Priory Education Services Limited

Oxen Barn

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

Oxen Barn provides accommodation for up to seven males between the ages of 18-65 with learning disabilities. This home comprises of individual self-contained accommodation, with en suite bedrooms, bathroom, lounge, dining room, kitchen and a large garden. The home is situated in the Longmeanygate area of Leyland in Lancashire and is in a quiet semi-rural area. People are placed from various local authorities due to the specialism of the service.

This inspection took place on the 17 and 24 March 2015 and both dates were unannounced. We also visited on a third day, 24 April 2015, specifically to follow up on two areas of concern that had been brought to our attention. We had previously inspected Oxen Barn on 13 June 2014. The service was found to be fully compliant under the six outcomes we looked at.

There was no registered manager in place at the time of our inspection. A temporary manager had been appointed who was overseeing Oxen Barn and a neighbouring location until a suitable replacement was found. We were told that a recruitment process was in place to fill the vacancy. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.

We found medicines were administered safely and that arrangements were in place to minimise risks associated with medicines by reducing the number of staff responsible for administering them. This was in response to concerns reported to the local authority in the later part of 2014. We found a small number of potential issues in relation to how medicine was labelled, dispensed and recorded. We have made a recommendation regarding medication procedures.

Staff were aware of their responsibilities to safeguard people from abuse and were confident to report any such concerns.

Principles of the Mental Capacity Act 2055 (MCA) had not been embedded into practice and we found some concerns over how people valid consent had been obtained.

Care plans for people at the home were not up to date. This meant that staff were referring to documents that did not accurately reflect the current assessed needs of each person living at the home.

People were supported to access routine health care services of a specialist nature. Care workers were able to recognise changes in people's needs and took appropriate action when they did so.

Staff at the service demonstrated a good understanding of their role and the needs of people they supported. However, staff were not supported to undertake their role effectively as they were not regularly supervised, appraised or trained. Inductions for new staff did not always take place or were not always completed.

The processes for monitoring quality and assessing risk across the service were not effective. This was because they had failed to identify a number of risks and areas for improvement prior to them happening. Management had shown lack of leadership around how the requirements of the MCA had been implemented within the service.

We found several breaches of the Health and Social Care Act (2008) (Regulated Activities) Regulations. These related to consent and capacity, supporting workers, care and welfare of service users and the monitoring of safety and quality across the service.

These breaches amount to breaches of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. These related to need for consent, staffing, safe care and treatment and good governance.

We want to ensure that services found to be providing inadequate care do not continue to do so. Therefore we have introduced special measures. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the

system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to cancel their registration.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staffing levels were not always in place to meet the assessed needs of the people in the service. This was evident when medicines were being administered: the person responsible for administering medicines was part of the staffing team on the rota to deliver dedicated staffing hours to people at the home, and this meant that those hours were not in place during the this time.

Due to recent staffing changes and changes in protocols, the medicines management processes needed to be embedded and appropriate training given to staff with a responsibility for administering medicines.

Staff were aware of their responsibilities to safeguard people from abuse and were confident to report any such concerns.

The home had effective recruitment policies and procedures in place which we saw in operation during our inspection.

Is the service effective?

Inadequate

The service was not always effective.

Whilst staff were observed to put the principles of the Mental Capacity Act into practice, their knowledge of what they were doing and why was limited.

Staff were not inducted, supervised or appraised with any consistency. Some staff felt they were not supported to carry out their role effectively.

People's nutritional needs were assessed and effectively monitored. People were provided with the support they needed to maintain adequate nutrition and hydration.

Is the service caring?

Requires Improvement

The service was caring.

Staff were knowledgeable about the people they cared for and spoke passionately about them to us.

We observed staff during our inspection and they displayed a caring, attentive and professional approach.

People were referred to other professionals appropriately to ensure there health and well-being were maintained.

Is the service responsive?

Inadequate

The service was not responsive.

Summary of findings

Relatives told us they knew how to raise issues and make complaints. However, they also told us that they did not feel confident that complaints or issues would be dealt with appropriately.

