Oak Farm (Taverham) Limited

Oak Farm

Inspection report

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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 caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 3 September 2018. At the last inspection carried out on 31 May and 2 June 2017, we found that there were areas which required improvement including three breaches of regulations. At this inspection, we found that the service had made some improvements, however there remained areas which required improvement. We found that there remained a breach relating to good governance and quality assurance systems.

Oak Farm is a 'nursing home' and a rehabilitation support unit which provides care and support to people who are living with a brain injury. At the time of our inspection there were 36 people living at Oak Farm. The provider has on site a multi-disciplinary team which includes a physiotherapist and two part-time occupational therapists as well as therapy and activity assistant staff, nurses and care staff. People in care homes receive accommodation and nursing, personal care or rehabilitation as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Oak Farm accommodates people in two adapted buildings across a one floor. There were 36 people living in the home when we inspected, many of whom were living with complex health conditions including the effects of traumatic brain injury.

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. The registered manager was not available at the time of our inspection, and we were supported to carry out the inspection by other members of staff, such as administration, the area manager, the care coordinator and the clinical lead.

At our last inspection of 31 May and 2 June 2017, we found that staff did not always obtain consent from people. Improvements were needed with regards to the management of medicines, staff training, mealtimes and systems for monitoring the service.

At this inspection, staff obtained consent from people before delivering care. Staff understood people's mental capacity and supported them to make decisions.

There had been improvements in the management of medicines, and there were protocols in place when needed. However, further improvements were needed in the administration of topical medicines.

We found at this inspection on 3 September 2018 that further improvements were needed in respect of the quality monitoring of the service. The systems for identifying issues and monitoring the service were not fully effective. Medicines audits had not identified that there was limited and inconsistent recording around some prescribed items, and the auditing process did not include checking the medicines administration records

(MARs).

Improvements were needed to ensure that care plans remained up to date and relevant, as they did not always contain sufficient information about people's needs. For example, in some areas such as communication, skin integrity and activities or occupation.

There were enough staff to keep people safe and they had received some further training related to supporting people living in the service. However, further improvements were needed in this area, as some poor practice remained relating to manual handling. Staff felt supported in their roles.

There were improvements in staff supporting people in a caring way, however some poor practice remained. Staff were caring towards people's families.

Staff knew how to report safeguarding concerns and there were health and safety checks which contributed to keeping people safe.

People received a choice of food and enough to eat and drink. They were also supported to access healthcare. People received in house treatment from nurses, physiotherapists and occupational therapists according to how the service was commissioned for people.

There were trips out and group activities held in the home, such as gardening and word games. Therapy staff worked with some people, for example on their mobility.

People and their families knew how to raise a concern or make a complaint, and these were responded to. Feedback was sought from people in the form of surveys, and feedback had been used to make some improvements to the service.

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.

Risks to people had not always been fully identified and mitigated, and there was not always accurate guidance for staff.

Medicines were administered as they had been prescribed, with the exception of topical creams.

There were staff available to people when they were needed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training related to their role, however there was limited specialist training relating to the management of long term, complex health conditions. There were also concerns about whether the training was always effective.

People's mental capacity had been assessed for individual decisions relating to their care. Best interests' decisions and consent had been sought regarding aspects of people's care.

People had enough to eat and drink and were given a choice.

People were supported with access to healthcare when they needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Not all staff supported people in a dignified and respectful way.

People, family members and staff developed good relationships.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care planning was not always done in a person-centred manner,

and care records were not properly reviewed and kept up to date.

There were activities on offer, however there was little evidence that these were based on people's hobbies or interests. There were not always care plans around activities for individuals.

There was a complaints process and concerns were investigated thoroughly.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance systems in place had not identified the issues and concerns that were raised during this inspection.

The staff team worked well together and the management team were approachable.

Oak Farm

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 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.

The inspection team consisted of three inspectors.

Before the inspection, we reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Prior to the inspection, the provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection, we also obtained feedback from the local authority. Following our last inspection, we asked the provider to send us an action plan detailing how they would improve the service provided. They sent us this, which we reviewed for this inspection.

