Oakfield Psychological Services Limited

Wellfield

Inspection report

City Gate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Tel: 01619451378
Website: www.oakfieldpsychservices.co.uk

Date of inspection visit:
01 June 2023
02 June 2023

Date of publication:
04 January 2024

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
This was a targeted inspection that considered parts of the safe and well-led key questions. Based on our inspection of these areas, we found areas that the provider needs to make further improvements to keep children who use the service safe.

An admissions and discharge policy was in place, however, it was unclear how all information that had been made available from previous placements had been used in a way to keep young people safe upon admission to Wellfield.

Although many risk assessments and risk management plans had been completed, information contained in these plans was inconsistent and did not provide the most up to date information for staff to follow.

Systems had not been established to make sure that effective strategies used to mitigate identified risk to young people were in place and had been consistently followed.

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

Systems had not been established to make sure that all environmental risks had been identified or mitigated as much as practicably possible. For example, ligature risks had not always been identified and information to support young people and staff to exit in the event of a fire had not been updated.

The provider had not operated a system to effectively monitor the care provided at Wellfield or effectively identify and manage risk.

The provider had not made sure that policies and procedures were available or up to date with the most current information. This meant that staff were not always supported to provide safe care.

Although incidents had been reported, it was not always clear how these had been reviewed in a way that would identify all areas that needed further improvement to reduce the risk of similar incidents happening again.

Staff and leaders at Wellfield had worked jointly with external partners when needed. This included working closely with social workers and practitioners from other services such as Child and Adolescent Mental Health Services (CAMHS).

The provider had taken action to make some improvements following our last inspection.

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) 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
We undertook this targeted inspection to check on a specific concern we had about how young people who lived at Wellfield were being looked after safely.

We use targeted inspections to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

During this inspection, we also followed up on actions we told the provider to take at the last inspection.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches and have imposed conditions on the provider's registration in relation to safe care and treatment, good governance, and safe staffing. Although the provider took actions to address the concerns after the inspection, further improvements are still required.

Please see the action that we have told the provider to take at the end of this report.

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

The service was not always safe.

Details are in our safe findings below.

At our last 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

The service was not always well-led..

Details are in our well-led findings below.

At our last 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 on a concern we had about how young people who lived at Wellfield were being looked after safely.

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
This inspection was unannounced.

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.

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 our last inspection this key question was rated requires improvement. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check a concern we had about whether young people who lived at the Willow had been kept 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

- The provider had an up-to-date policy and procedure for safeguarding both children and adults. This contained important information, such as types of abuse, when referrals should be made and who this should be completed by.
- During the inspection, we sampled incidents that had been reported, and found that information had been shared appropriately when safeguarding concerns had been identified. The provider had kept a log which provided an overview of all safeguarding referrals.
- Leaders informed us that all staff had been required to complete level three safeguarding training for children as well as level two safeguarding training for adults, which was in line with best practice guidance. However, records indicated that not all staff were up to date with this. For example, only three out of nine staff were up to date with level three safeguarding training for children.

Systems had not been established to make sure that all staff had received the required level of training to undertake their roles effectively. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Although we found that an admissions and discharge policy was in place, it was unclear how all information that had been made available from previous placements had been used in a way to keep young people safe. For example, although one young person had a significant risk of absconding, the provider had not taken all reasonable steps to mitigate this as much as practicably possible.

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 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.

- We noted that there had been a high number of adverse incidents reported between 25 April 2023 and 2

June 2023 which had placed young people at an increased risk of avoidable harm. On reviewing these incidents, it was not clear whether the provider had taken all necessary steps to reduce the risk of these incidents happening as much as practicably possible.
● Records indicated that many risk assessments and risk management plans had been completed for young people who lived at Wellfield. However, we found that the information contained in these plans was inconsistent and did not provide the most up to date information for staff to follow. For example, care plans for one young person did not clearly identify the minimum number of staff that were required to care for them safely, nor did it include information about when this should be decreased or increased.

Systems had not been established to make sure that risk assessments and risk management plans had been updated consistently. 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.