Care plans were being updated for all the people using the service at the time of our inspection however, we found information that was not up to date, incomplete and not signed or dated appropriately.

Whilst we were told, and saw some evidence that review meetings took place, care plans were not updated to reflect this. This meant that staff were referring to out of date information when providing care for people.

Is the service well-led?

Inadequate

The service was not well-led.

There were no appropriate and effective processes in place to make sure that the quality of service was assessed and monitored to ensure people received safe and appropriate care.

There was a lack of communication with both staff and people's families from management regarding the actions taken by the provider to make the necessary improvements to the service.

Oxen Barn

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 17 and 24 March 2015 and 24 April 2015. All dates were unannounced.

On the first day, the inspection was carried out by two adult social care inspectors including the lead inspector for the service. One of the Inspectors was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) lead within the Care Quality Commission (CQC). There was also an expert by experience present on the first day of the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection the lead inspector and a pharmacy specialist advisor attended the service. On the third day the lead inspector and an Inspection Manager attended the service.

Prior to the inspection we gathered information from a number of sources. This included notifications we had received from the provider about significant events that had occurred at the service. There had been a number of safeguarding issues prior to our inspection, mainly in relation to medication errors and the use of physical restraint. We had also received concerns from families of people who lived at the service, and had also received information from a solicitor representing one of the families of a person using the service.

We spoke with a range of people about the service, this included relatives of all seven people using the service, as six of the seven people living at Oxen Barn were not able to vocalise their opinion of the service and one person did not want to speak to us. 11 members of staff were spoken with including the acting manager, area manager and deputy manager for the service and commissioners of the service. The expert by experience spent time observing how staff interacted with people living at Oxen Barn as they were unable to communicate their opinion and experiences verbally.

We spent time looking at records, which included four people's care records, six staff files, training records and records relating to the management of the home which included audits for the service.

Requires Improvement

Is the service safe?

Our findings

We spoke with relatives of all seven people who lived at Oxen Barn and observed staff interacting with people throughout the first day of our inspection. When we asked relatives if they felt their loved ones were safe within the service the response was mixed. Positive comments included, "It is an improving service, a good place for my relative." "My (relative) is safe here, some staff go the extra mile". "(My relative) is looked after very well, I'm pleased with where they are living".

However, we did received negative concerns from some relatives regarding the safety of the service, namely regarding how medicines were administered and how staff were deployed. One relative told us, "I have real concerns with how medication is dealt with. There have been numerous occasions where mistakes have been made. There have been times when senior members of staff have called in sick and other staff have given medication who I don't think are appropriately trained to do so." Another relative told us, "I believe the lack of consistent staff has led to an increase in my relative's negative behaviour." A different relative told us, "I have concerns with some staff, some people who are meant to be on 2-1 (2 staff to one person receiving care and support) at all times only have 1-1 for long periods because the other member of staff is off doing something else. I think there needs to be more staff on at certain key times of the day".

The relatives we spoke with who had concerns told us that over the few weeks prior to our inspection that they could see the service begin to improve. This included a more consistent staffing team, improvement in communication and improvements to the environment of the building. This had been cited as another concern for some relatives. They did however think this was as a result of safeguarding involvement from the Local Authority and following concerns raised with the Care Quality Commission directly, as they felt that concerns and complaints they had made directly to the home had not been dealt with effectively.

We looked at the systems for medicines management. Senior managers for the organisation had taken all, except four members of staff, off medication duties until all staff had been re-trained. This was due to recent medicine administration issues. Detailed policies and procedures were in place and those staff with a responsibility for administering medicines told us that they had read and understood them. However, there was no written protocol identified for the use of homely medicines provided to people by their family, e.g. multivitamins.

All medicines stocks in the home had been re-ordered at the beginning or March 2015 to ensure that stock control was managed effectively. A registered nurse had been supporting the service to give advice on medicine management processes. All homely medicines and PRN (as required) medicines had been added to medication administration record sheets (MARS). A colour coded system had been introduced to remind staff of any special instructions. This review process needed to be included in to the medicines management processes to ensure practice was consistent across the service.

