Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Harwood House

BRIDGEND

Mae’r adroddiad hwn hefyd ar gael yn Gymraeg

This report is also available in Welsh

Date of Publication

22 February 2019

Description of the service

Summary of our findings

Harwood House is a children's home operated by Bridgend County Borough Council. The home can accommodate up to three children aged 8-19 years who have a learning disability. There is a manager in post who is registered with Social Care Wales and the responsible individual is Laura Kinsey. The home is located in a residential area of Bridgend.

Summary of our findings

1. Overall assessment

Children's individual needs are understood and the service strives to ensure these are provided for and met; there is evidence that children are achieving good outcomes. They are given opportunities to enjoy themselves and learn new skills.

Staff are committed to the children in their care but not properly supported or equipped with the necessary training to meet their complex needs. Safeguarding and behaviour management practice and training requires urgent attention to ensure children's welfare.

Staff were not always clear what was expected of them and management oversight of the service was not always evident. The systems in place to review and monitor the service do not demonstrate a commitment to service improvement.

2. Improvements

This was the first post registration inspection.

3. Requirements and recommendations

Section five of this report sets out the action service providers need to take to ensure they meet their legal requirements and recommendations to improve the quality of the service provided. These relate to safeguarding, behaviour management, the recording of children's wishes and views, management oversight and quality assurance systems.

1. Well-being

Summary

Children and young people experience caring, supportive relationships with staff who know them well. They are able to express their likes and dislikes, and exercise choice as to how they spend their time.

Our findings

Children's communication needs are understood, but more could be done to evidence that children have a voice. None of the children were able to communicate verbally but a variety of other methods were used to allow them to communicate their wishes to staff. One young person had a 'switch', which they could use to signal a choice of two activities, and staff were also supporting the children to use sign language. We saw a 'sign of the week' on display which all staff were helping the child to learn and was relevant to the festive season. One child was bilingual and we saw a list of common English words and phrases with the Welsh version alongside which staff used to maintain familiarity with some Welsh words in the home. There was evidence that children could exercise choice for example in how they spent their time or the food they ate. The manager informed us that some staff had completed training in working with children with communication difficulties but further training was being sourced via the local school. Social stories were used frequently to prepare children for a variety of events. We saw a good example of a social story being used to prepare a child for a medical appointment. We were shown a bank of resources for staff to access.

There were a number of references in documents to children being unable to contribute due to being "non verbal" and having limited ability to use other communication methods. House meetings did not take place as due to the children's needs these would not be meaningful. However, we discussed with the manager whether other ways could be developed to consult with children about their care experience, particularly as this aspect was also missing from the reports of the monitoring visits we viewed. We noted that there was a young person's version of the independent living skills activity sheet but these were generally completed by staff. There was a Children's Guide to the service, however this appeared to be a generic document for children's homes and not suitable to the needs of children living in Harwood House. Children's rights are promoted, however we discussed with the manager the need to be more creative in establishing children's wishes and views.

There was evidence of children achieving good outcomes and receiving warm, responsive care. We saw a number of references in documentation to evidence that their day to day care was good and references to the need to ensure that children are well presented and encouraged to take pride in their appearance. Children had made progress in a number of areas of their lives since living in Harwood House. We witnessed kind, good humoured interactions between the staff and children. Staff we spoke with described themselves as "being all for the children" and "passionate" about their jobs. Staff described the

environment as being like a family home. All the children were attending school daily and records indicated that their health needs were met. Staff were clearly proud of the children's numerous achievements in terms of their behaviours and social skills. Children receive care in a way which is likely to build their self esteem.

Children's contact with family and other significant people is promoted. Staff supported a variety of arrangements of the children's contact with parents and extended family members. This ranged from contact in Harwood House to contact at family members' homes and was sometimes supervised or with a care worker present to provide additional support. Children were also seen to be supported to maintain relationships with the people who cared for them before they lived in Harwood House. Consideration was given to ensuring that contact was safe and meaningful. Children maintain relationships with people who are important to them.

