Oakfield Psychological Services Limited

Wellfield

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Wellfield is a children's home which is registered for accommodation for people requiring personal or nursing care as well as treatment of disease, disorder, or injury. The service can accommodate two people. The service provides therapeutic psychological support to children and young people with mental ill health and additional needs, such as neuro-developmental disorders.

Ofsted are the lead regulator for services registered as children's homes, however, the service was not registered with Ofsted at the time of our inspection.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support: Model of Care and setting that maximises people's choice, control, and independence.
Right Care: Care is person-centred and promotes people's dignity, privacy, and human rights.
Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive, and empowered lives.

People's experience of using this service and what we found
We had continued concerns that the provider had not always taken all reasonable steps to make sure that risk management plans contained sufficient information to support staff in making sure that young people who used the service were kept safe from avoidable harm.

Although records indicated that most medicines had been well managed, there was not enough information to support staff to correctly administer an 'as and when required' (PRN) medicine. On occasions when this had been administered, records were not clear why it had been needed.

The way in which safeguarding incidents had been managed had not been consistent and safeguarding referrals that had been made to the local authority did not always contain enough information.

Systems had not been established to make sure that incidents had been reported, investigated, and managed in a way that reduced the risk of similar incidents happening again. This was not in line with the provider's own policies and procedures.

Although the provider had done a lot of work to update their policies and procedures, we found that important areas, such as information governance, were not covered. In addition, policies and procedures had not always been further updated to reflect the most up to date practice.

The provider had taken action to make some improvements following our last inspection. For example, more effective systems had been introduced to reduce the risk of absconding. Also, training records indicated that all staff had now completed appropriate safeguarding training for adults and children.

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 requires improvement (published 15 July 2022). This service had also been inspected on 1 and 2 June 2023 (published 21 July 2023) as well as 21 to 23 August 2023 (published 31 October 2023), and the service had previous breaches of regulations.

At this inspection, we found the provider remained in breach of regulations.

As this was a targeted inspection, the ratings from the last inspection have remained the same.

Why we inspected
The inspection was prompted in part due to concerns about the effectiveness of the provider's systems and processes to keep young people who lived at Wellfield safe. A decision was made for us to inspect and examine those risks.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, safeguarding and good governance.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At a previous inspection we rated this key question requires improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service well-led?

Inspected but not rated

At a previous inspection we rated this key question requires improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Wellfield

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.

This was a targeted inspection to check on a concern we had about the effectiveness of the provider's systems and processes to keep young people who lived at Wellfield safe. The ratings from the last inspection have remained the same.

Inspection team
The inspection was carried out by a lead CQC inspector, along with an additional CQC inspector.

Service and service type
Wellfield is a children's home which is registered with the CQC for accommodation for people requiring personal or nursing care as well as treatment of disease, disorder or injury. Ofsted are the lead regulator for services registered as children's homes, however, the service was not registered with Ofsted at the time of our inspection.

The service can accommodate two people. The service provides therapeutic psychological support to children and young people with mental ill health and / or additional needs, such as neuro-developmental disorders.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We used a range of information to plan this inspection, including on-going monitoring information such as complaints and concerns about the service, as well as information received from other stakeholders. We also used information that we found during our last inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with staff who worked at the service and members of the management team, including the registered manager, as well as professionals from other stakeholders such as the local authority. We also spoke with any young people who lived at the service.

We reviewed a range of information both during and following the inspection. This included important information such as care records, as well as policies and procedures.

Inspected but not rated

Is the service safe?

Our findings

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

At a previous inspection this key question was rated requires improvement. We have not changed the rating as we have not looked at all the safe key questions at this inspection.

This was a targeted inspection to check on a concern that we had about the effectiveness of the provider's systems and processes to keep young people who lived at Wellfield safe. We will assess the whole key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we found that not all safeguarding incidents had been effectively managed and that safeguarding referrals that had been made to the local authority had not been done in a consistent way and had not always contained enough information.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● Although records we reviewed during the inspection indicated that safeguarding information had been shared consistently with the local authority or social workers, we found that sufficient information about the safeguarding concern as well as the wider risk of the young people who used the service had not been included. This was also an area that we identified as an area for improvement during our last inspection.
● However, we did find that the provider had taken action to make sure that all staff had completed the required level of training for safeguarding children as well as adults. This was important as it gave staff the skills and knowledge to identify safeguarding concerns when needed.

Assessing risk, safety monitoring and management

At our last inspection we found that risk assessments had not been updated consistently. This was a breach of regulation 12(1) 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.

● Although the provider had many risk assessments and processes in place for young people who lived at Wellfield, we found that these still did not always contain the most up to date information. For example, we found that the minimum numbers of staff to provide support in the community safely did not reflect the most up to date practice that was being used.

● On arrival at Wellfield, staff directed us to paper copies of the most up to date care plan and positive behaviour support plan of young people who lived at Wellfield. However, we noted that the most up to date plans were not available, meaning that visitors or members of staff who did not visit Wellfield frequently would not have enough information about the current risks that were present.
● We also found that the provider had implemented strategies for staff to use, which were in addition to the risk assessments that were already in place. This meant that it was sometimes difficult to know which documents contained the most up to date information, and more importantly, meant the information contained within them was sometimes inconsistent, meaning that there was an increased risk that staff would not follow the correct guidance.
● Records indicated that the provider had recently introduced a crisis protocol as well as a risk pathway to support staff in supporting young people effectively. However, importantly, staff who we spoke with were not clear about this. This meant that there was an increased risk that 'high risk' items would not always be removed to keep young people safe.
● We identified continued concerns that the provider had not taken timely action to remove all known risks. For example, although there had been a high number of reported incidents between 24 August 2023 and the date of inspection when there had been inappropriate use of a mobile phone, it was unclear how the provider had taken all reasonable steps to reduce the risk of avoidable harm as much as practicably possible.
● However, we did note that the provider had taken further actions to better manage the risk of the young people absconding. This was important as on previous inspections we had identified that harm had been caused because of effective systems and processes not being in place. Staff who we spoke with confirmed that they now felt more confident in managing this risk effectively.