All medicines had a date received noted on the labels and liquid medicines and eye drops had a date opened annotated on the container. A daily audit had been introduced for each medicine to reconcile administration with remaining stock. This process had only been introduced two weeks prior to our inspection and needed to be reviewed regularly to ensure practicality and to ensure that any concerns were picked up and learning shared with all staff who administered medicines.

We found that some labelling of medicines needed to be optimised to provide more appropriate and clear instructions for staff, especially in the case of "when required" medicines and eye drops. This needed to be communicated to the pharmacist who provided the home with medicines. The ordering system had recently changed to an electronic ordering system for some of the people in the service which meant the home now ordered directly from the GP for those people. This had the potential to cause miscommunication between the home, GP and pharmacy as some people medicines were still being ordered via a paper based method.

We found a small number of potential issues in relation to how medicine was labelled, dispensed and recorded. One person had nine bottles of medicine which equated to approximately one week's supply per bottle. There was no order of how bottles were opened or which were in use and one bottle had the wrong dosage instruction. One person had a PRN medication that had been opened for 11 months and the medicines policy for the home stated that stock was not to be kept for longer than three months. One medicine had been dispensed by the pharmacy with no

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Is the service safe?

manufacture's expiry date as the original bottle was not in use. One person, due to previous issues with their medicine, had dual systems of recording in place for one of their medicine regimes. This meant that recording errors were more likely. The same person had a supply of an emergency medication for a particular condition. Only one person at the service knew how to use it, A protocol for the administration of this medicine needed to be produced and kept with the medicine so staff could administer it in an emergency.

We found that the MARS sheets contained no errors for the two week period prior to our inspection. We saw that all the people who lived at the service were stable on their current medicines. The team leader we shadowed on the medicines round had a good rapport with the people in the service and had a caring approach. They were knowledgeable about the home's processes and had good knowledge of each person and their medical needs. We observed that the process for administering medicines could take a few hours to complete and this time was not protected. As there had been a lot of changes at Oxen Barn, within staffing and processes, the medicines management processes would need to be embedded and staff provided with the appropriate training to ensure that the people in the service were fully supported with this element of their care.

Issues had been raised with the CQC and Local Authority about the inconsistency of staff and high use of agency staff over the previous few months prior to our inspection. Staff we spoke with told us they felt that staffing changes had affected the behaviour and mood of the people at the service. One member of staff told us, "The people here have been affected; they have had to get used to a new set of faces and get to know them (new staff). There has been no consistency for them although this is slowly getting better." Another member of staff said, "I think some people have regressed and a lot of good work has been undone, it's really frustrating."

We saw evidence by looking at staff rotas and speaking with staff that the use of agency staff had reduced greatly. This view was echoed by relatives we spoke with. As mentioned previously, the member of staff with responsibility for administering medicines would benefit from having that time protected as they were included on the staffing rota of which four people were on 2-1 staffing ratios and the other three people were on 1-1 staffing ratios. When the medicine round was taking place this meant that the appropriate staffing ratios were not in place during that time. There were processes in place that meant staff could position themselves to offer support if needed when incidents occurred, but staff we spoke with told us that this was not done with any consistency.

The service had procedures in place for dealing with allegations of abuse. Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns. Staff members spoken with said they would not hesitate to report any concerns they had about care practices. They told us they would ensure people who used the service were protected from potential harm or abuse.

The home had effective recruitment policies and procedures in place which we saw in operation during our inspection. We reviewed four staff files and found that pre-employment checks had been carried out. We found completed application forms, Disclosure and Barring (DBS) clearances, references and identification checks were in place. Staff we spoke with confirmed that they had attended a formal interview and did not begin work until appropriate references and employment clearances were obtained.

We would recommend that going forward, the person with responsibility for the medicine round is given protected time to ensure that medicines administration remains a high priority and that people receive their medicine in a timely manner. A commonly agreed system of medicines management would need to be introduced for all the people in the service.

Inadequate

Is the service effective?

