Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

Inspection Report on

Golwg Camlas/Bannau

Brecon

Date of Publication

Wednesday, 9 May 2018

Description of the service

Golwg Camlas and Golwg Bannau are operated by Powys County Council and provide residential and short breaks for children and young people with disabilities. Golwg Camlas provides a short break service for up to three children and young people between the ages of eight and eighteen with complex needs. Golwg Bannau is a six bed provision providing residential care and short breaks for children and young people with Autistic Spectrum Disorder. The interim Head of Care is Hannah Griffiths and there is a nominated responsible individual.

Summary of our findings

1. Overall assessment

Young people are looked after by a caring and committed staff group who understand the needs of the young people and provide person centred care so that overall the service to young people is satisfactory. However we found that the registered provider has not ensured that there are robust quality assurance systems in place for monitoring and improving the quality of care. Recruitment and retention of staff which was highlighted in the last two inspections remains an issue. At the time of the inspection approximately one third of care worker posts were vacant. A full and stable staff team is particularly important to ensure that young people's attachments are not overly disrupted and that they are looked after by staff with the appropriate levels of skills and experience.

2. Improvements

We did not identify any particular areas of improvement at this inspection.

3. Requirements and recommendations

Section five of this report sets out our recommendations to improve the service and the areas where the care home is not meeting legal requirements. These include the following:

- Recording and administration of medication.
- Staff who are appropriately skilled and experienced
- Staff qualifications
- Monthly monitoring visits,
- Quality of Care reports
- Children's Guide

1. Well-being

Summary

Overall young people are looked after by a staff team who have a good understanding of their needs and individual preferences. Young people living in, or staying at Golwg Bannau and Golwg Camlas are provided with opportunities to exercise choice and to express themselves. Young people would benefit from being offered a wider range of fun activities and social and leisure opportunities.

Our findings

Young people have positive relationships with the staff who care for them. Staff spoke with warmth and knowledge about the routines, habits, likes and dislikes of the young people accessing both homes. We saw that staff were attentive and reassuring. We read documentation in one young person's file that showed that staff were sensitive to their particular and changing health need and what this might mean for activities they could participate in. We also saw from Looked After Children Review minutes that parents felt that there were good relationships between their child and staff. A social worker commented *"the staff, when questioned, have a knowledge of [the young person's] likes, dislikes, triggers and can identify when [the young person's] anxieties are raised".*

We were told about the arrangements for introducing new young people referred to receive respite in Golwg Camlas. The key worker visited the child and family at their home and parents completed a booklet about their child to share information about their child's routines, behaviours, likes and dislikes. Staff often had some knowledge of the children as they attended the school which shared the site. Plans for first visits or overnight stays were developed in consultation with the family and included tea visits or visits with family as appropriate. Staff said they tried to make the environment at Golwg Camlas a "home from home" by following routines as closely as they could while also trying to ensure children were able to access a variety of activities and experiences. Young people are looked after in an environment where staff understand the things that are important to them.

Children are able to exercise choice, using their preferred communication methods. We saw reference to young people using Makaton, PECS (Picture Exchange Communication System) or hand gestures to communicate. The daily routines for each young person were displayed on the dining room wall using velcro pictures and we saw that these were used in different ways for different young people. Records evidenced that young people expressed preferences over the activities they participated in and meals offered. We saw one young person in Golwg Bannau helping staff to prepare lunch. One young person had a copy of their Personal Behaviour Support plan in an easy read format. We read in one young person's file, a recording which included their views of living in Golwg Bannau. There was a version of the Children's Guide which was young person friendly and suitable to the needs

of young people who used the Picture Exchange Communication System (PECS). Young people are given opportunities to participate in the way their care is delivered.

