been assessed as safe for the person.
- Issues found with aspects of medicine management had not been identified by the provider's medicine audit.

The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. This was a breach of regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following and during the inspection, the provider took action to address these issues.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics; Working in partnership with others; Continuous learning and improving care

● Relatives gave mixed feedback on whether they felt involved in the running of the service. Relatives told us they regularly received questionnaires to comment on the quality of the service. Relative meetings had been suspended through the COVID-19 pandemic, but a meeting was planned for the end of June.

● Staff told us they felt supported by the management team. One staff member told us, "Management are nice and supportive. We all work together as a team for the people we look after." Staff told us they received regular meetings and supervisions and were given the opportunity to give their views on the service.

● Staff worked in partnership with other professionals and professionals were positive about working with the service. One health professional told us, "The communication between myself and the home has always been excellent, and the staff know their residents well. "

● There was a home improvement plan for the service. This was an action plan that recorded all feedback and observations around areas that needed improvement. There was a timescale for the improvements needed and a member of staff responsible for making the improvements recorded. This action plan was updated regularly.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We observed staff spoke with people kindly and spent time engaging people in conversation. Staff provided people with reassurance when they were upset or worried. One person told us they had been upset about a letter they had received the previous day. The person told us, "Staff could see I was getting stressed and made sure the right person came to help me. It's all sorted now and I feel much better about it all."

● Staff treated people with kindness and respect. People we spoke with were positive about the caring nature of staff. One person told us, "They are a really super bunch, they are kind and friendly and always look after me." Another person told us, "Staff are lovely and look after me really well."

● People's relatives told us they felt staff were open and honest. Comments included, "I find the staff very responsive and certainly feel that they are open and honest." And, "I just feel that they do a very good job and are always very open."

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety had not always been assessed and action had not always been taken to mitigate any such risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment. People must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. This is was a breach of regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. This was a breach of regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.