We spoke with eight staff members including a physiotherapist, an occupational therapist, a cook, two care staff, a nurse, the care coordinator, the clinical lead and the area manager. We also spoke with a person using the service and two relatives. As there were some people who were not able to give us verbal feedback about the care they received, we also made observations throughout the day of support delivered and interactions around the home. We looked at nine care plans in detail, and the medicines administration records (MARs), as well as a range of quality assurance and health and safety records.

Requires Improvement

Is the service safe?

Our findings

We last inspected this service in 31 May and 2 June 2017 and it was rated 'Requires Improvement' in this area. The provider sent us an action plan which detailed what improvements they would make, and they said these would be made by June 2017. Actions included creating further medicines protocols, medicines training and further audits. At this inspection we found that although some improvements had been made, there remained shortfalls and further improvements required in this domain. Therefore, it continued to be rated, 'Requires Improvement' in safe with one remaining breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to safe care and treatment.

We found that some risk assessments remained the same as we found at our last inspection in 2017. For example, one person's falls care plan stated that they used a handling belt with staff. We identified at our last inspection in 2017, and during this inspection in 2018, that this was not the case. Staff did not use a handling belt with the person and the area manager confirmed they had never used one. The care plan had been reviewed with 'no change' written in, however we saw it had not been updated with current and valid information.

Some tools used did not always assess people to reflect an accurate level of risk. The falls risk assessment had a higher score for females than for males. We asked the area manager about this who told us it was because females were more likely to have osteoporosis. However, osteoporosis was also scored separately on this falls risk assessment under the medical section. The tool was not relevant for people cared for in bed or in a chair, as it only assessed people who were able to mobilise on foot. It was still used for people cared for in bed and not identifying any risks of falling out of bed or a chair, therefore people were assessed as low risk when the tool was not applicable to their needs. We were therefore not clear on the accuracy of the assessment as a tool to assess risk.

One person's falls risk assessment identified them as medium risk, but their manual handling plan had no guidance for staff about mitigating risks. The handling plan said that if the person fell to the floor, they would be likely to require a hoist. It did not have any further information about how to manage this, regarding the person's conditions and what equipment staff would need to use.

Where bed rails had been risk assessed, they had not always been reviewed or updated with changes in people's needs or behaviour. For example, we saw one risk assessment completed 6 June 2017 and not updated. However, there had been significant events and changes to the person's care over the time.

At our last inspection in 2017, we saw some unsafe manual handling practice. At this inspection we saw the same practice taking place. We saw a care worker support someone to transfer from a wheelchair into an armchair, and later back again. The care worker supported the person to stand by putting her hands on the top of the person's back to support them to lean forward and stand. The breaks were not put on the wheelchair which posed a risk not only to the person and the staff member, but also to another person nearby who was sitting in their wheelchair. The person then stood and landed abruptly in the armchair. The care worker supported them later back to the wheelchair, and we saw that the care worker had their hand

under the person's arm. The care plan stated not to do this, and to support the person with positioning their hands and feet prior to standing. This did not happen. Furthermore, there was no further verbal prompting to support the person to transfer as independently as possible and safely. The care plan stated that the person required verbal prompts throughout transferring. The poor manual handling posed a risk of injury to the care worker and the person and did not demonstrate care according to the care plan.

We could not be assured that staff were managing the risk of people developing pressure areas. One person had a skin integrity care plan which stated 'no problem or need'. However, the pressure care risk assessment tool identified the person as high risk. This had been completed on 7 June 2018 and reviewed once. We also found in their bathroom a prescribed skin cream. There was no date on this, and no directions or records around it, except one reference to it being used by staff to apply on 31 July 2018. There was no body map or reference to this is the care plan.

People who had prescribed creams, including those to support the prevention of pressure areas, did not always receive these as prescribed. Body maps were not always in place, and those that we saw were not in consistent use to show staff where on the body these medicines should be applied. There were no recording administration charts for these medicines, and they were being stored unsecured in people's rooms. They were not fully covered in the care plans with guidance for staff on how to administer them, and they posed a risk of being used inappropriately because they were not secured.

