

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 well-led?	Inadequate ●

Summary of findings

Overall summary

About the service

Oak Farm is nursing home providing rehabilitation to people living with brain injuries. The home can support up to 32 people and at the time of the inspection was supporting 22. There is both a main building which can accommodate up to 28 people and a smaller unit supporting four people.

People's experience of using this service and what we found

We had continued concerns around the provider's governance structure. Only limited aspects of service delivery were audited to provide the information required for service improvement. The service needed to be more proactive at working with partner agencies and ensure it collected the views of the people they supported and their families.

We found continued concerns in that people's care needs were not always effectively risk assessed and management plans, where developed, were not routinely followed.

Improvement had been made in both the safe recruitment of staff and the environment, which had been refurbished to allow for better infection prevention and control. Medicines were safely managed and families of people told us they were received, when needed, by staff who knew their role and were supported by a large enough team to meet their family's other support needs.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)

The last rating for this service was Inadequate (published 24 October 2018) and there were multiple breaches of regulation. At this inspection we found some improvements had been made however, the provider remained in breach of two of the regulations associated with safe risk assessment and good governance. We have also given two recommendations in relation to partnership working and gathering people's views.

The service has been in special measures since January 2020. During this inspection the provider demonstrated improvements had been made. The service is no longer rated Inadequate overall but remains inadequate in well led due to continued breaches over four inspections. As such the provider remains in special measures.

Why we inspected

We carried out an unannounced comprehensive inspection of this service on 4 and 5 November 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, fit and proper persons employed, the safe management of equipment and the premises, people's nutrition and hydration needs and the governance of the service.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements except regulation 14 which was also breached. Whilst we did not check the entirety of this regulation, we ensured people's nutrition and hydration needs were safely managed under regulation 12.

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 coronavirus and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oak Farm on our website at www.cqc.org.uk.

We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this report.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and the action the provider took to ensure the service delivered met the needs of the people living there. We issued a notice to place conditions on the providers registration. The conditions were aimed to assure us the provider took the required action to keep people safe. The provider must send the Care Quality Commission monthly reports on how they are monitoring and managing the risks to support people's health and wellbeing.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:

The overall rating for this service is 'Requires improvement'. However, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.
Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led.
Details are in our well-Led findings below.

Inadequate ●

Oak Farm

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 Care Act 2014.

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

Two inspectors completed a site visit when inspection activity started on 26 November 2020. The rest of the inspection was completed remotely finishing on 14 December 2020 when feedback was given.

Service and service type

Oak Farm is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who had recently begun working at the service. They were currently registered with the Care Quality Commission but at another of the provider's services. The manager was to deregister and re-register for this service. At the time of this inspection the provider was legally responsible for how the service was run and for the quality and safety of the care provided.

Notice of inspection

We gave a short period notice of the inspection so the provider had chance to safely arrange a room for the inspection team and gather evidence to leave in the room prior to our arrival.

What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is

information we usually require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service and looked at information available in the public domain. We used all of this information to plan our inspection.

During the inspection

During the inspection we spoke with six staff face to face or over the telephone and had contact with three others via email. We spoke with a range of staff including the manager, therapists, care coordinators, senior carers and carers. We also had contact with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with one person that used the service and three family members of people living in the service.

We looked at nine care plans on the electronic system and looked at paper records sent to us electronically. We also reviewed information on the management of the service including medicines records, team meeting minutes, personnel files and monitoring and audit information.

After the inspection

As this inspection was mostly completed remotely, we continued to seek clarification from the manager on the evidence reviewed until the draft report was written.



Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to assess and manage the risks to people living in the service. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- The provider had recently introduced an electronic care planning system which, when completed, showed where actions had been taken to mitigate identified risk. We found the system identified action had regularly not been taken and senior staff were not aware of this. This increased the risk of people not receiving the support they needed.
- We found risk assessments were not routinely followed, were not consistent with care plans and did not always identify risks to people. This included where one person chose to eat foods which were considered unsafe. Risk management plans were developed which stated this was mitigated by staff observing the person when they ate and being trained in first aid. Other records clearly showed that the person often chose to eat independently without staff observation, thus creating a risk which was not mitigated in line with the risk management plan.
- Records used to monitor the support provided to people at increased risk were often not completed in line with risk assessments. One person's malnutrition and dehydration risk assessment clearly identified action to take when the person refused food, monitoring information showed the person went long periods of time refusing food with actions identified to mitigate this, not being followed.
- The recording of accidents and incidents had improved since the last inspection. However, those records were not routinely signed off by the manager and did not result in risk assessments and care plans being reviewed and where necessary, updated to better support people where risks had increased.
- The manager told us, they believed issues were compounded with the electronic records as staff were not completing them accurately. We reviewed paper records for the monitoring of two people's food and fluid intake and the issues of inconsistency, poor recording and lack of action to mitigate observed risk, remained the same as on the electronic care planning system. This meant the issue may not be addressed by moving to paper records and more thought was required to improve records.

