Oakfield Psychological Services Limited

The Willow

Inspection report

City Gate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Tel: 01616417192

Date of inspection visit:
21 August 2023
22 August 2023
23 August 2023

Date of publication:
05 January 2024

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**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
The Willow 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 one person. The service provides therapeutic psychological support to children and young people with mental ill health and additional needs, such as neuro-developmental disorders. At the time of our inspection there was one person using the service.

Ofsted are the lead regulator for services registered as children's homes, however, the service was not registered with Ofsted at the time of our inspection.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support: Model of Care and setting that maximises people's choice, control and independence
Right Care: Care is person-centred and promotes people's dignity, privacy and human rights
Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.

People's experience of using this service and what we found
The provider had not always made sure that person centred care was provided in a way that met the needs of service users, particularly in relation to their diagnosis of autism as well as nutrition and hydration.

Action had not been taken to make sure that changes to the way in which CCTV was used at The Willow protected the privacy and dignity of service users.

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

The provider had not made sure that observations of service users had always been undertaken when needed, potentially exposing the service user to an increased level of harm.

Restraint had not always been used in a way that reduced the risk of avoidable harm to service users and in the least restrictive way possible.

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

Policies did not always reflect current practice.

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

An effective risk management system to make sure that all risks at the Willow had been identified and mitigated as much as practicably possible was not in place.

Systems had not been established to make sure that incidents had been reported, investigated and managed in a way that reduced the risk of similar incidents happening again.

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

The provider had taken action to make some improvements following our last inspection. This included making sure that the living quarters of the service user had been cleaned and that service users had access to an independent visitor, allowing them to raise concerns and seek independent advice when needed.

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 31 May 2023) and the service had previous breaches of regulations.
At this inspection we found the provider remained in breach of regulations.

The service remains rated requires improvement.

At our last inspection we also recommended that the provider needed to make improvements against other important areas, such as making sure that important information, such as health plans were available for staff to use, as well as making sure that nutrition and hydration needs were better met. At this inspection we found that the provider had not acted on all recommendations and had not made all improvements needed.

Why we inspected
We undertook this targeted inspection to check whether the Warning Notice that we previously served in relation to Regulations 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. This inspection was also undertaken to check on a requirement notice that was also issued in relation to breach of Regulation 12, as well as several other recommendations that we made to the provider.

We use targeted inspections to follow up on Warning Notices or 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.

Enforcement and Recommendations
We have identified breaches in relation to person centred care, privacy and dignity, safe care and treatment, safeguarding, good governance, staffing and duty of candour.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At 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 effective?

Inspected but not rated

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

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.

The Willow

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

This was a targeted inspection to check whether the provider had met the requirements of a Warning Notice in relation to Regulations 13 (Safeguarding), and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as well as a requirement notice in relation to Regulation 12 (Safe Care and Treatment).

The inspection also checked on other recommendations that had also been previously made to the provider.

Inspection team
The inspection team consisted of two inspectors from the Care Quality Commission.

Service and service type
The Willow 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 one person. 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.

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.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage

the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

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

What we did before the inspection
We used a range of information to plan this inspection, including findings from our last inspection of the service, on-going monitoring information including complaints and concerns about the service, as well as information received from other stakeholders.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with staff who worked at the service and members of the management team, including the registered manager, as well as professionals from other stakeholders such as the local authority. We also spoke with the young person who lived at the service and their parent.

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

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At 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 if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we found that effective safeguarding policies and procedures in place to manage allegations of abuse when made against members of the senior management team were not in place. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

- Since our last inspection in February 2023, we found that the provider had taken time to update their policies and processes, providing updated guidance for how allegations of abuse should be managed, particularly if against members of the management team.
- For example, an independent person had been employed to undertake investigations of abuse, potentially reducing the risk of a closed culture developing within the service.
- Although we found that the independent investigator had completed a review of an allegation that we identified in February 2023, we had concerns that the provider had not made sure that they had the correct skills to undertake this role effectively. For example, recruitment records indicated that the independent investigator did not have any safeguarding experience and there was no evidence that they had completed safeguarding training for adults or children.
- During the inspection, we were informed by managers that the young person living at The Willow had made regular allegations against members of staff. However, we did not see any records of this and more importantly, it was unclear what actions had been taken to make sure that the young person had not been placed at an increased risk of harm.
- The young person living at The Willow raised concerns during the inspection, informing us that there had been occasions when a member of the management team had behaved in a way that was deemed threatening. We raised this with the provider during the inspection so that appropriate actions could be taken to keep the young person safe.

