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

The published date on this report is the date that the report was republished due to changes that needed to be made. There are no changes to the narrative of the report which still reflects CQCs findings at the time of inspection.

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. At the time of our inspection there was one person using the service.

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
The provider had not always taken all reasonable steps to make sure that risk management plans had been updated when needed or had contained sufficient information to support staff in making sure that service users were kept safe from avoidable harm.

The way in which safeguarding incidents had been managed had not always been effective and effective safeguarding policies and procedures to manage allegations of abuse against staff were not in place.

The provider had not operated a system to assure themselves of the safety and quality of the services provided at Wellfield.

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.

The provider had not always made sure that staff had received the required level of training to undertake their roles effectively.

The provider had taken action to make some improvements following our last inspection. This included making sure that most daily, weekly, and monthly safety checks had been completed as well as making improvements to the way that environmental risk was managed.

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 again on 1 and 2 June 2023 (published 21 July 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.

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

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 and provided a rating for the service under the Health and Social Care Act 2008.

This was a targeted inspection to check whether the provider had met the requirements of enforcement action in relation to Regulation 12 (Safe care and treatment), and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. At the time of our inspection there was one person using the service.

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
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We used a range of information to plan this inspection, including on-going monitoring information including 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 the young person who lived at the service and their parent.

We reviewed a range of information both during and following the inspection. This included important information such as care records, court of protection orders 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.

The purpose of this inspection was to check if the provider had met the requirements of enforcement action we previously served. 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 staff had received the required level of training to undertake their roles effectively. This was a breach of regulation 13(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 13.

- On reviewing training records, we found continued concerns that staff had not completed the correct level of training for safeguarding adults, and it was unclear from training records how many staff had completed the training that had been made available. This was because the training matrix provided had not included this information, and following the inspection the provider was only able to provide evidence of a small number of staff having completed this.
- Although we found that the provider had informed the young person's social worker of all safeguarding incidents that we reviewed, we had concerns that safeguarding referrals that had been made to the local authority as direct referrals had not been done in a consistent way, meaning that there was an increased risk that the local authority responsible for the young person would not have effective oversight of all safeguarding incidents that had happened.
- In addition, when safeguarding referrals had been made directly to the local authority, we found that sufficient information about the safeguarding concern as well as the wider context of the young person had not been included.

Systems had not been established to safeguard service users from abuse and improper treatment as safeguarding incidents had not always been effectively managed. Safeguarding referrals that had been made to the local authority as direct referrals had not been done in a consistent way and had not always contained enough information. This placed people at risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At our last inspection we found that risk assessments and risk management plans 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.

We also found that systems had not been established to make sure that effective strategies used to mitigate identified risk to young people, as much as practicably possible, were in place and had been consistently followed. 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.

● We noted during this inspection that the provider had changed the way that documentation was used to capture risks for young people who lived at Wellfield. This made risk assessments easier to find.
● Although we found that some improvements had been made to improve the consistency in the way that risks had been documented, we found that the strategies in place for staff to follow had not always been effective and that they had not always been followed.
● For example, on one occasion, the young person who lived at Wellfield absconded, accessed the community, and came to harm as a result. Because of this incident, the young person had needed further access to other services so that their needs following this incident had been met. On review of this incident, the provider had failed to put all necessary strategies in place to support staff in keeping the young person safe, and where these had been put in place, staff had not always followed them.
● In addition, we saw that there had been a further incident of when the young person had absconded, and was left without timely intervention from staff, leading to increasingly escalated behaviour, exposing the young person to an increased risk of harm.

At our last inspection we found that that important safety checks had not been completed when needed. This was a breach of regulation 12(1) 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 12.

● We took time to review documentation which had been used to record important daily, weekly, and monthly checks, such as daily room checks and phone sweeps. We found that the way in which these had been documented had been made clearer, and on sampling these, we found that checks had mostly been completed when needed.
● Although improvements had been made, we identified concerns that improvements made had shown signs of not being sustained. For example, the personal items belonging to the young person who lived at Wellfield had been signed in and out before and after use during June and July 2023. However, in August 2023, we found that this had not been done consistently in August 2023, potentially exposing the young person to an increased risk of avoidable harm.

At our last inspection we found that systems had not been established to make sure that all known risks had been mitigated as much as practicably possible when young people had been admitted to Wellfield. This was a breach of regulation 12(1) 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 12.

● During this inspection managers informed us that changes had been made to the policies and processes that related to admissions of young people at Wellfield. We saw that improved checklists had been put in place to better support the admission process, which included important information such as safety as well as meeting individual needs.
● Although we found that improvements had been made to these processes, we could not fully assess the effectiveness of the changes made as there had not been any admissions to Wellfield since our last inspection.

At our last inspection we found that systems had not been established to make sure that all environmental risks had been identified or mitigated as much as practicably possible. This was a breach of regulation 12(1) 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 12.

● We found that the provider had taken action to identify and mitigate environmental risks at Wellfield. For example, we found that ligature risks had been assessed and removed as much as possible. In addition, during the inspection we found that staff areas had been kept locked at all times, reducing the potential risk of harm to the young person who lived at Wellfield.
● The provider had also taken action to make sure that important health and safety checks had been completed, such as portable appliance testing (PAT).

