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

Oak Farm is 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 an occupational therapist

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.

At this inspection we found that the provider was not meeting the requirements of three Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's medicines were not always managed safely, and there was not always an adequate skill-mix of staff deployed across the home. We also found that there were not fully effective systems in place to monitor the service and identify potential problems. You can see what action we told the provider to take at the back of the full version of the report.

Staff did not routinely obtain verbal or implied consent before delivering care, and care was not always delivered in a compassionate manner. Staff did not take opportunities to give people choices, however where people had made choices, these were respected.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and report on what we find. Mental capacity assessments had been carried out for specific decisions where appropriate and some people had been lawfully deprived of their liberty.

Improvements were needed with regards to the administration and management of medicines. Some medicines were at risk of being given inappropriately and stock levels did not correspond with records.

Improvements were needed with regards to staff training in challenging behaviours, manual handling and supporting the specific complex needs of the people at Oak Farm.

The systems in place to monitor, analyse and improve the service and identify concerns were not always effective.

We found that improvements were needed to the mealtime experience for people as staff did not always support them in a dignified, compassionate and interactive way, to eat their meals.

Staff supported people to eat special diets when they needed, and to drink enough. Staff also supported people to access healthcare when they required. There were enough staff to keep people safe and there

were safe recruitment strategies in place. However, there was not always an adequate skill mix of staff available to meet people's needs. People were supported to access healthcare promptly when they needed it.

There were comprehensive care plans in place for people and staff delivered care to individuals that met their specified preferences. The therapy staff supported people to maintain their mobility and to set and achieve goals. There were activities that people could get involved in during the week, and people were supported to access the community.

There was not always visible leadership in place throughout the home, however the staff worked as a team and were supported by the management team. People were not always asked for feedback in a way that they understood, however people knew how to complain.

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 consistently safe.

The management and administration of medicines required improvement.

Staff knew about safeguarding procedures. Risks to individuals were assessed and managed safely.

There were enough staff to support people and staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were aware of people's capacity to make decisions, however staff did not always obtain consent from people before delivering support.

Improvements were needed to ensure that staff were trained to meet people's specific needs.

Staff supported people with their meals and drinks when required. However, improvements were needed with regards to the mealtime experience.

People were supported to access healthcare.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always support people to eat in a dignified manner, and were not always compassionate and reassuring towards people in communicating with them when delivering care.

Staff built supportive relationships with people and their families.

People's privacy was not always respected as the care records were kept in an open, communal space.

People and their families were involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were inconsistencies in the detail and quality of care plans across the home, and some care plans did not provide enough guidance to staff on people's health needs.

People were supported to engage in outings and activities within the home. Staff respected people's choices.

People and relatives knew how to raise any concerns should they have any, however improvements were needed in checking whether the service met people's preferences.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were some effective systems in place to monitor, analyse and improve the service, however there were some areas in need of further improvements.

The registered manager was supportive to staff and there was positive morale. The staff worked effectively as a team.

The home had developed strong links within the local community.

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 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 inspection took place on 31 May and 2 June 2017 and was unannounced. The inspection team consisted of two inspectors. As part of the inspection, we reviewed the information available to us about the home, 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.

During the inspection, we spoke with 12 members of staff. This included the registered manager, the care manager, the clinical lead, an activities coordinator, the physiotherapist, an occupational therapist, two nurses and four care staff. We also spoke with three people who lived in the home and two relatives who were visiting. Not everyone living at Oak Farm was able to speak with us and tell us about their experiences of living in the service in detail so we observed how care and support was provided to people in the home. We checked five people's care records in detail and samples of additional care records, and five medicines administration records (MARs). We also checked records relating to how the service is run and monitored, such as audits, recruitment, training and health and safety records.

Requires Improvement

Is the service safe?

Our findings

People were not always safely supported to take their medicines as they had been prescribed.

We looked at the storage of medicines kept in bottles. We found that not all bottles in the medicines trolley were dated when opened. This posed a risk that medicines could be used past the recommended time of opening and may no longer be effective.

We found that for medicines that were given on an 'as required' (PRN) basis, there were no protocols in place to guide staff on when, and how to give these. Where these were medicines prescribed to support people to manage their stress and anxiety, there was no guidance in place for staff to instruct them what approaches to try before giving the PRN medicines. Therefore, there was a risk that these medicines could be used inappropriately.