Our findings

We spoke with families regarding how well the service helped their relatives to eat and drink. Some relatives told us there had been problems with this area in the past but told us that things had recently improved. We did not observe any issues with regards to people's nutritional and hydration needs during our inspection.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the acting manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We saw that policies and procedure were in place for Oxen Barn in respect of the MCA and DoLS. The current MCA policy (version 08) had last been reviewed on 22 February 2015. This was cross referenced with other policies for Consent and DoLS both of which had also been regularly reviewed.

One of the first statements contained in the policies and procedures for the MCA was: 'All staff will need to be familiar with Section 44 of the MCA'. Section 44 of the MCA defines a specific criminal offence relating to Ill-treatment or neglect of people who may lack capacity. None of the staff we spoke with were familiar with this. Staff we spoke with had not received training on the MCA and DoLS. Care staff were only able to give general answers about how they would obtain valid consent and had no detailed knowledge of the MCA or DoLS. The temporary manager had a good understanding of the MCA and DoLS, however he was the only one of the people we spoke with who did. The training list we were provided with showed a lack of training on the MCA and DoLS. Whilst staff were witnessed to put the principles of the MCA into practice, their knowledge of what they were doing and why was limited.

Care plans we looked at contained formal mental capacity assessments and tests where decisions around some aspects of care had to be made. We saw that these had only been completed where there was some suspicion that the person concerned may be unable to make the decision for themselves due to their cognitive level. They were not 'blanket' capacity assessments around a range of issues. Where people had been deemed to lack the capacity to make such decisions we saw best interest decisions had been made and recorded appropriately. Recordings were detailed and contained good rationale around the decisions made. However, we did note that all the capacity tests on care plans had been completed by a previous manager and dated as far back as 2012. They had been reviewed in 2014 but the review had consisted of a number of people; manager, staff and relatives signing and dating the back page of each capacity test instead of completing another up to date test and record. This meant there was no current record of the person's capacity around each decision. One of the capacity tests and subsequent best interest decisions we looked at was for the use of covert medication for one person. This is where medication is crushed up or mixed in with foods or liquids to ensure a person, who may be resistant to taking medication, receives their required medicine to keep them safe. The medication for the person had been changed since the first capacity test in 2013 and their capacity test or best interest decision did not reflect this.

We noted on one person's record, from a letter dated 11 December 2013, that they had been registered as an 'Organ Donor'. This was a person who had previously been deemed to lack capacity to make any decisions around their care and welfare. We saw no evidence of a capacity test or best interest decision around this enrolment. The previous manager had noticed this and made contact with a relative on 17 December 2013. However, from the email conversation we saw, the manager had just accepted from the relative that it had been done as part of the GP registration and was: "therefore fine". As result, the matter had not been pursued further. We spoke with the temporary manager about this situation. It was confirmed that the relative did not have any Lasting Power of Attorney (LPA) in respect of this person's care and welfare. LPA's are made by people at a time when they have full capacity. They legally grant other named people the authority to make decisions for them in the event that they should lose that capacity in the future. To register a person as an organ donor is a serious ethical and personal decision and should at the very least have been the subject of a capacity test and best interest decision, but more appropriately a decision for the Court of Protection (CoP) The CoP is a High

Inadequate

Is the service effective?

Court which protects the rights of vulnerable people who do not have the capacity to make some decisions for themselves. We asked the temporary manager to address this situation as a matter of urgency.

This was a breach in regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We spoke with the temporary manager at Oxen Barn about DoLS. We were informed that all seven people who lived at Oxen Barn were the subject of DoLS standard authorisations. We looked at the relevant documentation and care plans for these people. We saw that all aspects of the recording and filing of DoLS applications and subsequent authorisations were good. Where conditions had been placed on the home as part of a DoLS authorisation, we found that theses had been incorporated into the person's care plan. We saw good records when the home had issued themselves with an urgent authorisation for a person: a standard request had been submitted to the local authority and there had been a delay in the assessment process. As an example, if they had not heard anything from the local authority by the end of seven days there was evidence of chase up, extension requests and regular contact with the relevant local authority for each person.