Staffing and recruitment

At our last inspection we found that not all staff had received the required level of training to undertake their roles effectively. This was a breach of regulation 18(1) 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 18.

● The provider had made some changes to the way that staff training had been recorded, meaning that it was easier to identify whether all staff had completed the minimum amount of training that had been identified for them to undertake their roles effectively.
● Records indicated that most staff had now completed important modules such as first aid training, which was an improvement since the last inspection.
● We also found that the provider had changed the way that training completed by agency staff had been documented, and steps had been taken to make sure that all members of agency staff who had worked at Wellfield between 24 August 2023 and the time of inspection had completed important training, such as safeguarding level 3 for children.
● However, despite improvements being made, we had continued concerns that the provider had not strengthened their overall systems and processes, meaning that there was an increased risk that these improvements would not be sustained.
● For example, the provider's training policy did not indicate the minimum level of training that agency staff were required to complete and did not indicate how often substantive staff were expected to complete refresher training.

● Staff at Wellfield included a small team of residential support workers who were supported by a clinical team, including a psychologist and assistant psychologists.
● We identified continued concerns that it was not clear how many staff were needed to keep young people at Wellfield safe. For example, although risk assessments for the young person stated that they needed to be always supported by a minimum of three members of staff, we were informed by staff that this was increased to four members of staff, particularly when supporting the young person in the community. This had not been reflected in risk assessments.
● We took time to review rotas between 24 August 2023 and the date of inspection, finding that a minimum of three members of staff had been achieved to support the young person on all occasions.

Using medicines safely
● We found that the provider had a medicines management policy that was in place at the time of our inspection.
● On reviewing medicines charts that had been completed between 24 August 2023 and the time of inspection, we found that medicines had been signed by two members of staff, which was in line with the provider's policy.
● However, on reviewing records, we were concerned that sufficient information was not available to staff regarding the administration of a PRN medication that had recently been introduced. This was important as PRN medication is only to be taken as and when needed, meaning that it is important for clear guidance to be available to support staff in understanding when to offer this medication.
● Although managers informed us that the use of this additional medication had been added to the young person's coping toolbox, records indicated that the PRN medication had been administered on most days since it had been introduced, but more importantly, records did not indicate why the medication had been administered.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service as the provider had not made sure that enough information was available to staff to support them to administer PRN medication safely. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

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 a previous inspection this key question was rated requires improvement. We have not changed the rating as we have not looked at all of the well-led key question at this inspection.

This was a targeted inspection to check on a concern that we had about the effectiveness of the provider's systems and processes to keep young people who lived at Wellfield safe. We will assess the whole key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection we found that systems had not been established to effectively monitor the services provided at Wellfield or effectively identify and manage risk. This was a breach of regulation 17(1) 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 17.

- Following our last inspection of 21 to 23 August 2023, we were informed that two members of the senior management team had left the service. We had concerns that the provider would be unable to make further sustainable improvements to the services provided. Managers informed us that they were currently in the process of recruiting a new manager which would add capacity to the management team.
- During the inspection, we found that actions had been taken to make improvements in some areas. For example, we found that most staff had now completed appropriate levels of safeguarding training for children and adults.
- Although we found that the provider had managed the risk of absconding more effectively, we also found that improvements had not always been made in other key areas. For example, information contained in risk assessments did not always provide enough information and was sometimes inconsistent, meaning that there was an increased risk that staff would not always have enough information available to help them keep the young people living at Wellfield safe.

At our last inspection we found that systems had not been established to make sure that policies and procedures were available or up to date with the most up to date information available to support staff. This was a breach of regulation 17(1) 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 17.

● Although the provider had done a lot of work to update all the policies and procedures that they had since a previous inspection on 1 and 2 June 2023, we found that there were still areas that required additional improvement. For example, we noted that the provider did not have an information governance policy. This was important as all providers are expected to keep information in a way that protects the privacy of people who use the services provided.
● Managers informed us during the inspection that archived electronic records had been transferred from the main storage drive to a portable drive, and that this would need to be found for archived information to be viewed. Importantly, the provider did not have policies and procedures which outlined how archived information should be stored securely.
● We also found that several key documents that had not been signed and dated. Because of this, for example, it was unclear when important actions had been completed, such as when managers had reviewed incidents, as well as when newly implemented protocols had been put in place.

Continuous learning and improving care

At our last inspection we found that systems had not been established to make sure that all reported incidents had been reviewed in a way that would identify all areas that needed further improvement and reduced the risk of similar incidents happening again. This was a breach of regulation 17(1) 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 17.

● We had continued concerns that not all incidents had been reported in line with the provider's policy. For example, between 24 August 2023 and the date of inspection, we found incidents that had happened which had been reported as safeguarding concerns but had not been reported as incidents. This meant that it was unclear what actions managers had taken to better understand what had caused these incidents, but more importantly, what actions had been taken to make improvements.
● Although managers informed us that they did not believe that all safeguarding concerns needed to be investigated as incidents, this contradicted the provider's incident management policy.