● Although staff who we spoke with were aware of the risks that were posed by the young person living at Wellfield, staff were not always clear about up-to-date strategies that had been implemented to mitigate the risk to the young person as much as practicably possible.
● Strategies used to keep the young person safe, such as when accessing the community, had sometimes been ineffective. For example, although leaders informed us that safe access to the community was determined by the young person's mood, this was not clear in the risk assessments and risk management plans that we reviewed. Staff who we spoke with had a mixed understanding of this also.
● Although one young person presented as a high risk of absconding, it was unclear whether the provider had taken all reasonable steps to reduce the risk of this. For example, although leaders were committed to using restrictions for one young person as little as possible, it was unclear how the restrictions available had been used in a way to keep one young person safe.
● Strategies used to manage the risk of self-harm had sometimes been ineffective. For example, there had been one occasion when a young person had accessed a community setting outside of the times that had been agreed and with insufficient numbers of staff. This had placed the young person at an increased risk of harm.

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 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.

● Following the inspection, the provider informed us that they had made changes to the environment to better manage the risk of the young person absconding. In addition, the provider acknowledged that improvements were needed, and indicated that they planned to change the way that risk assessments were documented, helping make sure that staff had access to the most up to date information.
● Records indicated that important safety checks had not always been completed, meaning that there was an increased risk of avoidable harm to young people living at Wellfield. For example, daily checks of one young person's room had not been completed on five occasions during May 2023. This was important as this was to make sure that there were no unsafe items available for the young person to injure themselves or others.

Systems had not been established to make sure that important safety checks had been completed when needed. 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.

● We found that environmental risks that were present at Wellfield had not always been identified or effective action had not always been taken to reduce these as much as possible. For example, ligature risks had not always been identified, and staff areas had not always been locked, placing young people at increased risk of harm.
● We noted that the provider had completed fire risk assessments and that regular fire drills had been undertaken. However, planned exit routes for young people and staff to use in the event of a fire were not always available. The provider took action during the inspection to rectify this.
● The provider had not operated an effective system to make sure that all portable appliance testing (PAT) had been completed to check for electrical safety. Although records indicated that this had been completed by a third-party provider, we found electrical items at Wellfield that had not been tested. Following the inspection, the provider informed us that outstanding checks had been completed.

Systems had not been established to make sure that all environmental risks had been identified or mitigated as much as practicably possible. 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.

Staffing and recruitment

● 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, leaders informed us that one young person required 3:1 staffing. However, although we were informed that this had sometimes needed to be increased, it was not clear how this had been determined.
● We were informed during the inspection that staff retention had been a recent challenge, meaning that an increased number of agency staff had been needed to fill shortfalls. Rotas that we reviewed for May 2023 indicated that a minimum of 3:1 staffing had been achieved on most occasions.
● Records indicated that staff had received an induction at the start of their employment. Initial training included a variety of courses, including modules designed to meet the standards set out in the Care Certificate. 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.
● However, training records indicated that only three out of nine staff had fully completed this. Importantly, training records did not indicate which parts of the care certificate had not been completed.
● Although staff who were employed permanently had completed training in the use of restraint, it was unclear whether an appropriate level of restraint training had been completed by all members of agency staff who had worked at Wellfield. This was important as the use of restraint had been needed on a high number of occasions.

Systems had not been established to make sure that all staff had received the required level of training to undertake their roles effectively. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were informed that all new members of staff, including agency staff were required to complete a location specific induction at Wellfield. In addition, the provider had developed a 'golden book' as an easy access reference guide so that staff had access to important information all in one place.

Using medicines safely

● The provider had an up-to-date medicines management policy. At the time of our inspection all medicines were locked away securely and had been prescribed appropriately by an external prescriber.
● Medicines administration records had been completed regularly and reconciliation records were accurate.

● Records indicated that medicines had been administered by two members of staff, which was in accordance with the provider's policy. All staff had received appropriate training to manage and administer medicines safely.

At our last inspection we found that medicines had not always been administered in line with the provider's policies and procedures. This placed people at risk of harm and was a breach of regulation 17(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 17.

● During this inspection, records indicated that when medicines had been administered or disposed of two members of staff had signed to confirm that this had been completed, reducing the risk of medicines being administered in an unsafe manner.

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 our last 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 a concern we had about whether young people who lived at the Willow had been kept 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

● The services provided at Wellfield were overseen by a senior management team which consisted of a registered manager, a nominated individual, a governance lead as well as a psychologist. Although a manager had not always been available on site at Wellfield, leaders informed us that a member of staff had been identified on every shift as a team leader.
● However, it was unclear how the arrangements that were in place had been fully effective. We noted that plans were in place to recruit a new manager to oversee the service provided at Wellfield, and the provider had planned for this to include an increased on-site presence.
● The provider had some systems in place to monitor the services provided, including health and safety as well as cleaning checklists. Although we found that these had been completed regularly, they had not been effective in supporting leaders to recognise areas of poor performance.
● For example, although daily, weekly, and monthly checklists were in place for staff to complete, important areas such as portable appliance testing (PAT) not being completed had not been recognised. In addition, it had not been recognised that other important safety checks, such as daily room sweeps had not always been completed.
● Although regular management meetings were held to discuss the risk posed to young people at Wellfield, and to agree if changes to care plans were needed, inconsistencies in risk assessments and risk management plans had not been recognised, meaning that staff did not always have the most up to date information available to keep young people safe.