The care plans showed people had been involved in planning their care as far as possible. We saw evidence where people had given valid consent and where people were unable to do so, we saw that their relatives had been involved in discussions around the care plan as part of best interest decision making. We saw within peoples care plans that referrals were made to other professionals appropriately in order to promote people's health and wellbeing. Examples included referrals to GP's, dentists, speech and language therapy, psychiatrists and opticians. We were given specific examples of how people had made progress with behavioural issues and how other professionals, as well as staff within the service, had worked together to achieve this.

There had been safeguarding issues around the inappropriate use of restraint which had been investigated by the local authority. On one occasion the safeguarding allegation had been upheld. The service, at the time of our inspection, was using an accredited form of restraint called, 'Team Teach'. This was to be replaced by another accredited form of restraint called, 'Proact-skip' in line with the organisations other adult services. We were told by the area manager that a training programme was to be rolled out in the near future to ensure staff were appropriately trained. Staff we spoke with told us they felt confident using the current restraint techniques and that they were trained to do so.

During our visit, we spent time in all areas of the home. This helped us to observe the daily routines and gain an insight into how people's care and support was managed. People were relaxed and comfortable with staff. Staff spoke to people in a considerate manner and used appropriate methods of communication. Communication aids were used, namely in the form of Picture Exchange Communication Systems (PECS) boards. These were placed at key points within the home for people living at Oxen Barn and a mobile PECS system was also used either via computer tablets or booklet. Issues had been raised regarding the use of PECS systems by relatives. For example, computer tablets not being charged or boards not being updated. We observed the PECS systems being used appropriately several times between different members of staff and people at the home. This included at lunchtime and when choosing activities. Activities that had been completed were removed from PECS timetables and staff were seen to encourage people to do this for themselves.

We spoke to staff and asked them if they felt supported by the service, both informally and through formal supervisions, appraisals and training. The responses we got were mainly negative. However, most of the staff we spoke with told us they had seen some improvements over the weeks preceding our inspection. One member of staff told us, "We are meant to get supervisions every six weeks; I haven't had one for over three months now. The current staff team are really good, they just need some guidance." Other staff told us that they had not had a recent formal supervision for a number of months, and one person not for nine months; others told us that they had not received a formal induction. One member of staff told us they were unsure if they had passed their probation period after working at the service for over six months. This was the period of time when the standard probation period expired. We did see evidence of inductions within some of

Is the service effective?

the staff files but this was inconsistent. A recent round of appraisals had been organised by the acting manager, and all the staff we spoke with had either had a recent appraisal or had one booked in over the coming weeks.

The lack of support given to staff through appropriate inductions, supervisions and appraisals was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Within the four staff files we looked at in detail, two did not have any record of an induction taking place. One had an induction plan within it but no dates or details had been completed other than a few initials by several sections. One file contained notes from a recent supervision (January 2015) which had been called in response to issues cited by the member of staff. These issues included the poor attitude of other colleagues, the poor state of the mini-bus used for transporting people and the potential neglect of one person at the service who needed their continence pad changing. No actions were noted within the supervision record, and no outcomes were noted. Neither the supervisor nor supervisee had signed or dated the record. Two people had received supervision sessions within the past six months; the other staff member had a supervision record within their file that had taken place over twelve months previously.

Staff responses with regard to training were similar. Staff could access e-learning which included areas such as safeguarding, moving and handling, infection control and a range of other 'mandatory' and some specialist subject areas. However, we were told that little in the way of face to face, practical or classroom based training was provided. One member of staff we spoke with told us that they were dyslexic, and had struggled with e-learning, although they had completed most of the course within the e-learning modules. We discussed these issues with the area manager and saw that face to face training in areas such as medicines management and restraint techniques did form part of the action plan the home in place.

Requires Improvement

Is the service caring?

Our findings

We asked people if they were happy with the care their loved ones received at the home and if they felt as though their loved ones, and they, had positive relationships with staff. The feedback we received was mixed. One relative told us, "(Name) is happy, they have lots to do and their support levels are good. They seem happy with staff and whilst staff do change, there are experienced staff here to support them." Another relative told us, "(Name) is looked after very well. I'm pleased with where they are. Staff are nice and I am kept informed. I'm aware of a few issues but I feel they are being dealt with". However, one relative we spoke with told us, "Some staff do not know my relative". Another relative gave us examples of poor care their relative had received, adding, "Some staff are ok, others are not so good."