Young people's engagement in a variety of activities is not consistent. Children living or staying in Golwg Camlas and Bannau had access to the facilities of the local school including an outdoor playground, hydro-pool and soft play area. We saw feedback from a health professional for one young person's LAC Review which praised staff for managing to get one young person out on an activity which they had enjoyed although had initially not been keen to go. We also saw a record of a discussion initiated by a care worker in a team meeting about how best to encourage one young person to be involved in more activities. Staff at Golwg Camlas told us that they tried to ensure that at least one off site activity would take place for a young person on weekend respite. Records we viewed showed that young people were offered a range of activities but that in practice this was often going out for a walk or for a trip in the car. Young people would benefit from more focus on them being purposefully engaged in their free time. This would mean that their care and support would be more consistent with the aims set out in the Statements of Purpose- to enable them to "develop skills and widen their experience" (Camlas) and "participate in inclusive community activities" (Bannau). There were play facilities and equipment for the young people's use but overall their involvement in a range of different and fun social and leisure opportunities is limited.

2. Care and Support

Summary

Young people receive individualised care and support packages delivered in collaboration with other professionals but the link between the day to day care young people experience and the intended outcomes of the placement is not clear. The importance of partnership working with parents is evident.

Our findings

There are systems and structures in place to enable staff to meet young people's care and support needs. Placement plans were individualised and detailed. They covered areas such as risk assessment, health, personal care, education, pocket money and leisure. We saw that there was manager or deputy manager oversight of young people's plans and key records such as physical incident records. Files also contained 'risk assessment profiles'. These were detailed and we saw that they had been updated to communicate to staff about the changing behaviours of the young people and management strategies to be employed. A social worker wrote in a report for a LAC Review for one young person that staff were aware of their care plan and risk assessments. However, it was not always possible to see how the records kept by Golwg Camlas and Golwg Bannau linked with Local Authority Care and Support plans as the 'aims and objectives' sections of the files we read were empty and some Local Authority documentation records were not available or not easily retrievable on Powys's I.T system. Overall young people receive person centred care.

Young people's health, including sexual health is promoted. Young people living in Golwg Bannau were registered with local dentists, G.Ps and opticians and accessed more specialist services as appropriate. We saw in case files evidence of contact with the G.P for advice, and that young people's medication had been reviewed in the past year by CAMHS. We saw that at a LAC Review Golwg Bannau staff had been tasked with referring to the Occupational Therapy Service for a piece of equipment and that was done and the equipment in place. As some of the young people living or staying in Golwg Camlas and Golwg Bannau had self injurious behaviors, for example when frustrated or upset, body maps were completed twice a day and in between if necessary, to record all marks. Records indicated that parents and social workers were updated appropriately. We saw that young people's plans referenced encouraging young people to manage as much of their personal care as appropriate to their abilities. Overall we concluded that young people are supported to be healthy.

Staff work in partnership with parents and professionals. Staff we spoke to understood the importance of close liaison with parents to ensure that care was provided in a way that was consistent with the young person's needs and known preferences. Records showed that parents were routinely informed about incidents and accidents in a timely way, and that

staff had more general conversations with parents about their child at a level agreed with them. Records indicated that the manager of the home and the specialist learning disability nurse had developed a package for the young people on sexual health issues and appropriate behaviour and that they planned to deliver this to young people jointly. Staff worked closely with education staff to prepare the children for their introductory visits and later overnight stays using social stories if appropriate. Records of LAC Reviews evidenced that relevant agencies including, health, education and adult services attended reviews or were at least consulted. Young people benefit from staff working proactively with parents and other agencies to best understand them and meet their needs.

3. Environment

Summary

Overall, we found that young people are cared for in a safe and clean environment which meets their needs. Young people are able to personalise their bedrooms. The interior is spacious and accessible for the young people. Appropriate health and safety arrangements are in place to ensure the young people are safe.