Where the pharmacy had written 'use as directed' rather than given specific instructions on some medicines, staff had requested specific instructions from the pharmacy and GP and these had still not always been given. These items should not be applied by care staff without guidance on how and where they should be used,

Although most of the home appeared clean there were certain areas that required attention. There were some older and visibly worn pieces of equipment such as an old commode chair with a canvas back. The floor in the main bathroom appeared dirty and worn. Some people's en-suites were extremely cluttered, and whilst staff told us this was some people's choice, it created a trip hazard and made some areas difficult to clean. One person's en-suite contained many continence products which were being stored on the floor and around the room, creating a trip hazard. There were also exposed pipes which could become hot and pose a risk in the event of a fall, of burns. These risks had not been identified on any risk assessment.

The above concerns resulted in a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that improvements had been made to the safe management of 'as required' (PRN) medicines. When people were prescribed medicines on a PRN basis there was written information available to show staff how and when to give them to people. This is called a protocol, which was also attached to a care plan if needed, relating to that medicine.

With the exception of prescribed creams, medicines were stored securely for the protection of people who used the service and at correct temperatures. Members of staff who handled and gave people their medicines had received training and had their competence assessed. We observed part of the morning medicine round and saw that staff followed safe procedures when giving people their medicines. They also administered medicines safely where they were administered via people's PEG (Percutaneous endoscopic gastrostomy) feeding tubes. We counted two random medicines and found that the stock added up to what was recorded, and we also checked medicines associated with a higher risk. These were signed for by two staff and stored appropriately. There was also a detailed medicines protocol and plans in place for one

person who had diabetes.

We saw that people had care plans in place for positioning which guided staff with photographs and descriptions of what equipment was needed. This helped to ensure people were supported to be comfortable and safe in their positions, which may be affected by their conditions. Risks associated with people's diabetes were thoroughly assessed and care plans were in place to guide staff, including checking people's feet and when to check blood glucose levels.

We found that some areas of risk had been assessed and there were improvements since our last inspection relating to the management of behaviours which some people may find challenging. There were care plans in place with guidance for staff on how to manage these behaviours and mitigate risks of people harming themselves or others.

Staff had knowledge of safeguarding and felt confident to report any concerns around potential abuse.

There were enough staff to keep people safe, and one person and a relative confirmed that they came when needed. We saw that staff were available to people throughout the day of our inspection, and staff absence was covered by agency staff. Staff we spoke with told us they felt there were enough staff. The service assessed each person's dependency levels in order to assess how many staff they needed, however these were not always regularly reviewed.

Service staff were recruited with systems in place to contribute to keeping people safe. This included the service requesting a DBS (Disclosure and Barring Service) check, which checked whether potential staff were considered suitable to work at the service, as well as references, prior to employment.

There were regular health and safety checks within the service, which included fire, water, food safety and electrical equipment checks, as well as checks for the lifting and bathing equipment. These checks contributed to keeping people safe.

We saw that equipment was available to staff to prevent any spread of infection, such as aprons or gloves. We saw that the staff were following the provider's policy in relation to any potentially infectious conditions. There was a large room specifically for storing chairs and lifting equipment.

We saw that any accidents and incidents had been analysed, and action had been taken to further mitigate risks resulting from any accidents or incidents. Some improvements had also been made to the service, for example the introduction of the PRN protocols, since our last inspection.

Requires Improvement

Is the service effective?

Our findings

We last inspected this service in 31 May and 2 June 2017 and it was rated 'Requires Improvement' in this area and had a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the deployment of enough competent staff. Following the last inspection, the provider sent us an action plan which detailed what improvements they would make, and they said these would be made by June 2017. Actions included further training, observations of staff practice, and altering hours to suit people's needs. At this inspection we found that although some improvements had been made and there was no longer a breach, there remained shortfalls and further improvements required in this domain. Therefore, it continued to be rated, 'Requires Improvement' in effective.

At our last inspection in 2017, we had some concerns about whether staff were trained effectively to support the complex needs of the people living at Oak Farm. This had resulted in a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection in September 2018, whilst there had been some improvements in staff training and competency checking, and there was no longer a breach of regulation, further improvements were still needed to ensure that staff were empowered to meet people's complex needs.