We observed staff interaction with people living at the service throughout the first day of our inspection. In the main we saw that staff showed a very caring approach whilst spending one to one time with people. One member of staff was giving a foot massage to one individual and they told us that this was something they always tried to do whilst on duty as they knew how much that person enjoyed it. We saw a member of staff working on puzzles with another person who was engaged and obviously enjoying this activity as they were humming songs linked to the puzzles they were doing. The member of staff encouraged the person throughout the activity and challenged them in a positive way.

On a separate occasion we did see some poor interaction between staff and one person. The person living at Oxen Barn spent a lot of time looking out of the window and two members of staff had little interaction with him for a sustained period of time. On one occasion the staff spoke over the person to each other. This was fed back to the acting manager of the service on the day of the inspection who told us they would remind staff that this was not acceptable.

Staff we spoke with were knowledgeable about the people living at the home and showed compassion for the people they cared for. This was reflected in the conversations we had with staff who spoke very passionately about the people they cared for and reflected the fact that they wanted the best possible outcomes for people. One member of staff we spoke with told us, "The support workers here are really good; they do a heck of a job in a difficult environment. We all care about what happens here and want the best for the people living here but it has been really difficult with all the changes to keep any level of consistency for them." Another member of staff said, "I love the job I have, all I want is for the people here to be treated well and to have a brilliant life, it's the very least they deserve. Don't get me wrong, things are improving and there have been a lot of changes recently, but people have suffered, they haven't had the attention and input they have needed on a consistent basis. It's no wonder there have been issues." When we discussed these comments with the area manager at the service, there was an acceptance that the levels of care had dropped below an acceptable level. The management team told us that a range of additional support had been brought into the service several weeks prior to our inspection and we saw evidence to support this. The people we spoke with, including families and staff, conformed this to be the case. This had resulted in a more consistent staffing team and a reduction in the use of agency staff.

Prior to our inspection some families had raised issues with the CQC and Local Authority regarding a range of issues. Some of these concerns included dignity issues such as other people's clothing being worn and found in other people's rooms. There were also some issues raised regarding the cleanliness of people's bedrooms and bathrooms. We saw no evidence of unclean or untidy bedrooms, bathrooms or communal areas throughout our inspection visit. Relatives we spoke with did not raise any further issues regarding the environment of the home or dignity issues when we spoke with them. Each person, barring one, had had lockable medicine cabinets placed in their rooms so that they could receive their medicines in a more private and dignified manner. The person who did not have a cabinet had been assessed, that the risk assessment highlighted that this type of furniture was not appropriate.

The home had policies and procedures that covered areas such as confidentiality, privacy and dignity. Staff we spoke with told us how they provided intimate care and did so in a very professional, caring and compassionate way. They told us that they explained what and why they were carrying out certain tasks and that people's dignity was always considered.

Requires Improvement

Is the service caring?

We saw that some people used independent advocacy services. One person's care plan we looked at showed that they had access to an Independent Mental Capacity Advocate (IMCA). An IMCA provides independent safeguards for people who lack capacity to make certain decisions. We spoke with the person's IMCA who told us they had no concerns with the care provided by the home and they felt that they were cared for appropriately.

Inadequate

Is the service responsive?

Our findings

We looked in detail at four people's care plans and other associated care documents. We saw that care plans contained a wide range of information and were split into 15 different sections. It became apparent that care plans were, at the time of our inspection, being updated and reviewed. New templates had been inserted into some sections that were blank or incomplete. We asked staff if they found care plans helpful when providing care and assistance to people. We received a number of comments from people telling us that care plans had not been updated for approximately 12 months and therefore some of the information was not helpful. We found some evidence to back this up. In one person's care plan we saw that they had one and three month goals in place. Outcomes had been set for each but the last entry had been made over 12 months prior to our inspection. Within the same person's care plan the last 'behaviour support plan' had been completed by a former registered manager and was dated nearly 12 months previously. There were several other examples found of reviews and reports being over 12 months old. There were several examples of forms within care plans not being signed either by the service or next of kin / advocate. Some forms and assessments were not dated. One review form stated that a six monthly review would take place however, it was not apparent when the review took place so it would be impossible to know when that six month period was due.