We also found that there was no accurate stock check in place for some PRN medicines. For example, one person's MAR stated that they should have, 'half to one tablet', however, the staff had not recorded consistently whether the person had been given half a tablet or a whole one. Therefore, it was not possible to keep an accurate record of the stock. There was no guidance on the use of variable dose medicines, which increased the risk of inappropriate usage.

We looked at another person's MAR, and found that they received a medicine daily in the mornings, to reduce agitation prior to receiving personal care, and were prescribed two tablets. A nurse told us that at times only one tablet was sufficient. There was no record of this in the persons MAR, and it had not been raised with the prescriber to review this medicine.

We checked four stocks of medicines to see if they were consistent with what staff had recorded. Two out of these four were incorrect. This meant that the service was unable to demonstrate that medicines had been administered as the prescriber had intended.

We found that for people who received covert medicines, appropriate capacity assessments had been carried out and the correct people had been involved with these decisions. However, they were not being reviewed regularly to ensure convert administration was still appropriate. One record had not been reviewed since 2013 and another two were last reviewed in 2015. This meant that the service was not able to demonstrate that alternative approaches had been considered over time.

Not all risks to people had been assessed adequately. For example, in one person's falls risk assessment, there was no mention of a splint that was specified in their manual handling assessment, which they needed to wear when mobilising. Their manual handling assessment also suggested that staff used a handling belt. We saw that staff did not use a handling belt when supporting the person to transfer from the armchair to a wheelchair. We then saw for this person, that they had a lap belt fitted when they were seated in a wheelchair. There was no risk assessment or plan in place for this which detailed when this was necessary to be used.

These concerns meant that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We brought our concerns to the attention of the clinical lead nurse and they immediately took steps to put into place PRN protocols for people, and they had started this process during our inspection so that these would be in place providing guidance for staff on when and how to give these medicines.

We looked at the way in which medicines were stored, and found that medicines were stored securely and during our visit, at a safe temperature. However, the daily temperatures within the medicines room and the fridge were not consistently monitored. The temperatures that had been taken were within limits of recommendations for medicines storage, and the room was cool with an air conditioner on.

Qualified nurses administered the medicines and they told us that they received yearly competency checking as well as training in this area. We observed a medicines round and found that the nurse administered medicines in a caring manner, interacting with people whilst they were doing so. They ensured that people had taken their medicines before they signed them off as having been given on the records. They also administered medicines safely where they were administered via people's PEG (Percutaneous endoscopic gastrostomy) feeding tubes.

We looked at records relating to medicines administration for people with diabetes, and saw that the correct procedures and care plans for checking people's blood sugars were in place, and that the specialist nurses were contacted if there were any concerns.

Staff had been trained in safeguarding and were able to tell us about the different types of abuse and how they would report any suspected abuse. One staff member said, "If I saw any signs of abuse, such as physical, emotional or mental abuse, I would record it and report it to my manager". However, not all staff we spoke with knew who they could report concerns to outside of the organisation.

Risks to individuals were assessed and there was guidance for staff on how to mitigate risks, for example, of people developing pressure areas, and people using certain equipment to move around. There were also risk assessments in place with guidance on how to meet people's specific health needs, such as diabetes and weight loss. Other risks to people and their environment, such as the safe use of bed rails, were assessed and plans were in place to mitigate these risks to people. 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 equipment. These checks contributed to keeping people safe.

There were enough staff to keep people safe and meet their needs. One staff member said, "I think we are very privileged with the staffing levels here". Some staff told us that there were less staff on at weekends, and we ascertained that this was because the therapy, activities and management staff did not work weekends so there were less staff overall. Whilst this did not always have an impact on people's safety, it meant that there was not always adequate skill mix on shifts to deliver the support that people required. For example, some people were not able to wear splints at the weekends because they were only applied by the therapy staff who worked during the week. There was a dependency assessment of each person's needs, and the service was staffed according to people's dependency levels.