At our last inspection in 2017 we saw one member of staff deliver inappropriate manual handling support to one person, which we also saw during this inspection in September 2018. The staff member carried out poor manual handling, not in line with the care plan, in front of three inspectors, which demonstrated to us that this remained usual practice. The area manager told us the staff member had been working in the service for many years. This demonstrated to us that manual handling training was still not always effective.

We identified during our last inspection in 2017, that care staff did not all receive training which was specific to the people they were supporting and their specific health requirements and support needs. We found at this inspection in September 2018, some improvements had been made. Staff still did not receive training in communication support, muscle stiffness (tone) and swallowing problems (dysphagia), which affected the majority of people at Oak Farm and heavily influenced their support needs. Staff did not always support people to move in a way that promoted their independence and worked with them to overcome their physical disability. The physiotherapist and the occupational therapist told us that they carried out therapeutic interventions for people. They had created care plans for other staff to follow so that people were supported therapeutically in between sessions with a qualified professional, these were not always followed. We saw no evidence of inhouse training provided to care staff by the therapy staff to embed the practice relating to their interventions and care plans.

Oak Farm is a specialist rehabilitation unit for people with neurological conditions. We looked at records of staff training with this in mind. We saw that some further training in brain injury had been provided to staff, and they also had training in dementia and epilepsy. One staff member told us about some training they had attended in person-centred care and dignity which they found useful. Other training that the service deemed as mandatory, included safeguarding, Mental Capacity Act 2005 (MCA), first aid and medicines administration for nursing staff. Qualified staff had attended further training in areas such as pressure care

and PEG feeding. Therapy staff had also attended further training in brain injury.

We saw improved practice around the mealtime at this inspection which reflected some improvements in staff training and supervision. Staff demonstrated a better understanding of people's support needs. The care coordinator showed us some observations they had introduced since the last inspection which had effectively identified some areas where staff needed to improve and this was acted upon. However, further training and a cohesive approach to supporting people with neurological deficits was not yet embedded and sustained.

We spoke with a new member of staff who was a member of the therapy team. They explained to us that they were receiving regular weekly supervision to discuss their role. Another member of staff explained to us that new staff shadowed more experienced staff before working alone. The care coordinator also showed us an induction booklet which all new staff worked through before working alone with people.

We saw that there were some staff who were not regularly attending supervisions. The area manager explained that they were introducing a new 'supervision agreement' with staff to address this. Staff told us they felt they could go to any of the team for further support or advice when they required it.

There were thorough pre-assessments carried out to ascertain what people's needs were and whether the service was able to meet these. This included information about people's preferences. People and their families were also invited to visit the service to see how they felt about living there.

There was a choice of meals, and one person confirmed to us that staff used pictures to help them choose what they wanted, due to their communication difficulties. We saw that when people had lost weight in a short amount of time, action had been taken such as referring to a dietician and starting a fortified diet. The cook we spoke with had good knowledge of different people's dietary needs and told us that if people did not like what they received, they were always able to have something else to eat. We saw that staff regularly supported people to drink throughout the day. When people were on food and fluid charts so that staff could monitor their intake, we saw that these were completed.

There were weekly multidisciplinary team meetings attended by nursing and therapy staff as well as a psychologist and a member of the care team. This provided an opportunity to discuss any changes in people's needs and review care, and enable any further organisations to be involved in people's care where needed. The team followed any recommendations made by people's healthcare professionals such as consultants who were involved in people's care.

People were supported to access healthcare when they needed. This included regular access to a psychologist who worked regularly in the service. External referrals were made when needed, for example to dieticians. Staff supported people to attend hospital appointments when needed, and a GP visited the home regularly. People were also supported to access services such as a chiropodist and specialist healthcare professionals.

The environment of the home was purpose-built, with even flooring and communal areas such as a lounge and dining area. There was a wet-room and a bathroom and people had en-suite toilets. One person had a wet room specially made for them in their en-suite so the service was able to meet their showering needs.

The 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 Act 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. A staff member explained to us how they followed the principles of the MCA, assuming people had capacity and supporting them to make decisions when needed.

People's mental capacity had been assessed in light of specific decisions. Where best interest decisions had been made, there were records of who was involved and consulted about these decisions.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager was awaiting authorisation for the applications that had been made, and we saw that they were using the least restrictive methods to provide safe care and treatment.