We were told that one person had had a recent review of their care, and that several actions had been agreed as a result of this. None of this information had been transferred into that person's care plan over two weeks later. This meant that there was a risk that people would be providing care for that person without being aware of the agreed strategies from the review. We were told by the acting and area manager that care plans were being reviewed however, we could find a defined plan to do this, and there was little evidence to show that relatives were involved consistently in the process.

This was a breach in regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Relatives we spoke with told us they knew how to raise issues or make complaints. However, five of the seven relatives we spoke with did not feel confident that complaints, or general concerns they raised would be dealt with appropriately. One relative who had made a formal complaint told us, "It took several weeks for my complaint to be followed up and some of the agreed changes have not taken place." Another relative we spoke with said, "Some issues that I have raised in the past have not been dealt with. I was not told about a review meeting that took place either". Changes to management and staff were given as the main reasons for this happening. We saw that different relatives had different communication systems in place and due to this, and the changes in staff, this had contributed to some issues not being addressed appropriately.

We were told by the area manager that communication strategies were now in place with some families as a result of problems being raised by them. This was so that families were aware of what was happening at an agreed timescale. For some, this was on a daily basis. A newsletter was being drafted as another means of keeping families aware of what was happening at the service, e.g. staffing updates, training, activities, etc. We saw that a complaints file was in place and we saw that recent complaints had been acknowledged and followed up within an appropriate timescale.

We spoke to families and staff regarding activities that took place at the home. There were a number of planned activities that people were involved with externally, and transport was provided for this via adapted mini-buses. Activities included swimming, walks, cycling and visits to pubs and restaurants. We saw within people's care plans that individualised goals had been set for people to achieve, although as previously stated, much of this information was not up to date or accurate.

Inadequate

Is the service well-led?

Our findings

There was no registered manager at the service at the time of our inspection. The previous manager had resigned several months earlier. An acting manager was in post who was also the manager of a neighbouring home within the same organisation. The previous manager had been registered to manager both Oxen Barn and the nearby home, since the neighbouring home had been opened in October 2014. From speaking to families, staff at Oxen Barn and other professionals who visited Oxen Barn, such as social workers, there was a general consensus of agreement that this arrangement had not worked and was part of the reason the service had not picked up on issues earlier. We discussed this issue with the acting manager, area manager and other managers within the Craegmoor group who all recognised this as a problem. We were told that a registered manager would be appointed to each site independently and that the recruitment process had begun.

Families we spoke with talked positively about the acting manager. They felt he was knowledgeable, approachable and knew the needs of the people at Oxen Barn. However, it was apparent when speaking to families that there had been issues at the service in terms of how the service was led. We received a number of negative comments from them. One relative told us, "Things went downhill when Bannister (neighbouring service) started. There is no proper manager at the moment. The (Acting manager) is good and has the right personality to turn the service around but we have more or less given up on the service. It is run on a shoestring and we have no confidence in the senior management." Another relative told us, "Standards have dropped in the last 8-10 months". A relative for another person said, "The previous manager did not have experience of people with autism; the senior care staff were running things and they were running it badly. The (Acting) manager is good at his job and I can now say it is an improving service". There was recognition that the service was beginning to improve and almost all the families we spoke with stated that in the weeks preceding our inspection they had noticed improvements in a number of areas such as communication, staffing and the environment of the home.

We asked staff if they thought the service was well led. Again, there was recognition that the acting manager had made a difference over the previous few weeks and that as a result morale had begun to improve. It was very apparent that staff were unhappy with how the service had been managed for a number of months. One member of staff told us, "Morale is an issue and needs to improve. Management need to follow through on promises. Previous reassurances have not happened." Another member of staff said, "I only know what I'm doing when I arrive on shift due to my own knowledge. There is little guidance or support from managers. You get no rewards from the management: no incentives, or congratulations or thanks. You just get blamed for how bad things have become and told you can leave if you don't like it." One member of staff we spoke with told us that things were not well organised. They gave us an example of workmen turning up to carry out minor repairs to the building on the first day of our inspection. They said, "Staff had no idea they were turning up, things like that affect the people living here as it means they have a slightly different routine".