Children's participation in activities has been inconsistent. Each child had a structured weekly plan as routine and predictably were important for them. Staff knew how children liked to spend their time both in and out of the home and those we spoke with told us that they tried to occupy the children's time but also allow them to relax at home if they indicated that is what they wanted. Activities in the home ranged from sensory play, watching TV or DVD's and baking. Outside the home children enjoyed going swimming regularly, trips out to the beach or to 'Folly Farm', shopping, going on walks, and attending after school or sports clubs. Records evidenced that children participated in a range of activities, however, we also noted in documentation, reference to children being unable to do activities due to staff shortages. There was also a reference to a referral to an advocacy service to ensure that one child's access to activities was not compromised because of the ratio of staffing required. We discussed this with the manager and were assured that measures were now in place to minimise the risk of this happening in the future. Overall we concluded that children have access to a range of social and leisure opportunities.

2. Care and Support

Summary

Training and practice around safeguarding and behaviour management requires urgent attention. Children and young people are cared for by staff that have a good understanding of their needs and how best to care for them, however documentation was not always up to date and did not evidence that staff had read and understood changes and updates.

Our findings

Attention is required to ensure that responses to safeguarding concerns are robust and timely. Prior to the inspection, a child had sustained an injury which was not managed appropriately. We were also concerned that there was a delay in updating a child's case file in response to some developing behaviour. We asked for a copy of the home's safeguarding policy and were provided with Bridgend's Corporate Safeguarding policy which was a generic and high level document. This was not compliant with legislation in terms of its fitness for purpose. The manager informed us that the provider did offer a number of safeguarding training courses some of which were relevant to the particular needs of children living in the home. However the training matrix we were given showed that in practice, few staff had completed courses beyond the mandatory e learning training and it was not clear how frequently this should be refreshed. Although staff told us that they understood the procedures they should follow, a child had sustained a non accidental injury and no cause had been identified through enquiries carried out under section 47 of the Children Act. Children's risk assessments had not been updated to reflect possible explanations or strategies put in place to minimise the risk. Children's plans and strategies identified that they should all be supervised on a one to one basis at all times; some staff told us they were worried because they recognised that on occasions they might have to leave a child unattended to support a colleague dealing with another matter. They were concerned that this was not always acknowledged by senior management. We were told that a management review and a learning event was planned by senior management in relation to the incident. We recommended that as well as these actions, an urgent review of training is undertaken to include assurance that all staff receive training relevant to the needs of children living in the home, and safeguarding training is provided as a matter of priority where gaps are identified in individual training plans. Staff should also be provided with detailed practice guidance. Children cannot be reassured that the staff who care for them are properly trained and supported to safeguard them from harm.

Children and young people's needs were reviewed regularly, however records did not evidence that all staff had read and understood updated documents. Children had personal plans based on information received prior to placement. These were then reviewed in line with statutory Looked After Children (LAC) reviews. Key workers also completed monthly key worker reports. These covered the children's holistic needs and included actions taken in response to needs, outcomes and whether any further action was indicated. Further detailed guidance for staff was included in risk assessments and individual behaviour management plans. Although we saw guidance from the manager for staff in the

communications book to read updated documentation, those we viewed had not been signed by staff to indicate they had been read and understood. We were told that each child's behaviour management plan was reviewed in detail in every team meeting so that staff could contribute to updating and amending them from their knowledge of what has worked for the children and to consider new outcomes to work towards. However, we discussed with the manager that one child's behaviour management strategy document should have been updated at least on an interim basis when a repeat of potentially concerning behaviour had been noted. The manager was aware of this issue and told us that it was planned that this would be discussed at the next team meeting and the child's plan updated accordingly. Overall children and young people receive purposeful care from a staff team who are knowledgeable about their needs but documents which guide staff responses must be updated on a more timely basis.

Children are encouraged to develop independence skills. It was a particular priority for the manager that children were encouraged to develop the skills, and given experiences that would allow them to have a level of independence appropriate to their capabilities and potential. The manager and staff were proud of the progress children had made in terms of self-care skills with for example children previously unable, now sitting at the table to eat and using a knife and fork. Children were also seen to have made good progress in terms of their personal care skills. Each child had an individual independent living skills assessment and one of the senior members of staff had responsibility for planning appropriate independent living skills tasks for them. The staff team were expected to implement these with the aim of continuous development of skills at the child's pace. One young person had independence skills integrated within their weekly activity plan. Children are encouraged to reach their potential.