Our findings

There are measures in place to ensure young people's needs are met within their environment. The design of the building gave the young people room to move around freely and communal areas were spacious giving independence to young people who use wheelchairs or mobility equipment. There was ample space for young people to be able to relax and there was a 'rumpus room' (containing soft play equipment) for young people to have time out if this was required. The kitchen areas were spacious and there were appropriate safety measures in place to prevent young people accessing the kitchen if it was deemed unsafe. We saw that each young person staying in Golwg Camlas had their photograph on their bedroom door and young people were encouraged to bring some of their belongings with them during their stay to help with a sense of continuity. There were blinds and curtains up in the kitchen and various pictures and paintings in the hallways to give a homely feel.

Young people have the opportunity to personalise their bedrooms. We were told that the bedrooms were painted with the young people's choice of colour. Each bedroom had underfloor heating to ensure adequate temperature for each young person. The bedrooms were spacious with one room having an en-suite, a small hallway and an array of the young people's belongings. Therefore, young people's individual needs are considered and met.

We found that attention is given to young people's physical safety. Track hoists were in place in some of the bedrooms and bathrooms. There was a television in the kitchen to monitor young people who were upstairs via CCTV in Golwg Camlas as well as sound monitors. We were advised that the bedroom cameras and audio were only on at night time when the young people were in bed to monitor any movement or activity and to alert staff if young people are in difficulty. These were only used if parental consent was given and we saw those consents on the young people's files. We were advised by staff that these were used to ensure young people were kept safe and there was no intention to intrude on their privacy. There was frosted glass in the bedrooms for added privacy and safety restrictors on the windows. One young person slept with their bedroom door open and there was a safety gate in place. Additionally, there was padding in young people's bedrooms for protection to prevent them causing injury to themselves. Staff informed us that some bedrooms had more belongings in them than others due to young people's own choice or

because of potential risks to their safety. All doors had a lever to open the doors in both directions to prevent young people barricading themselves or becoming trapped in the event of a fire for example. Some young people had stick on Velcro black out blinds for their protection in case they pulled them down.

There are appropriate health and safety systems in place. Young people can be reassured that visitors to the home cannot gain entry without invitation. Identification was requested on our arrival to the home and the visitor's book was completed. There was secure access from all external doors for the safety of young people. We saw that the home had regular systems in place to ensure the testing and servicing of equipment is undertaken and on the whole completed within the specified timescales to ensure the young people were safe. Overall young people's safety is prioritised.

4. Leadership and Management

Summary

On the whole we found that there are systems in place to support and guide staff. Staff recruitment and retention which was identified in the last two inspections remains a concern. The quality assurance systems for the service require improvement to ensure compliance with regulations.

Our findings

We found a commitment to ensuring that there are staff support structures in place. Supervision was generally monthly and we saw that staff were able to raise issues of concern and discuss the needs of young people and how these could be best met. They were also able to discuss their own learning and development. We saw that team meetings were held, though not always at the frequency aimed for, i.e monthly. Staff confirmed that they were encouraged to put forward agenda items and the minutes showed that the meetings provided opportunities to discuss individual young people with staff contributing ideas and suggestions. Meetings were also used to enable the manager to provide direction to staff on, for example, record keeping or supervision arrangements when young people were having contact visits with their family. It was evident from the minutes of meetings that staff actively participated in the discussions and that they were encouraged to put forward their own views. Although staff felt supported by the manager and each other, we found staff morale to be low as a result of delays in implementing plans for the service and uncertainty as to its future direction. We saw that staff were informed of developments in team meetings and those we spoke to said that they were “hopeful” that the service would now get the attention and investment they felt the service deserved. Overall there are systems in place for staff support.

Recruitment and probationary systems are in place. Personnel files evidenced that appropriate recruitment processes were followed, with references taken up and DBS checks in place prior to employment. Staff files evidenced that employment was only confirmed on satisfactory completion of a probationary period. Young people are looked after by staff who are properly vetted.