Staff raised issues with how colleagues were managed. They gave examples of ineffective management processes in relation to poor punctuality, people ringing in sick at the last minute, poor attitude and poor work ethic. We were told by the area manager that the area operations director and national operations director had visited the service over recent weeks to address some of these issues and impress on staff the importance of issues such as punctuality and attitude. The staff we spoke with confirmed this.

There was evidence of a lack of leadership around how the requirements of the MCA were implemented within the service. The temporary manager had a good understanding of the principles of MCA and DoLS but the provider and management team had not ensured this level of knowledge had been passed onto the staff team. This was evidenced through staff's lack of understanding of both MCA and DoLS, through the lack of coordinated training for care staff and the fact that the services own policies were not being followed as a result.

Three members of staff we spoke with said they had witnessed or experienced bullying whilst working at the home. They also said that the staff team could be 'clicky' at times. One staff member told us they had raised these issues with a manager, and had been told that their concerns would be acted on. But they told us, "Nothing is followed through." We passed these concerns on to

Is the service well-led?

management of the service, some of which they were aware of, and we were told they would be addressed. One issue was deemed as a potential safeguarding issue due to the inappropriate language used by a member of staff. This was reported through to the Local Authority safeguarding team by the area manager for the service and the staff member was suspended until an appropriate investigation had been undertaken.

A number of staff told us that the opening of the new service nearby had affected the operation of Oxen Barn, stating that a lot of experienced staff had left to take up posts within the new service. Families we spoke with also cited this as an issue and one relative told us, "This is when the problems started." We discussed this issue with the acting manager, area manager and operations director. There was a difference of opinion when speaking to managers in how the new service had impacted the quality of the service at Oxen Barn. One manager told us they felt it had had little impact whilst another admitted that the opening of the new service had not been managed well. They told us the opening of the new service had, "Caused difficulties at Oxen Barn as experienced staff had left to work at the new site."

We saw that there were a range of audits completed by the service and that these were inputted into the service's e-compliance system. Examples included behaviour logs to monitor incidents and accidents, weekly returns for staffing, training and predictors for use of agency staff. Weekly conference calls took place between registered managers, area managers and the head of operations every Friday. During these calls issues and areas of concern were discussed. Other audits included daily vehicle checks, weekly fire checks by the maintenance worker and medication audits which were now taking place daily due to previous issues at the service. We discussed with the area manager why some of the issues at the service had not been flagged as a result of these checks. We were told that the previous registered manager had not been inputting the required data into the system or reporting issues through to senior managers.

We found this to be a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 (2) (a) and (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We were told by staff that handovers did take place at the end and beginning of each shift and that this information was useful. We were also told that team meetings took place. However, team meeting notes were not formally written up or distributed and the area manager told us that they were available in a hand written format for staff to read if they wished to do so. We could find no system in place that made staff aware of this and staff we spoke to were not sure how to find the notes.

Since the beginning of 2015 a number of people within the organisation had been brought into Oxen Barn to address the issues at the service. This included bringing people in to look at medicine management, safeguarding recording, care planning and training. They had also spoke directly to staff about the various concerns. Staff we spoke with were unaware as to who some of the people were and what they were doing at the service. They were unaware what their role was to help improve the service. Whilst almost all the families and staff we spoke with stated that some improvements had been made, it was unclear as to how changes were being communicated with staff. A detailed action plan was in place, which did address the issues at Oxen Barn, and this had been shared with us and commissioners for the service. However, the fact remained that families and staff told us that communication remained an issue.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not protected people's human rights in accordance with the MCA and the DoLS.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that staff received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have suitable arrangements in place to make sure that care and treatment was provided in a safe way for service users. Regulation 12 (1) (2) (a) (b) (c) (e) (g) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have suitable systems in place to establish effective assessment, monitoring and improvement of the service. Regulation 17 (1) (2) (a) (b) (c) (e) (f).