Behaviour management practice and recording should be reviewed as a matter of urgency. We were provided with a training matrix which indicated that only half the members of staff working in the home had attended the training required to equip them with both preventative and reactive behaviour management approaches. This meant that some members of staff were restraining children without training in this area; putting the children and themselves at risk. We were told that some training had been offered some months previously but the notice had been too short to find staff cover for any staff from the home to attend the course. We also found that the corporate documents used for incident reporting were not fit for purpose as they had been designed to record accidents. Children's views were not sought following incidents of physical restraint but we recommended to the manager that other methods for gaining these should be considered and at the least detailed observations of the child's behaviour and demeanour should be recorded as an alternative. Care needed to be taken with language as one child removing food from other children's plates was described in reports as "stealing" which infers the behaviour was naughty or wilful whereas with patience and consistent messages from staff, the behaviour had stopped. In another instance a child was described as being "left to their own devices", and given that one explanation for a child sustaining an injury was that they had been left unattended, we raised this with the manager. Children cannot be reassured that measures of control are safe, suitable and recorded appropriately.

3. Environment

Summary

Harwood House provides a safe environment for children. It is a small home but comfortably furnished and with necessary amenities. There are systems in place to ensure their health and safety but these require greater management oversight.

Our findings

Children and young people are cared for in an environment that is suited to their needs and is safe. The home was seen to be secure with locked gates, front and back doors. We were asked for our identification when we arrived.

Although suitably furnished, and containing all necessary facilities, the home was painted the same neutral colour throughout and appeared rather bare. Accepting that the children's needs might prevent the putting up of pictures and photos consideration could be given to other ways to create a homely feel. To the interior, the property consisted of a lounge and a lounge/diner which allowed for children to have some space and time away from each other if they chose. It was nearing Christmas when we inspected, and the home had been decorated accordingly. We viewed young people's bedrooms which were personalised to their tastes and contained as many or few of their personal belongings and possessions as they wanted. The kitchen was well equipped and overall the home was in good repair, and appeared clean and tidy throughout.

Outside, the property had a garden where young people could spend time playing or participating in other outdoor activities. One staff member was responsible for the garden and told us how the children had been involved in growing flowers, herbs and vegetables earlier in the year. We concluded that the interior and exterior of the home is suitable for the needs of the children living there.

There are systems in place to ensure that health and safety requirements are met, however the checks required are not always undertaken. We sampled a range of documentation and saw evidence that checks on fire safety equipment and emergency lighting had not been undertaken weekly in accordance with what we were informed were expected timescales. Fire alarms had not been tested weekly in accordance with the home's statement of purpose. Fire evacuation drills had not always been undertaken monthly as specified in the home's statement of purpose or last Quality of Care Report dated September and March 2018 respectively. Records showed the time the drill had taken place, but we advised the manager that records indicated that one child did not appear to have been present for a fire drill since moving into the home. Children had PECS versions of evacuation procedures which we were told staff regularly went through with the children.

Visual checks on the condition and safety of the premises were carried out monthly and we were told that any maintenance jobs were carried out promptly. Although documentation

showed that health and safety tasks, including cleaning jobs assigned to night staff were routinely carried out, the picture regarding day staff was inconsistent. We discussed with the manager the gaps in the records of fire safety and health and safety checks and a lack of evidence of management oversight of the completion of the range of checks. . Young people live in a home where there are structures to ensure the home is clean and safe however the manager should undertake a review of systems and structures to ensure that the children's home environment is consistently clean and safe.

4. Leadership and Management

Summary

Overall we found that staff were committed, knowledgeable about the children's needs and circumstances and enjoyed their work. However there was a lack of management oversight in a number of areas including staff training, and the structure in place for monitoring and improving the quality of the service were not adequate.