Requires Improvement

Is the service caring?

Our findings

We last inspected this service in 31 May and 2 June 2017 and it was rated 'Requires Improvement' in this area. This was because the staff did not always support people in a compassionate manner and uphold their dignity. At this inspection, we found this had improved, however we found some poor practice remained and this area remains rated 'Requires improvement.'

We saw, and people and relatives confirmed, that people were supported in a dignified way. There was one exception to this where we saw a staff member at breakfast time who supported one person. The person had spat some food out and the staff member, whilst standing over them, pulled their top forward from their body so they could see it, and they said, "Look what you've done." They did not attempt to offer them something else and they had not offered the person an apron to protect their clothes. We brought this to the attention of the area manager. They told us that the staff member had been in service a long time and knew the person well.

Two relatives we spoke with told us they felt staff were caring. One said they, "Couldn't fault them," and another confirmed that nothing was too much trouble for staff supporting their relative. People and staff developed good relationships.

We observed the meal at lunchtime in the dining room. We saw that care staff sat with people when supporting them to eat, offering drinks and talking them through what they were doing and what the food was. A staff member told us, "We're one big family here, we sit and have a chat, there's nothing worse than feeling lonely."

All of the relatives we spoke with at the inspection said that staff were caring towards them and their family member, and kept them informed of any issues. The service had also received many compliments about staff, including from healthcare professionals. The staff working in the service knew the people they looked after well and were able to tell us about how people preferred to be cared for. We saw that staff interacted with people's families in a compassionate way and involved them in discussions about people's care.

We also found at this inspection that staff had more time to spend with people when needed, and one staff member confirmed this, saying, "Everyone has a shower every day now." They felt they were more able to meet people's needs and had more time.

Personal care was always carried out in private behind closed doors and people were supported to maintain their dignity. Care files were kept confidential and only shared with people appropriately. Care staff told us how they supported people to be as independent as possible in some areas, for example encouraging people to do what they were able to during personal care. Families were able to spend as much time with their loved ones if they wished, and were also able to support their relative to go out and on home visits.

Requires Improvement

Is the service responsive?

Our findings

We last inspected this service in 31 May and 2 June 2017 and it was rated 'Requires Improvement' in this area. At this inspection we found that although some improvements had been made, there remained further shortfalls in some areas and further improvements were required in this domain. Therefore, it continued to be rated, 'Requires Improvement' in responsive.

At our last inspection we found that the people and their families felt that there was not enough occupation, therapy and activity for people. This had improved during this inspection in September 2018 as we found that more staff were available to provide this throughout the week. We saw that surveys carried out within the last year showed that there had been increased satisfaction from people and their families around the therapy service in the home.

We found shortfalls relating to people's care planning. The care plans did not always contain enough detail to guide staff on how to support people. For example, one person's care plan stated that they became 'aggressive and difficult' at times during personal care. However, the personal care plan for the person simply said that the person may need prompting. There was no plan identified by the occupational therapist as to how the person could be prompted and how staff should support them with washing and dressing, to ensure they received a consistent approach. Furthermore, the language used to describe the person's behaviour did not reflect a person-centred, responsive approach to their needs. One staff member we spoke with told us the person could do some parts for themselves if staff handed them a flannel – this level of detail was not given in the care plan. The person also had strong muscle contractures in one limb due to their condition, and this was not covered in the care plan for personal care. For another person who lived with partial paralysis, cognitive and communication problems, their personal care plan simply stated that they needed assistance to wash and dress. It did not give any detail about how this assistance, and what prompting, should be given.

Care plans did not contain sufficient guidance around people's communication. For example, one person's communication care plan stated that the goal was 'to communicate and speak well', and to 'continue with a conversation partner'. The care plan then stated that there was no conversation partner and there were no further plans in place. There was no guidance for care or activity staff about how to support the person to communicate and further develop these skills. Therefore, there was no evidence of any opportunities for this person to use and enhance their communication. The person had an OT (Occupational Therapy) review in August 2017, which had identified they were able to initiate simple conversation such as asking what someone's name was, and this was not included in the communication care plan, or built upon. For another person, we saw that they had some pictures to guide their communication. These had not been mentioned in the communication care plan.

