Oakfield (Easton Maudit) Limited

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Inspection report

Easton Maudit
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

During our inspection in April 2016, we found that although staff had an understanding of abuse and the safeguarding procedures that should be followed to report potential abuse, that the systems in place were not always followed which meant that appropriate action was not always taken to keep people safe from abuse or neglect. Potential safeguarding incidents between people had not been reported to the relevant external agencies. This was a breach of legal requirements and meant that systems and processes were not operated effectively to ensure that people were protected from potential abuse.

We also identified that the registered person had not consistently implemented effective systems or processes to assess, monitor and improve the quality and safety of the services being provided. Quality monitoring systems and processes were not always used as effectively as they could be to ensure that they were meaningful and that action was taken to make improvements when required. Audits checks and satisfaction surveys had been completed but there had been no attempt to analyse or have oversight of the outcome of these in order to drive future improvement. This was a breach of legal requirements.

Following the inspection the provider sent us an action plan detailing the improvements they were going to make, and stated that improvements would be achieved by 20 May 2016. During this inspection we returned to see if the service had made the required improvements. We found that the provider was now meeting these regulations.

This report only covers our findings in relation to the outstanding breaches of regulation. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Oakfield (Easton Maudit) on our website at www.cqc.org.uk.

Oakfield (Easton Maudit) provides care for up to 18 people who have a range of needs including learning disabilities. It is situated in the rural area of Easton Maudit, close to Wellingborough. On the day of our visit, there were 18 people living in the service.

The inspection was unannounced and took place on 5 July 2016.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection, we found that improvements had been made to the systems in place within the service, to ensure that safeguardings were reported appropriately to the local authority. Staff had strengthened their practice in respect of monitoring and overview of accidents and incidents to ensure that these should not be raised as possible safeguardings, and had worked hard to ensure the systems in place were more thorough.

We reviewed the audit and quality monitoring systems in place, and found that these had been strengthened. The processes in place were more robust and more regular audit checks were taking place of all aspects of supervisions and quality monitoring feedback. Because of this issues were now identified and addressed in a more timely manner.

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

We found that action had been taken to improve the safety of the service.

The systems and processes in place in respect of safeguarding management had been strengthened.

While improvements had been made we have not revised the rating for this key question; to improve the rating would require a longer term track record of consistent good practice. We will review our rating for safe at the next comprehensive inspection.

Is the service well-led?

Requires Improvement

We found that action had been taken to improve the management of the service.

We found that monitoring of quality assurance and audit systems had improved since our last inspection but required further time to become embedded. Because of the strengthening in the quality assurance systems, we observed an improvement to the way in which records were managed, monitored and updated.

While improvements had been made we have not revised the rating for this key question; to improve the rating would require a longer term track record of consistent good practice. We will review our rating for well-led at the next comprehensive inspection.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was now 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 5 July 2016 and was unannounced. The inspection was undertaken by one inspector.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We also spoke with the local authority and clinical commissioning group to gain their feedback as to the care that people received.

We spoke with two people who used the service to obtain their views of the care they received and to make sure they were happy with the care and support they received. We also spoke with the registered manager.

We looked at staff supervision records and further records relating to the management of the service, including safeguarding referrals and the systems to overview these. We also reviewed action plans and audit systems, in order to ensure that robust quality monitoring processes were now in place.

Requires Improvement

Is the service safe?

Our findings

During our inspection on 9 March 2016, we found that potential safeguarding incidents had not always been reported to the local authority or the Care Quality Commission (CQC) by the registered manager of the service. We checked accident and incident records which had been completed appropriately, with clear actions having been taken to ensure the safety of the person involved. However, the records we reviewed showed that some incident reports involved injuries, such as a scratch to one person's face or person to person incidents of aggression. As these incidents were not reported to appropriate external organisations, it was not possible for them to investigate and take action to ensure that people were safe from avoidable harm or abuse. In addition, there was no evidence to show that potential safeguarding incidents had been analysed or used to identify trends which may indicate that abuse had taken place. This meant that people were not always protected from avoidable harm or abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found that the provider had followed the action plan they had written, to meet shortfalls in practice as described above.

People told us they felt safe in the service and had no concerns about their safety. The registered manager and senior staff had made improvements to the systems in place to ensure that all accidents and incidents were monitored and overviewed, to determine if they should be raised as potential safeguardings. We were told that a solid relationship had been forged with the local authority safeguarding team, so that conversations could take place about any concerns which were raised. This source of additional information had improved the existing systems and processes and meant that staff had been supported to keep people safe. Records showed that since our last inspection, four safeguarding alerts had been raised with the local authority, along with appropriate action to ensure that people were kept safe. We found that the outcome of these were discussed with staff which meant that lessons could be learnt and the future delivery of service enhanced.

Requires Improvement

Is the service well-led?

Our findings

During our inspection on 9 March 2016, we found that although the service had monitoring systems in place, these had not been used as effectively as they could have been; for example, in respect of monitoring of accidents and incidents and whether these should be raised as potential safeguardings. In addition, we found that despite the service having had a full health and safety audit completed by staff in December 2015, no action had been taken to address areas identified for improvement or to implement dates for the completion of the required action points. Furthermore, we also identified that there had been not been consistent managerial oversight of staff supervision to ensure that all staff had received regular supervision in line with the provider policy. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found that the provider had followed the action plan they had written, to meet shortfalls in practice as described above.

The registered manager confirmed, and records showed, that the service now had a system to monitor and overview quality monitoring systems in more depth. Responsibility for monitoring staff supervision had been given to another staff member, who was able to overview when supervisions were due. Records showed that action had been taken to bring staff supervision up to date and ensure that this now happened on a more regular basis. Where action was required to be taken, in respect of the health and safety audit we reviewed at our last inspection, we found that supervisions detailed the content of what was discussed and gave clear timescales for completion of any required action.

The registered manager explained that formal analysis of the feedback from satisfaction questionnaires had taken place. We reviewed the outcome of this and saw that the information had been taken to drive future improvement and make changes for the benefit of the people who used the service.

We also found that action had been taken to make improvements to the audit systems and processes in place. The registered manager told us that the service would continue to work on streamlining processes to ensure that they were able to provide on-going monitoring and oversight of all service delivery. This showed that the service had taken action to address the breaches in regulation we found and had embedded systems to ensure that robust monitoring of service delivery could be maintained.