Our findings

Management oversight of the service was lacking. The manager of Harwood House also managed a second local authority home, spending approximately half the working week in each home and with senior staff expected to be responsible for the day-to-day running of the home as appropriate. We discussed with the manager that there were a number of areas that might indicate that this arrangement was not working as well as it could:

- Oversight of health and safety systems
- Risk assessments and behaviour management plans not always reflecting behaviours of concern.
- Oversight that staff had read and understood changes to behaviour management plans and risk assessments.
- Incomplete records in 'measures of control' record book.
- Sanctions records not signed by the manager.

Children cannot be confident that the home is consistently and efficiently organised and run in a manner that delivers the best possible care.

Staff are not always clear what is expected of them and this was a contributory factor to a dip in staff morale when we visited. Primarily this appeared to be because of the safeguarding incident referred to earlier and staff being unclear as to how they could carry out their range of responsibilities while maintaining the level of supervision outlined in children's care and support plans. We also noted that records of sanctions, incidents and physical interventions were not recorded in a consistent fashion, and that this had also been highlighted in two monitoring visit reports we read. We were told that there were no clear guidelines for staff about these matters but a service review and learning event was in the planning stage and it was hoped that this would address these issues and provide clarity for staff.

Staff have not been equipped with the skills and knowledge to care for and support children safely. We were provided with a training matrix which showed that there were gaps in people's training in key areas of safeguarding, working with children with autism and

learning disabilities, and in approved and accredited behaviour management techniques. Children cannot be confident that they will be cared for by staff who are trained and competent to meet their complex needs.

There are systems in place to monitor service quality. However, there is no evidence that these provide a robust overview of the quality of the service or support service improvement. This was because:

- A suitable annual review of the quality of care provided by the service had not been completed. The last report was completed by the manager under the Care Standards Act in May 2018. This did not cover the matters required by legislation at that time or provide a clear plan for the improvement of the service going forward. The home had since been registered under new legislation, and a quality of care review was not yet due. However there was no evidence that the previous quality of care report was considered in either the manager's supervision records or the monitoring visits to the service.
- Monthly monitoring visits were previously carried out by managers of other local authority homes. These were found to be inadequate as they did not provide evidence or detail and did not include those matters required.
- Monitoring visits did not include an update on actions from the previous visit but we noted from the content that similar issues were highlighted in August and September 2018 and had still not been addressed when we inspected.
- The responsible individual had carried out a monitoring visit in October 2018 but the manager had not received a copy two months later.
- Although the manager informed us that they received supervision with the responsible individual monthly, they did not receive a copy of the record of the meetings.
- We were provided with a business plan which was not dated or updated and planned actions had not taken place.

People cannot be reassured that children's well-being is promoted through the arrangements in place to monitor and improve the quality of the service.

5. Improvements required and recommended following this inspection

5.1 Areas of non compliance from previous inspections

This was the service's first inspection.

5.2 Areas of non compliance from this inspections

During this inspection, we identified areas where the registered person is not meeting the legal requirements and this is resulting in potential risk/and or poor outcomes for children. Therefore we have issued a non compliance notice in relation to the following:

Regulation 6- The service has not been carried on with sufficient care and competence
Regulation 26- The service is not provided in a way which ensures that individuals are safe and protected.
Regulation 29 – Appropriate use of control and restraint.

Details of the actions required are set out in the non compliance notices attached.

Regulation 19- information about the service. This is because the written guide to the service is not in a format that reflects the needs and understanding of the children who use the service.

We did not issue a notice of non compliance on this occasion, as there was no immediate or significant impact upon the children using the service.

5.3 Recommendations for improvement

- The manager should ensure that each child living in the home has the opportunity to practice fire evacuation procedures.

- Review recording procedures with particular regard to formalising the system whereby staff are required to sign records such as behaviour management strategies and risk assessments to indicate that they have read and understood any amendments.

- The manager should ensure that the child's voice is consistently recorded in records and documents, and where children are not able to communicate verbally, more creative ways should be developed to ensure that their rights are upheld.

- Monitoring visits need to be more robust and should include a discussion with the staff on shift and with the children where possible, or at least observing the children with staff. In addition to parents, carers and other stakeholders where possible.