The provider failed to ensure that risk assessments always identified the action staff should take to mitigate identified risks. This is a continued breach of regulation 12 (Safe Care and Treatment) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had failed to maintain a safe and clean environment, this was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

- The provider had invested in the environment since the last inspection and areas of the service which had been more difficult to keep clean and free from contamination had all been replaced. The provider had taken additional steps and was following current guidance to ensure precautions were taken to minimise the risk and spread of infection.
- We were assured that the provider was preventing visitors from catching and spreading infections and they were providing guidance to meet shielding requirements and social distancing rules.
- Where PPE had not been previously accessible at point of need, this had been addressed and we were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was admitting people safely to the service and that the provider was taking action to reduce risks of infection outbreaks and had plans in place to manage them should they occur.
- The provider had an up to date infection prevention and control policy and we were assured that the provider was accessing testing for people using the service and staff.
- The provider had introduced additional cleaning procedures and hygiene practices and we were assured safety was promoted.

Staffing and recruitment

At our last inspection the provider had failed to ensure that staff were safely recruited to support vulnerable people. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

- Comprehensive audits had been completed on all personnel files and steps had been taken to gather any missing information and complete any required risk assessments. We also saw that each person employed since the last inspection had been consistently interviewed allowing a fair and equal opportunity to available posts.
- Staff were safely recruited and checks were made on their character from previous employers and on their suitability through the DBS service.
- Staff and family members told us there were enough staff on shift to meet the needs of people using the service. One family member said, "I have no concerns about the staff, there are enough of them and they all seem to know what they are doing." We found there were enough staff on site with the appropriate skills and knowledge to meet people's needs.

Systems and processes to safeguard people from the risk of abuse

- Everyone we spoke with told us people were safe in the service. One family member told us, "Staff working at the service are doing so for the right reason, they love their job and what to make a difference to [family

members] day."

- We saw safeguarding procedures were available to staff, they had received appropriate training and staff told us they knew how to raise concerns.
- The provider had raised concerns with the local authority as required.

Using medicines safely

- The provider had introduced a new electronic medicines management system. We were told it was working well and had reduced the risk of recording errors. Staff told us they had received enough training in the new system and were confident in using it.
- We observed a medicine round and saw medicines were administered as directed and in line with people's care plans. We completed a stock count of one person's medicines which showed us the medicine available was correct to that shown on the system.
- Family members we spoke with told us they understood people got their medicines on time and in a way they were happy with.
- The service had introduced new topical medicines procedures to improve practice found at previous inspections and we saw these were working well.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the last three inspections the provider has failed to show there was an effective system of good governance at the service. This has been a repeated breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider did not have an effective governance system. Audits and monitoring completed did not assure the provider had met the needs of people living in the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement has been made at this inspection and the provider was still in breach of regulation 17.

- Governance and oversight at the service required improving. This had been an issue for some time and we identified that audits and monitoring were not effective in identifying concerns and driving the improvements required.
- There had been a recent decline in the quantity and quality of audits completed. Some appeared to be simple tick lists with little content on issues or concerns which were evident. Actions we were told were to be taken to improve this area had not been implemented.
- We had ongoing concerns in relation to the quality and accuracy of care plans, daily records and the monitoring completed to support people with additional needs including dietary needs and people at risk of malnutrition. These records were still not being audited and the provider, did not have oversight of these records to ensure people received effective care that met their needs.
- Action plans sent to the commission following previous inspections where this regulation had been breached did not identify effective systems to address the concerns. Where action had been detailed to address concerns, there was no evaluation of its effectiveness.
- Some staff told us there had been times when communication had been poor, specifically when changes had been made to how the service was delivered. This included the introduction of the electronic care planning system and medicines system.

The provider failed to ensure an effective system was in place to assess, monitor and improve the quality and safety of the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- Whilst gathering information for this inspection we spoke with commissioners and representatives from the Local Authority. We were told of times when information had been difficult to obtain for investigations or delayed in being received. We were also told that when prompts had been made to the service to ensure appointments were being made for routine examinations and check-ups they were not made.
- We discussed this with the manager who, whilst new to post, was aware of some of the concerns, they assured us that steps would be taken to improve relationships with key stakeholders to ensure the service was meeting the needs of those it supported.

We recommend that the provider ensures reports and information are shared with partner agencies for the benefit of people living in the service.

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

- Whilst on site we saw some communications from family members praising the support provided to their loved ones. But there had not been a formal request for feedback in 2020 by way of a questionnaire or evaluation. Resident and family meetings had not taken place and family members we spoke with did not recall being invited to these or being asked for their opinion on the service their loved one received.
- A staff survey had been completed in 2020 but the information from this had not been collated to form an action plan to address any concerns raised.

We recommend the provider ensures feedback is gathered from the family members of people living in the service and where possible from people themselves to shape and improve the service.

- The commission received notifications from the service as required around specific incidents and the last inspection report was on display in the service and available on the provider's website.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not taken steps to ensure that risk assessments identified apparent risk, that those assessments showed suitable risk management and that the risk management was implemented to mitigate or reduce the risk. Regulation 12 (1) (2) a, b

The enforcement action we took:

issued NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not taken the required action to ensure an effective governance system had been developed, implemented and evaluated to ascertain its effectiveness. Steps taken to improve this area had not been introduced and oversight of the full service delivered remained poor. Regulation 17 (1) (2) a, b, c

The enforcement action we took:

Issued a NOP