Staff recruitment and retention difficulties mean that young people are not always looked after by skilled and experienced staff. Golwg Camlas and Golwg Bannau had experienced recruitment difficulties for a number of years. At the time of the inspection approximately one third of care worker posts were vacant. We were told by staff that the service relies on agency workers and relief staff to continue operating. Sometimes staff on the rota for Golwg Camlas were called upon to work in Golwg Bannau, and Golwg Camlas would then have to be closed due to insufficient staff. This was confirmed by some of the comments from parents in the last quality of care review. The Head of Care told us that he had tried to

minimise the impact on young people by employing only the same agency workers, and staff rotas showed that permanent staff often worked additional hours. The manager was in the process of recruiting more staff and there was also a plan in place to be more innovative in recruitment activities.

We viewed various documents relating to staff qualifications and training. We found that:

- Less than 80% of permanent members of staff had achieved a relevant care qualification.
- Three permanent members of staff were not registered as social care workers with Social Care Wales in accordance with legislation.
- Eight out of ten of the regular agency workers employed to work at Golwg Bannau/Camlas were not registered with Social Care Wales, and eight did not possess a relevant qualification.
- Around half of the staff working in Golwg Bannau, and a third of staff working in Golwg Camlas had not completed the in- house training course on challenging Behaviour and Autistic Spectrum Disorder (although most had completed an e learning course).
- Safeguarding training was provided on an e learning basis. We also explored with the Head of Care an out of hours incident in which a senior staff member had been uncertain of the correct procedure to follow. We recommended that the arrangements for safeguarding training be reviewed.

As the service is not able to attract and retain a stable permanent staff team young people cannot always be confident that they will be looked after by familiar staff who are appropriately qualified and experienced.

The systems in place to monitor the quality of the service are not adequate. We viewed the system for recording physical interventions which were not always accurately completed in respect of who had written the record and they were not always countersigned by a shift leader, deputy manager and Head of Care in a timely way, and in accordance with the home's 'Intervention behavior policy'. We noted that several Regulation 32 reports, including that of August 2017 had highlighted this, but several months later (at the time of the inspection), this was still an issue. The interim Head of Care told us that with two deputies now in place, oversight of record keeping was expected to be regular in future.

There are shortfalls in respect of the medication recording system. We viewed a sample of records which were appropriately completed and signed. We found that the controlled medications book was not always completed by two members of staff and there was no indication of this being followed up or that there was a regular audit of the records, by the manager.

The monthly monitoring visits and reports were not compliant with regulations as these were not always carried out monthly. Written reports were also not provided to the manager

in a timely fashion. For example the report for August 2017 was provided to the Head of Care in February 2018, and this report noted that the Head of Care had not received the report for the month before. The remaining reports for the period July 2017 to January 2018 were not available on the day of inspection. These were provided to the interim Head of Care on 5 March 2018, and subsequently to CIW. We noted that the reports referenced verbal feedback from the responsible individual to the manager on the day of the monthly visit and an acknowledgement that the Head of Care should be provided with written reports. However, the sections of all the reports except one, relating to the manager's comments, any actions agreed and a signature to confirm that the manager had read and understood the report, were empty. There was therefore no evidence that the manager acknowledged the issues being raised or was undertaking any actions in response.

Furthermore, we read the last two quality of care reports dated August 2016 and December 2017-January 2018. We found that these did not comply with regulations as they:

- Did not consider the matters set out in the relevant schedule.
- Although there was evidence of consultation with parents, staff and other stakeholders there was no reference to the young people having been spoken to.
- Were not carried out annually.

People cannot be confident that there is a robust system for monitoring and reviewing the quality of care young people receive at Golwg Camlas/Bannau or which effectively identifies and addresses shortcomings leading to efforts for continuous improvement.