- Managers monitor and review the support given to the core staff team in ensuring they feel supported at all times to carry out their role effectively.

- The manager must ensure that the systems to ensure people's health and physical safety are implemented fully and that there is proper management oversight that this is happening.

6. How we undertook this inspection

This was an unannounced inspection undertaken as part of CIW's programme of inspections. We made one unannounced visit to the home on 13 December 2018 from 9.35 a.m. to 16.20 p.m. and by arrangement from 9.30 a.m. to 12.30 p.m. on 6 December 2018. There were three young people living in Harwood House on the day of inspection.

The following methodology was used:

- We reviewed information about the home held by CIW.
- We observed interactions between the staff and the young people.
- We spoke with the registered manager and members of staff on duty.
- We reviewed two young people's case files.
- We looked at a range of documentation held at the home including the Statement of Purpose and monthly monitoring reports.
- Examination of records relating to safety of the premises.
- We viewed a sample of records and a selection of policies.

Further information about what we do can be found on our website:
www.careinspectorate.wales

About the service

Type of care provided	**Care Home Service**
Service Provider	**Bridgend County Borough Council**
Manager	**Debra Evans**
Registered maximum number of places	**3**
Date of previous Care Inspectorate Wales inspection	**Not applicable**
Dates of this Inspection visit(s)	**13/12/2018**
Operating Language of the service	**English**
Does this service provide the Welsh Language active offer?	This is a service that is working towards providing an 'Active Offer' of the Welsh language.
Additional Information:	

Care Inspectorate Wales

Regulation and Inspection of Social Care (Wales) Act 2016

Non Compliance Notice

Care Home Service

This notice sets out where your service is not compliant with the regulations. You, as the registered person, are required to take action to ensure compliance is achieved in the timescales specified.

The issuing of this notice is a serious matter. Failure to achieve compliance will result in Care Inspectorate Wales taking action in line with its enforcement policy.

Further advice and information is available on CSSIW's website
www.careinspectorate.wales

Harwood House

BRIDGEND

Date of publication: 22 February 2019

Care and Development	Our Ref: NONCO-00007164-PHBP
Non-compliance identified at this inspection	
Timescale for completion	**29/03/19**
Description of non-compliance/Action to be taken	**Regulation number**
Appropriate use of control and restraint	29(2) 29(3)

Evidence

- The registered person is not compliant with regulation 29- Control or restraint must not be used unless it is carried out by staff who are trained in the method of control or restraint used.

- This is because not all members of staff had completed training in Team Teach which is the approved approach used by the provider to manage children's behaviour including techniques for restrictive physical intervention.

- The evidence:

We carried out an inspection of the home on 13 December 2018
we were provided with a training matrix which showed that only seven out of fourteen members of staff had completed the approved training.
We were told that staff who had received appropriate and approved training were "showing" the staff who had not been trained, the techniques and strategies they should use in managing children's challenging behaviour.
There was no system for ensuring that a child subject to restraint had an opportunity to express their wishes and views (as far as they were able). where this was not possible because of the child's needs, a record should be made regarding any injuries and their presentation and demeanour.

- The impact on people using the service is that children's well-being is potentially being compromised because staff are not trained in techniques designed to promote positive behaviour and reduce the need for a restrictive physical intervention.

Leadership and Management	Our Ref: NONCO-00007162-BCLH
Non-compliance identified at this inspection	
Timescale for completion	**29/03/19**
Description of non-compliance/Action to be taken	**Regulation number**
The carrying on of the home with sufficient care and competence.	