Systems had not been established to effectively monitor the services provided at Wellfield or effectively identify and manage risk. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● An effective system was not in place to make sure that policies and procedures were available or up to date with the most recent information available to support staff.
● For example, the policy for breakaway and physical intervention was not available for staff to follow,

despite other policies indicating that this was in place. In addition, we noted during the inspection that the provider did not have a policy for induction and training, meaning that it was unclear what the minimum level training was and how this would be monitored.
● Following the inspection, the provider indicated that an induction and training policy had been implemented. However, this did not indicate important information, such as how often refresher training would be undertaken.

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 placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that the provider had not notified CQC of all notifiable incidents, which did not meet the requirements set out in the Health and Social Care Act (Registration) Regulations, 2009. This was a breach of regulation 17(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 17 regarding this issue.

● During this inspection, we found that improvements had been made, and notifications to CQC had been made for all reported incidents that we were made aware of during the inspection and met the criteria of being a notifiable incident.

Continuous learning and improving care

● The provider had a policy and procedure for identifying and reporting incidents. For example, staff had regularly reported when there had been incidents when restraint had been used.
● We sampled incidents that had been reported during the inspection, finding that a manager had reviewed them. There was evidence that some actions had been taken to make improvements to the services provided when needed.
● However, on reviewing incident reports, it was not always clear how reported incidents had been investigated in a way that identified when there had been a gap in wider systems and processes. This was important, as although there was evidence of immediate actions been taken, there was an increased risk that similar incidents would happen again.
● Staff had recorded the use of all restraint that we were made aware of during the inspection on incident report forms. These supported members of the management team to understand the type of restraint that had been used, how long it had been used for and whether it had been the least restrictive option.
● However, it was unclear how leaders had used this information to review all incidents of restraint and to determine if improvements to the way restraint had been used had been needed. This was important as for one young person, the use of restraint had been needed regularly, and sometimes for extended periods of time.

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 placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were informed that a weekly call involving all staff was undertaken to discuss concerns, disseminate any important information and to share improvements that had been made. We reviewed minutes of these meetings which indicated that this had occurred regularly.

Working in partnership with others

● Staff and leaders at Wellfield had worked jointly with external partners when needed. This included working closely with social workers.
● Leaders informed us that they had worked closely with a practitioner from the Child and Adolescent Mental Health Service (CAMHS) to help transition a young person to Wellfield. We found that the CAMHS professional had visited the service on a regular basis to provide additional support and advice on how best to manage the risks that had been identified for the young person.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 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. Systems had not been established to make sure that risk assessments and risk management plans had been updated consistently. 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. Systems had not been established to make sure that important safety checks had been completed when needed. Systems had not been established to make sure that all environmental risks had been identified or mitigated as much as practicably possible.

The enforcement action we took:

Following this inspection, we imposed conditions on the provider's registration in relation to breaches of Regulation 12; Safe care and treatment. The provider must not admit any service user to Wellfield without the prior written agreement of CQC and the provider must submit a report to CQC by 12 July 2023, setting out the actions taken to implement a safe and effective system for the assessment and management of admissions to Wellfield.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established to effectively monitor the services provided at Wellfield or effectively identify and manage risk.

	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. 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.

The enforcement action we took:

Following this inspection, we imposed conditions on the provider's registration in relation to breaches of Regulation 17; Good governance. The provider must not admit any service user to Wellfield without the prior written agreement of CQC and the provider must submit a report to CQC by 12 July 2023, setting out the actions taken to implement a safe and effective system for the assessment and management of admissions to Wellfield.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Systems had not been established to make sure that all staff had received the required level of training to undertake their roles effectively.

The enforcement action we took:

Following this inspection, we imposed conditions on the provider's registration in relation to breaches of Regulation 18; Safe staffing. The provider must not admit any service user to Wellfield without the prior written agreement of CQC and the provider must submit a report to CQC by 12 July 2023, setting out the actions taken to implement a safe and effective system for the assessment and management of admissions to Wellfield.