There were recruitment processes which contributed to people's safety, for example, obtaining a check from the Disclosure and Barring Service (DBS). This check helps employers to make a decision about a person's suitability to work with people who use the service. The provider also requested references from previous employers and asked applicants for their employment history and identification proof. We saw that for some

new staff, where references had not been given in detail, the provider had not always asked for an extra reference. The management team explained that they had recently put this extra check into place for when references are given with no detail, so they could improve the safety of the recruitment process.

Requires Improvement

Is the service effective?

Our findings

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 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. 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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with were able to tell us about different people's capacity to consent to their care. We also saw that staff had undertaken mental capacity assessments for specific decisions with people.

We saw that some people had been deprived of their liberty for their safety. The records we looked at showed that appropriate capacity assessments had been carried out. Where the person lacked capacity to make specific decisions, decisions had been made in people's best interests. We saw that the appropriate people, for example, family members and health and social care professionals, had been involved in these discussions. Consideration had been given to whether the action being taken in the person's best interests would amount to a deprivation of liberty. Where this was the case, applications had been made to the supervisory body for authorisation to do so. 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. We saw that restrictions were reviewed regularly.

We had some concerns about whether staff were trained effectively to support the complex needs of the people living at Oak Farm. We saw one member of staff deliver inappropriate manual handling support to one person, who required prompting and minimal support to stand and step around to their chair. We saw the member of staff hold under the person's arm to support them to get up, rather than to prompt them to push themselves up, before the person then dropped down into the chair with a thump. This posed a risk of injury to both parties, and was not conducive to safe transferring techniques. We spoke with the physiotherapist about this. They said they had trained staff in specific manual handling techniques. However, we saw that these were not always put into practice.

Oak Farm is a specialist rehabilitation unit for people with neurological conditions. We looked at records of staff training with this in mind. Care staff did not all receive training which was specific to the people they were supporting and their specific health requirements and support needs. For example, people with specific conditions such as stroke. Staff did not receive training in communication support, muscle stiffness and swallowing problems, which affected the majority of people at Oak Farm and heavily influenced their support needs. We saw that staff did not always adapt their communication in order to empower people to make decisions and engage with others. We also saw that 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 also told us that they carried out therapeutic interventions for people. However, they did not create programmes for care staff to follow so that people were supported therapeutically by care staff in between sessions with a qualified professional.

One member of care staff said, "I don't always feel confident with managing people's behaviour. We [staff] haven't had training in challenging behaviours. I need the knowledge". They added, "There is information in the care plans about how to manage behaviour, but I don't always get time to read these fully". Another staff member said, "I had one training course on challenging behaviour a long while ago, but I'd like more as people can become upset quite quickly". We observed staff delivering one to one support to two people living at Oak Farm, and we observed little interaction and stimulation. We also saw that staff did not always support people at mealtimes in a suitable way which respected their dignity, independence and choice. We concluded that staff were not always adequately trained to provide a high standard of individualised care to people living with complex needs in this environment.

We saw in records for two people, that they might become distressed on occasion and require staff to physically intervene to ensure their safety, but they did not contain adequate guidance about what this meant. Although a recent care plan updated in early April 2017 for one person stated that staff may need to use, 'physical intervention', the care plan did not contain any information about how, and when, staff should use this. We looked at records relating to a recent incident where one person had been restrained unsafely by a staff member who had not received any training in this area. This has resulted in significant anxiety for the person concerned and posed a risk of injury to the staff member. This meant that the impact of staff not having proper guidance or training in the area of restraint had a significant impact on their ability to deliver effective care, and in turn, protect people's rights and wellbeing.

We found that staff did not always ask people for consent before delivering care or support to them. We saw poor practice take place where this was concerned, for example, we saw one member of care staff go up behind one person's specialist tilting chair in the lounge, and tilt the chair up, without stating what they were doing or making themselves seen to the person. This could have resulted in distress for this person. In addition, on several occasions throughout our inspection, we saw different staff members move people in their wheelchairs from behind, or move their feet on their footplates, or wipe their faces, without interacting with them to gain consent or reassure them.

We spoke with staff about consent, and without exception, they were able to tell us about consent, and that it was important to not do things to people without obtaining verbal, or implied consent. However, we saw that they did not always put this into practice.

Consequently, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received an induction when they started working at Oak Farm, and this included a workbook about acquired brain injury. It also included shadowing more experienced staff and working alongside an experienced staff member so that they could check that new staff were competent in delivering different care and support tasks.