Evidence

The registered person is not compliant with regulation 6 : Requirements in relation to the provision of the service.
This is because the service has not been provided with sufficient care and competence having regard to the statement of purpose, the quality assurance structure is not robust and there is a lack of management oversight in a number of areas.
- The evidence:

We carried out an inspection of the home on 13 December 2018
The home is not operating in accordance with it's statement of purpose because staff have not attended the training outlined in the document, particularly in regard to safeguarding, safeguarding of children whose needs make them particularly vulnerable, communication with children with disabilities, behaviour management/restraint. Not all staff had completed the core training outlined in the statement of purpose
The home is not also not operating in accordance with the statement of purpose in regards to fire precautions. We sampled a range of documentation and saw evidence that checks on fire safety equipment and emergency lighting had not been undertaken weekly in accordance with what we were informed were the expected timescales. Fire alarms had not been tested weekly in accordance with the home's statement of purpose. Fire evacuation drills had not always been undertaken monthly as specified in the home's statement of purpose or last Quality of Care Report dated September and March 2018 respectively.
There was limited evidence of staff having read and understood key documents such as behaviour management strategies and risk assessments.
The manager informed us that although she received regular supervision she did not receive a record of this- rather the responsible individual and herself made separate notes.
Some staff had not received any training on working with children with autistic spectrum disorder when all children living in the home have this condition.
Some staff had attended training on autism but this was on an e learning basis, and there was no further or more advanced training available.
Only 2 staff had completed signalong training and there was no evidence of staff being trained in using PECS (which are the two communication approaches used in the home according to the statement of purpose).
Staff were not clear what to record and where. There was no written guidance and the incident reporting format was not fit for purpose. Staff were unclear as to how they could carry out their range of responsibilities while maintaining the level of supervision outlined in children's care and support plans. We also noted that records of sanctions, incidents and physical interventions

were not recorded in a consistent fashion, and that this had also been highlighted in two monitoring visit reports we read.
There was a lack of management oversight in a number of areas:

- Oversight of health and safety systems
- Risk assessments and behaviour management plans not always reflecting behaviours of concern.
- Oversight that staff had read and understood changes to behaviour management plans and risk assessments.
- Incomplete records in ‘measures of control’ record book.
- Sanctions records not signed by the manager.

The arrangements for the monitoring, reviewing and improving the service were not suitable. This is because the manager had not received a copy of the report of the last monitoring visit by the responsible individual two months after the visit, there is no evidence of the actions required to improve the service and no clear link between the different parts of the service quality systems i.e the reports of the review of the quality of service, manager's supervision and business plan.
There is insufficient evidence of children being consulted in the delivery of care and improvements to the service.

The impact on people using the service is that children's well-being is potentially compromised by living in a home where they cannot be assured they will be cared for and supported by staff with the knowledge and skills to meet their needs. The arrangements for the monitoring, reviewing and improving the service are not suitable. People cannot be reassured that children’s well-being is promoted through the arrangements in place to monitor and improve the quality of the service or that the home is consistently and efficiently organised and run in a manner that delivers the best possible care.

Well-being	Our Ref: NONCO-00007163-VGBJ
Non-compliance identified at this inspection	
Timescale for completion	**29/03/19**
Description of non-compliance/Action to be taken	**Regulation number**
The service has not been provided ina way which ensures that individual are safe from harm.	

Evidence

- The registered person is not compliant with regulation 26. The service provider must provide the service in a way which ensures that individuals are safe.
- This is because staff had not received adequate training, procedures were not followed on one occasion and the home's safeguarding policy was not fit for purpose.
- The evidence:

We carried out an inspection of the home on 13 December 2018.
We were provided with a training matrix which indicated that not all staff had completed safeguarding training.
The manager was not clear how often safeguarding training was required to be refreshed.
Only three members of staff had completed safeguarding training specifically for working with children with disabilities within the past two years.
The home's safeguarding policy was not adequate as it was generic. It did not include the needs of children with the complexities of those living in the home and did not include guidance on individual roles and responsibilities relevant to the staff working in the home.
Child protection procedures were not followed in respect of an injury sustained by a child in October 2018. We were informed that there was a possible explanation but if that was the case no child's risk assessment ofr behaviour management document reflected this.
In another case a child had displayed some behaviours of concern. However their behaviour management strategies and risk assessment documents had not been reviewed and amended in a timely fashion to reflect this.

The impact on people using the service is that children's well-being is potentially compromised by living in a home where the arrangements for keeping them safe are inadequate because staff do not have the guidance and training required to ensure that they are protected from harm.