5. Improvements required and recommended following this inspection

Areas of non compliance from previous inspections

At the previous inspection we advised the registered persons that improvements were needed in relation to:

- The administration of medication Regulation 21 (2b) and Regulation 21 (2c).
  At this inspection we found that there were still short falls in the systems for recording medication.
- The percentage of staff employed at the home holding a relevant qualification was less than 80%.
  We found that this was still the case at this inspection.
- Annual Quality of Care reviews (Regulation 33 (2)(a)) had not been held annually.
  We found that this was again the case at this inspection

Areas of non compliance identified at this inspection:

We advised the registered persons that improvements are needed in relation to:

- Following the written policy on the use of restrictive physical interventions (Regulation 17 (2)). The system for recording physical interventions was not being operated in accordance with the home's policy on 'Intervention behaviour'.
- Arrangements for recording and administering medication (Regulation 21 (1)). The controlled medications book was not always completed by two members of staff and there was no evidence of a regular audit of the records by the manager.
- Staff who are appropriately qualified, skilled and experienced (Regulation 25 (1),(1A) and (2A). Less than 80% of staff employed at the home held a relevant qualification, and less than 90% of the care staff were permanent employees.
- Staff being registered with Social Care Wales (Regulation 26 (2)(G)). Not all staff had registered as social care workers with Social Care Wales within six months of their appointment.
- Monthly monitoring visits (Regulation 32 (3), (4) (a) and 5 (a). The registered provider had not always visited monthly, had not provided written reports in a timely fashion and there was no evidence that the manager acknowledged the issues being raised or was undertaking any actions in response.
- Quality of Care reviews (Regulation 33 (2) (a), (b) and (c) (i) did not reference children who stay at the home having been spoken to, were not carried out annually and did not evidence the full monitoring and reviewing of the necessary matters.

Notices have not been issued on this occasion, as there was no immediate or significant impact for people using the service.

We expect the registered persons to take action to rectify this and it will be followed up at the next inspection.

Recommendations for improvement

- Consideration should be given to offering a wider range of interesting and enjoyable leisure and social activities and for individual activity planners to be put in place for each young person.

- The staff training programme should be reviewed so that the Registered Provider is satisfied that the range of e-learning and training courses provided is appropriate and sufficiently in depth to equip staff to work with the complexity of needs of the young people accommodated in Golwg Camlas/Bannau.

- The Head of Care should ensure that each member of staff has their training needs reviewed to ensure that they have undertaken appropriate core and refresher training in key areas such as safeguarding, working with young people with autistic spectrum disorder, challenging behaviour and restrictive physical interventions. Where these have not been undertaken or are not up to date, action should be taken to provide such training as soon as reasonably possible.

6. How we undertook this inspection

This was a planned unannounced inspection undertaken as a part of Care Inspectorate Wales programme. The inspection was undertaken on the 8 January 2018 by two inspectors

The following sources of information were used to inform this report:

- One announced visit to the home.
- We reviewed information held about the home held by CIW.
- Observations of interactions between the staff and the children.
- We spoke with the registered manager and members of staff on duty.
- We looked at a range of documentation held at the home including the Statement of Purpose and Children's Guides.
- Examination of records relating to safety of the premises.
- We viewed the premises, including the communal areas and the young people's bedrooms. We viewed a sample of general documentation held at the home including staff files and documentation relating to the placement of young people in the home.

Further information about what we do can be found on our website www.cssiw.org.uk

About the service

Type of care provided	**Childrens Home**
Registered Person	**Powys County Council**
Registered Manager(s)	**Interim Head of Care Hannah Griffiths**
Registered maximum number of places	**9**
Date of previous CSSIW inspection	**09/06/2015**
Dates of this Inspection visit(s)	**08/01/2018**
Operating Language of the service	**English**
Does this service provide the Welsh Language active offer?	**This is a service that does not provide an 'Active Offer' of the Welsh language. It does not anticipate, identify or meet the Welsh language needs of people /children who use, or intend to use their service. We recommend that the service provider considers Welsh Government's 'More *Than Just Words follow on strategic guidance for Welsh language in social care'.***
Additional Information:	