People's care plans did not always contain guidance for activities and occupation. It had been identified that one person enjoyed participating in a weekly musical group. This had not been running for the past year and was due to start up again. There was no care plan for activities based on the person's interests and needs. For another person, their care plan relating to behaviours stated that staff should give appropriate

social and emotional support, but no details about what this support should be.

Some points about people's ability had been established during a review by an occupational therapist, and we saw that the therapy staff, including physiotherapist, wrote some of the care plans relating to some areas of people's care. However, there was not always a cohesive therapeutic approach and we found these care plans were not always followed, and care plans were not always created and updated around people's individual needs. One care staff member told us, "We [care staff] don't really get involved with that [therapy]" Whilst they told us the therapy staff were highly supportive, they did not work closely together.

Care plans were not always properly reviewed and updated. Where there had been changes to people's health and needs over the years, the care plan remained as 'no change' in most cases. For example, where people had gradually lost weight, this had not been accurately reflected in nutritional care plans and had continued to say, 'no change' over the year. Weight changes had not always been used to reassess and update care plans in other areas, for example the pressure risk assessment. For another person, they had had important updates to their moving and handling, however the reviews had continued to say, 'no change'.

One person's care plan had identified in different areas that a stroke affected the left and the right side, separately, so it was not immediately clear which side, or whether both sides, were affected. Another person's care plan still referenced a previous partner who had moved away from the area.

In one person's care plan who was registered blind, there was a lack of consideration of this in some areas of their care plan. For example, the care plan for supporting them to eat stated they should sit upright, but did not cover information for staff about explaining to them what they were eating.

A member of therapy staff told us that they worked on people's goals, both shorter and longer term, with them. They also carried out assessments of people's daily living skills and contributed to developing care plans. We asked care staff about goals for people living in the service, and they described some people's goals, for example one person had achieved going to the local shop on their own, and made their own lunch. However, goals were not always included in people's care plans or integrated into their daily care.

We spoke with staff about people who were possibly nearing the end of their lives, and looked at one care plan related to this. There was no end of life care plan in place which expressed who should be consulted, and where the person should be at the end of their life, and any other preferences they might have with regard to the end of their lives. However, we saw that staff discussed it sensitively with family members where end of life care was being considered, such as whether someone would go into hospital or not.

The above concerns resulted in a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were trips out organised during the year, which included the theatre or going to the local pub. We looked at some photographs and records around achievements at Oak Farm, including days out. It also included a recent project renovating the outdoor area which care staff initiated. Some people enjoyed being involved in this work. There were also photographs of a recent surprise birthday party held for one person in the service.

One relative told us that staff did spelling or read stories to their family member which they enjoyed. There were group sessions which people could attend if they wished, including a gardening group. A member of the therapy staff told us they held a breakfast group once a week where people were encouraged to get their

own breakfast, and there were activities in house such as hangman. A member of the therapy team attended aquatic therapy sessions with people. There was also a gym with equipment for people such as a motomed (an assisted cycle machine), a tilt table and parallel bars.

We saw that complaints had been investigated and responded to appropriately, and people knew how to complain. The relatives we spoke with told us they felt staff and management were approachable if they needed to raise any concerns. Staff we spoke with demonstrated that they understood different people's ways of communicating, for example, if they were unhappy about something.

Requires Improvement

Is the service well-led?

Our findings

We last inspected this service in 31 May and 2 June 2017 and it was rated 'Requires Improvement' in this area and had a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the last inspection, the provider sent us an action plan which detailed what improvements they would make, and they said these would be made by June 2017. These actions included further oversight and observation of staff practice. At this inspection in September 2018 we found that although some improvements had been made, there remained a breach around good governance, with significant shortfalls and further improvements required in this domain. Therefore, it continued to be rated, 'Requires Improvement' in well-led.

The service's statement of purpose outlines that they will 'maximise cognitive recovery' and 'maximise opportunities for self-care' as well as promote activities and make achievable goals. We found that the support the service provided was not in line with the statement of purpose.