There was mandatory training that care staff were provided with that included training in first aid, catheter care and PEG feed care. One member of staff said, "I've done all my mandatory training, first aid, manual handling, and safeguarding". The physiotherapist and the occupational therapist told us about some additional training they were providing for the care staff in positioning people on shower chairs. A member of care staff said, "I get regular supervisions, and recently we [staff] had equipment training by the OT and Physio".

One nurse told us they received a lot of training, "Nurse's training covers end of life training, wound care, PEG feeds, catheter care, medicines, and tissue viability". Another nurse said, "I really enjoy working here,

training is very good". The physiotherapist told us about a useful course in acquired brain injury that they had attended, and this helped them to understand the needs of the client group at Oak Farm. We also found that the occupational therapist was knowledgeable about the client group and different approaches that could be used to improve outcomes for some people.

We observed the mealtime experience as part of our inspection visit. We found that improvements were needed to the mealtime arrangements for people. We saw that although people were given choices, they were asked the weekend before, for the coming week, what they would like for each meal. We saw that people were asked what they wanted to have verbally. The staff told us that with some people they had also used a book of photographs to support people making decisions. However, we saw that staff did not check people's choices with them when providing them with their lunches.

We observed staff supporting people to eat their meals. We saw two members of staff standing over the person they were supporting throughout their meal. One member of staff did not interact with the person during the entire meal. They did not explain what foods they were having or check that they were happy with their meal. We observed another member of staff to take a person's meal to the table and then leave again to get a chair. When they returned to assist the person we saw that they did not eat very much. The member of staff did not offer any encouragement or any alternative to the food they were given. The way that staff supported people during the mealtime did not promote a positive experience or maximise their nutritional intake. Two people said that they enjoyed the food they received and told us it was good.

We saw that staff regularly supported people to drink throughout the day, and most people living at Oak Farm required supervision and thickened fluids due to their health needs. For this reason, there were not always drinks available to individuals within communal areas as it may have posed a risk to those around them. One person told us, "I always have enough to drink." However, we felt that improvements were needed for staff to be more attentive to this during mealtimes and ensuring people were offered drinks whilst they were eating meals.

People were supported to access healthcare when they needed. This included regular access to a psychologist who worked regularly in the service. We observed a multidisciplinary team meeting where each person's health needs were discussed, and saw that consideration was given to whether any external referrals were required. Staff supported people to attend hospital appointments when needed, and a GP visited the home when needed. People were also supported to access services such as a chiropodist, and specialists such as a diabetic nurse, speech and language therapy, and learning disability nurse.

Requires Improvement

Is the service caring?

Our findings

We saw that some staff practices were not respectful and did not uphold people's dignity, for example the practices staff employed when supporting people to eat. We observed staff asking loudly over lunch for a dessert for one person from another care staff member, instead of asking discreetly at the kitchen. This was not respectful of the other people around or the person they were talking about. We heard another staff member talking about one person, saying, "Before [person] kicks off." This was not respectful language and did not uphold the dignity for the person.

The mealtime was a task focussed event, and we did not regularly see conversational interactions taking place with people. There were several occasions throughout the inspection where we observed up to four staff sitting in one communal area of the home at the same time, rather than interacting with people. There were many missed opportunities for staff delivering additional social stimulation to people.

We received mixed views from people living at the service about how caring the staff were. One person told us they were, "Reasonably friendly." Another person said that, "Some [staff] can be short-tempered." They said sometimes they told them to wait. A visiting relative said, "[Staff] have banter with [person]." Another visiting relative told us, "They do their job but they don't go beyond it." They did add, "The carers are happy and cheerful." We observed that staff did not always take opportunities to speak with, or to reassure people. However, we also observed some caring, kind and compassionate interactions between staff and people.

The care records for people were kept in a communal area of the home, and this meant that they were not kept confidential and therefore not respectful of people's privacy as anybody visiting would be able to look at them.

In some instances, staff supported people to develop their communication. The activities coordinator gave us an example of how they had supported one person to develop their communication over time, explaining the positive impact this had had on the person's confidence to go out and do more. The activities coordinator was also able to tell us about some people's preferred conversational subjects and interests. Staff we spoke with were also able to tell us about different people's needs and preferences, demonstrating that they knew people well.