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.

● We took time to review training records for staff who worked at Wellfield. Although the provider had made some improvements to the way that oversight of training completion had been kept, we had concerns that the provider was unable to provide evidence that staff had completed all training that had been required.
● For example, at the time of inspection, the provider was unable to provide evidence that staff had completed the Care Certificate at the start of their employment (The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme).
● Following the inspection, the provider submitted further evidence that only three members of staff had completed this.
● In addition, we found that staff had not completed all elements of other training that had been required.

For example, evidence of safeguarding training for adults and children was limited. Also, only five out of 11 staff who worked at Wellfield had completed first aid training.

● Following the inspection, evidence was provided that two further members of staff had completed first aid training since the inspection.

● We also had concerns that the provider had not made sure that agency staff who worked at Wellfield had completed all training that was needed for them to undertake their roles safely and effectively. For example, on reviewing records for agency staff during the inspection, there was no evidence of any of them having completed safeguarding training for adults and children.

● Following the inspection, evidence was provided that one member of agency staff had completed safeguarding training for children, and another had completed safeguarding training for children and adults since the inspection.

● Importantly, we noted that there had been a recent incident reported when a member of agency staff had behaved inappropriately with the young person who lived at Wellfield, and the provider had to act following this to make sure that they had completed safeguarding for children. Despite action being taken for this incident, the provider had failed to apply any learning from this, and had not sought similar assurances for other members of agency staff.

● The provider was unable to provide evidence of training for all members of the senior management Team. For example, we did not see any evidence that the unit manager had completed all training, this included training on safeguarding children and safeguarding adults, as well as restraint training. Importantly the unit manager was part of the on-call rota and was responsible for giving advice to staff on actions to keep children safe in the event of an emergency.

● Staff at Wellfield included a small team of residential support workers who were supported by a clinical team, including a psychologist and assistant psychologists.

● It was not clear how many staff were needed to keep young people at Wellfield safe. For example, although risk assessments for one 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 from lunchtime onwards. This had not been reflected in risk assessments.

● We took time to review rotas for August 2023, finding that a minimum of three members of staff had been achieved to support the young person on all occasions.

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.

The purpose of this inspection was to check if the provider had met the requirements of the enforcement action we previously served. We will assess the whole key question at the next comprehensive inspection of 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

- During the inspection, we found that the provider had implemented a new policy and procedure covering the Duty of Candour. On reviewing these, we found that sufficient information was contained within these to support staff in discharging their legal responsibility to be open and honest with people when something goes wrong.
- However, we found that the provider had not recognised when this had been needed or had undertaken the Duty of Candour in line with their own policies and procedures, as well as legislation. For example, we found one occasion when the young person who lived at Wellfield had come to harm because of provider failures. On speaking to managers, as well as reviewing documentation, there was no evidence of how the Duty of Candour had been applied to this incident.

Systems had not been established to make sure that the provider acts on the Duty of Candour when needed. This placed people at risk of harm. This was a breach of regulation 20(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- Since our last inspection, the provider had recognised the need to add additional capacity to the management team and had recruited a manager who was responsible for maintaining oversight of Wellfield

on a day-to-day basis.
● However, following the inspection, we were informed that two key members of the provider's management team had left, including the manager, meaning that we had further concerns that the provider would be unable to make further sustainable improvements to the services provided. At the time of inspection, the provider informed us that they had advertised this vacancy and intended to recruit a new manager as soon as possible.
● During the inspection, we found that actions had been taken to make improvements in some areas. For example, we found that environmental risks had been better managed and that safety checks had been better completed.
● However, we also found that improvements had not always been made in key areas. For example, we found that important information for staff had not always been available as well as occasions when guidance had not been followed by staff, leading to occasions when the young person had been exposed to an increased risk of as well suffering avoidable harm.
● We also found examples of when some improvements had been made, but there were concerns that these had not been sustained. For example, the personal items belonging to the young person who lived at Wellfield had been signed in and out before and after use during June and July 2023. However, in August 2023, we found that this had not been done consistently in August 2023, potentially exposing the young person to an increased risk of avoidable harm.

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.

● The provider had done a lot of work to update all the policies and procedures that they had since the last inspection. Most policies and procedures better reflected the services that were provided at Wellfield.
● However, we had concerns that although revised policies and procedures contained up to date guidance, these had not always been followed or understood, meaning that they would not be fully effective. For example, we saw one occasion when the need to act on the Duty of Candour had not been undertaken, despite the provider having put improved policies and procedures 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.

● The provider had a policy and procedure for identifying and reporting incidents. For example, incidents had been reported on occasions when restraint had been used.

● We found that the provider had made improvements to the way incidents had been documented, including what actions had been taken following incidents. We also found that incidents of restraint had been better documented and had included more detailed information about the management of restraint.
● However, we had continued concerns that the information that had been captured in incident reports was not always clear. In addition, we also had concerns that the provider had not always recognised areas that needed to be improved, meaning that actions had not always been taken to make further improvements to prevent similar incidents happening again.
● We identified concerns that not all incidents had been reported in line with the provider's policy. For example, 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.