Care file audits were not fully effective as they did not identify where there were inconsistencies, or where people's needs had not been fully and holistically planned for. Some areas we found within people's care plans did not contain sufficient information or guidance had not been identified. It had not been identified where risks to people were not properly assessed and mitigated, or where people did not have care plans for activity. Some people's care plans for communication and skin integrity were not sufficient, and some care plans had inaccurate or out of date information in them. Where people's care files had been reviewed, they had not always been updated with people's changing needs to ensure they remained current and relevant. When there was information that was no longer relevant or was inaccurate, this had not been identified.

Whilst we identified that staff knew people well, there was still a risk that the guidance was not always available so people did not always get consistent care. This was particularly important for new and agency staff. Care files had not been audited in terms of quality and whether they were in line with the provider's values.

The provider had introduced some observations which had been carried out on staff practice, however we found there remained some poor manual handling, similar to our findings at the last inspection. This was from established and experienced staff and had not been identified. When we raised our concerns with the management team, they responded the following day explaining that they felt the staff member knew the person extremely well and had not behaved inappropriately. They also said the staff member was 'spoken to' with regards to the manual handling incident. We were not assured that there was a suitable response to our concerns.

We saw in a meeting in January 2018 with night staff, that they had discussed the recording of topical medicines. This had not been followed up on and remained an area which was not being completed.

Medicines audits which had been carried out fortnightly since our last inspection had improved the accuracy of stock checking. However, the audits had not included any checking of the records around administration,

such as the MARs or front sheets, or the recording around topical medicines. There were some missed signatures which had not been identified, and there had been no checks to see whether staff had accurately transcribed information onto MARs when hand written, and check that protocols were up to date. The clinical lead had developed a new audit tool which they were going to roll out immediately following the inspection which included checking of records and topical medicines. It remains a concern that the areas we identified during the inspection had not been identified and acted upon by the provider.

The above concerns constituted a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where the provider had contacted the safeguarding authorities about incidents in the home, they had not always notified CQC of this. They are required to notify CQC of any information brought to the attention of safeguarding authorities, regardless of whether the incident is upheld as a safeguarding investigation. We saw that there had been some incidents this year which had not been notified. Prior to the inspection, we also saw that the provider was not transparently displaying the service's rating on their website. We had requested this in November 2017. We made a further request and the rating was put on the website by the time of our inspection.

The management team consisted of an area manager, a registered manager, who had been in post since March 2017, a care coordinator and a clinical lead, who was new in post. A representative from the provider also visited the service on a monthly basis.

There were checks in place such as staff observations of mealtimes which had been implemented since our last inspection. There were audits in place for health and safety and infection control. There were spot stock checks of medicines and we saw that action had been taken, for example of a medicines was out of date. A monthly clinical audit checked food charts, weights, any wounds and blood pressures. Actions were identified where needed, and these were then followed up at the monthly clinical meetings. The clinical lead told us about these clinical governance meetings where any concerns regarding people's care, such as weight, infections or continence were discussed. Checks were carried out by the clinical lead, the registered manager and the area manager to assess the service.

Where the service had received feedback from people in the form of surveys, and found concerns through quality assurance systems, they had used information to improve the service. For example, by implementing more staff cover since our last inspection.

We saw that the service maintained involvement with a regular agency they used and other organisations such as the Clinical Commissioning Group. They were also involved with the local community and some of the people living in the service regularly attended a local day centre for people with acquired brain injury. The provider's area manager had attended a conference put on by the Acquired Brain Injury forum network and they told us this was good for making links with others in this area of healthcare. There were also speakers there focussing on areas such as nutrition.

Regular meetings took place and staff confirmed they felt confident to raise any concerns and participate in discussions in these meetings. They said management team were approachable. Staff told us they felt supported in their roles and able to ask for further resources or training if needed. Some members of staff told us they felt staff worked better as a team since our last inspection. There was a system of 'employee of the month' which encouraged staff to do their best within their roles.

There was a monthly newsletter that was given to everybody which kept people informed of any changes to

the service or new staff members.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not always accurate and did not always contain guidance. Topical medicines were not planned for or recorded. 12 (1) (2) (a) (b) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place for monitoring the service were not always effective because areas for improvement were not always identified. 17 (1) (2) (a) (b) (c)