There were some examples of people being supported to increase their independence. The occupational therapist gave us an example of how they had enabled one person to become more independent through using a particular technique with the person over time, which had empowered the person to orientate themselves more easily without staff intervention. However, some practices we saw did not promote people's independence, for example, when staff did not take opportunities to consult people about their care.

People's families were involved in their care and the setting of goals. One relative said, "[Staff] are professional, they answer queries, they involve us in [relative's] care." The physiotherapist and the occupational therapist showed families techniques they could use to support their relative. Relatives were

also involved in reviewing and developing people's care plans. The relatives we spoke with said that they were involved in discussing the care and support plan reviews or any changes, and we saw that records reflected this.

Families were able to visit the service when they wished, and the staff at the service facilitated people visiting their families when possible.

Requires Improvement

Is the service responsive?

Our findings

Pre-admission assessments took place for each person which the registered manager carried out to ensure that they could meet a person's needs prior to them moving in to the service. We saw from records that there was a lot of relevant information gathered about people, and that the relatives had been involved where appropriate. One person we spoke with confirmed that they had been asked a lot of questions about how they preferred things to be done, prior to moving in to Oak Farm.

People had detailed care plans in place, and these catered for their specific health needs. For example, we saw that for people with diabetes there was guidance for staff about checking their feet and symptoms of high or low blood sugar. People's care plans also contained information about their medical history, and contained guidance for staff about how they should support people with their positioning in a chair or bed, and how they should support people to move. Where people had specific, complex needs with regards to positioning, guidance was sufficiently detailed and was accompanied by photographs which aided staff in being able to check that the person was positioned correctly. There was also concise guidance about how staff should support people to communicate.

The care records contained information about people's preferences, for example, one person expressed that they preferred a female carer. For another person, the plan detailed how they liked to have their bath and listen to music. There was also information about people's lives, families and histories. Some people we spoke with said that they felt staff met people's preferences, however one person living at Oak Farm told us they sometimes felt they had to wait a long time for personal care, and became uncomfortable.

Care records also contained some people's goals. We spoke with the occupational therapist who worked with people to achieve their goals. They gave an example of supporting someone to access the community and working with them to achieve a voluntary work placement. However, there was no guidance or training for care staff which covered people's individual goals and how they could support them to achieve these. A visiting relative also explained to us that the therapists carried out movements with their relative to maintain their limb movements, a few times a week, but stated that there were no more opportunities for support with physical movement.

One person required a specialist piece of equipment to assist them when mobilising. The physiotherapist was the only member of staff trained to fit the equipment and when they were not working the person did not have the equipment to support them. There was several people who wore hand splints on a daily basis, and the staff told us that the occupational therapist, or an occupational therapy assistant, were responsible for applying splints. The splints were in place for various reasons, to aid people with comfort, or muscle spasticity as well as to manage potential pressure areas. The care manager told us that at times, for some people the occupational therapist handed this over to senior care staff to apply the splints at weekends, but some people who had more complex splints did not wear them over the weekend. This meant that they could not receive the same level of support throughout the week.

The people told us they received physiotherapy, and we spoke with the physiotherapist. They told us they

saw everyone at Oak Farm throughout the week, but some people more than others. They carried out different exercises and standing practice, walking and transfer practice with people. People only received physical therapy input during their sessions with the physiotherapist. Two people we spoke with said that they would like to have more physical therapy input. One person said that the standing helped them with pain in one side, so they would like to have the opportunity to do this more often. A visitor explained that the hand massage was very beneficial for their relative, and that they would prefer it to be done more often. We also saw that in a recent survey undertaken with a person at Oak Farm, that this issue was raised. One care staff member who we spoke with also told us that there were no activities on offer for people at weekends, and that they would like to see this improved.

The physiotherapist told us that they showed some relatives stretches and positioning techniques if appropriate. The therapy staff were flexible in trying different approaches and equipment to support people in the best way. One relative said, "[Occupational therapist] is brilliant, [they] go out of [their] way to figure out ways we can all help [relative]."

There were activities available for people during the week. We spoke with an activities coordinator who told us they were preparing for the summer fete, and they did group sessions with people. These included word groups, board games and art group. There was also a weekly session, facilitated by the physiotherapist, at the hydro therapy pool. One person told us that they really enjoyed these sessions.

People were provided with the opportunity to go out, for example, to a local tea room or garden centre. Other people regularly attended local day centres. However, we found that when we visited the service's own bus was out of action due to needing repairs. We saw from the provider's records that this had been the case for several weeks. In the meantime, people were supported to get taxis.

People were not always asked for feedback about the service in a way that they could reasonably understand or use. There were surveys in place which people could carry out with the assistance from staff or a family member, however these were not issued in an easy-read format which would empower and encourage people to give more feedback. One person told us, "I've never been asked for feedback, no." We saw that some people had given feedback via these surveys with the support from a family member or staff member. We saw that people were generally pleased with the care provided, however some people had commented that they would prefer more therapy input. The people we spoke with said that they felt comfortable to speak with staff if they had a problem. We saw from records that individual complaints had been investigated and resolved with people.

Requires Improvement

Is the service well-led?

Our findings

During the inspection visit we saw examples of poor practice from staff. The care manager and the registered manager told us that they did not routinely check staff competencies or make observations throughout their employment, unless there was a concern about their practice. We saw that staff were not checked regularly in terms of their day to day practice in care. We saw that for new staff without care experience, they were paired up with a more experienced member of staff who observed their performance. However, there was no system in place for monitoring how staff delivered care and performed in their roles through regular competency checking or observations. Therefore the management team could not assure themselves that staff had obtained a thorough understanding of their roles, or that they had received adequate training. Consequently, the concerns that we found during our inspection with regards to the competency of staff in some areas, had not been picked up.

The service had not kept up with best practice in terms of medicines auditing and administration. The system in place for auditing medicines was not effective as the concerns we identified regarding the safe management of medicines had not been picked up through the audits. The audit had not identified that PRN protocols needed to be in place, and that staff had not always written the correct dosage or counted stock correctly.

Although the provider's audit checked some care plans, the service had not ensured that plans and guidance was in place for staff when they were required to use physical restraint on people. That had resulted in the risk of unsuitable restraint practices which could put people and staff at risk of harm. There was not a system in place which had identified this as a concern.

There was not always an adequate skill mix of staff throughout the week, meaning that people received different levels of support despite what was written in their care plans. For example, when people were not able to mobilise or position themselves in the same way because they were supposed to wear a splint. This had not been identified by the service as an inconsistency and there was no system in place to check whether people were receiving the support they needed throughout the week.

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

There was not always a visible presence and contact with people from the registered manager at Oak Farm. One person told us, "I don't know who the [registered] manager is, no." Other people referred to the care manager as the manager of the home. A staff member told us that the registered manager was not a visible presence throughout the home. The staff we spoke with told us that other members of the management team were more visible.

Staff we spoke with told us they were happy working at Oak Farm. They told us they worked well as a team, one saying, "I really enjoy my job, it's very rewarding, and we [staff] are pretty good at team working". Another staff member confirmed, "It is a lovely team, that's what makes this place." Staff also felt well-

supported in their roles. One said, "I feel valued by all of the senior staff, and I am listened to". This was reflected by all the staff we spoke with.

There was a weekly multidisciplinary team meeting which the professional staff such as a nurse, a therapist and a psychologist who visited the service regularly attended. We observed this and found that they shared any new information or concerns about each person. The care staff had separate team meetings, where they discussed their roles and any changes. They said these were helpful, "We have regular staff meetings, and I feel I am listened to".

The service worked closely with others within the local community to improve people's access to the community and social interaction. The occupational therapist told us, "We've had lots of clients who have benefitted from learning and development services, work skills and day centres." They went on to explain how they were supporting one person to volunteer locally through working in partnership with other organisations.

The registered manager was knowledgeable about what notifiable events they were legally obliged to inform other agencies such as the CQC or the local authority of.

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 The service did not ensure that there protocols in place which guided staff on safely administering medicine and audits were not correct. Regulation 12 (1)

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 There were not enough systems in place to check that the service delivered high quality care and concerns were not identified. Regulation 17 (1) (2) (a) (b) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always an adequate skill mix of staff trained to deliver people's specific care and support needs. Regulation 18 (1) (2) (a)