Systems had not been established to safeguard service users from abuse and improper treatment as

safeguarding incidents had not always been effectively managed when allegations of abuse had been made against members of staff. This placed people at risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although we found that the provider had informed the young person's social worker of all safeguarding incidents that we reviewed, we had concerns that safeguarding referrals that had been made to the local authority as direct referrals had not been done in a consistent way, meaning that there was an increased risk that the local authority responsible for the young person would not have effective oversight of all safeguarding incidents that had happened.
● In addition, when safeguarding referrals had been made directly to the local authority, we found that sufficient information about the safeguarding concern as well as the wider context of the young person had not been included.

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

At our last inspection we found that the provider did not have an effective policy and procedure for safeguarding vulnerable adults, and staff had not received appropriate levels of training in safeguarding vulnerable adults. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● During this inspection, we found that the provider had implemented a policy for safeguarding adults, which contained important information to support staff, such as giving examples of different types of safeguarding as well as how to report safeguarding concerns when needed.
● However, on reviewing training records, we found continued concerns that staff had not completed the correct level of training for safeguarding adults, and it was unclear from training records how many staff had completed the training that had been made available. This was because the training matrix provided had not included this information, and following the inspection the provider was only able to provide evidence of a small number of staff having completed this.

Assessing risk, safety monitoring and management

At our last inspection we found the provider had not always taken all reasonable steps to make sure that risk management plans had been updated when needed. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● During the inspection, we took time to review documentation for the young person who lived at The Willow, including important records such as risk assessments as well as care plans and positive behaviour

support plans.
● On the days of our inspection we had concerns that the risk assessments that had been made immediately available for staff were not the most up to date and did not include the most updated risks for the young person. This was important as staff informed us that this was the first place that they accessed to find important information.
● Risk assessments that were held electronically and were available to support staff in keeping the young person safe had not been updated in line with the provider's updated policies and processes. Risk assessments did not always provide sufficient information for staff to follow to keep young people safe.
● For example, we found that guidance available to support staff in removing high risk items from the young person during periods of dysregulated behaviour was unclear. Staff did not know what items to remove and when to do this, potentially placing the young person at increased risk of harm.
● Importantly, staff informed us that they found risk assessments difficult to navigate and gave examples of when this had led to staff not following the most up to date guidance, and therefore not supporting the young person in a way that was expected. For example, we were informed about one occasion when the young person had been allowed to have their mobile phone at a time outside of what had been agreed, placing the young person at an increased level of risk.
● Records also indicated that there had been two occasions when the young person had absconded from the service. On reviewing records which detailed these incidents and speaking with staff, we had concerns that staff had not taken all steps to reduce the risk of this happening on either occasion. For example, staff had not secured one of the doors at The Willow, allowing the young person to be able to abscond.
● On reviewing records that staff completed daily to record events that had happened throughout the day, we identified concerns that mandated observations had not been completed as expected. For example, although we were informed by staff that observations for the young person should be completed every hour at a minimum, we found 8 occasions between 1 and 30 August 2023 when this had not been done in the timeframes expected. This placed the young person at increased risk of harm.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service as the provider had not made sure that observations had been undertaken in a way that reduced the risk of harm to the young person. 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 identified concerns that when staff had needed to use restraint to keep the young person safe, this had not always been done in line with a way that would be expected. For example, during the inspection, we observed one occasion when the service user was placed at an increased risk of harm by the way in which the restraint was undertaken. Importantly, managers who we spoke with had not recognised that the way in which the restraint was undertaken was unsafe.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service as the provider had not always made sure that restraint was undertaken in a way that reduced the risk of harm to service users at The Willow. 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 The Willow included a small team of residential support workers who were supported by a clinical team, including a psychologist and several assistant psychologists.
● The provider had determined the minimum number of staff needed to care for the young person who lived at The Willow safely. Records that we sampled between 1 July and 20 August 2023 indicated that there had

been enough staff available.
● However, we did note that there had been two recent occasions when there had been no substantive staff present, meaning that support was provided by two agency members of staff throughout both evenings. Importantly, there was no documented evidence that either member of agency staff had completed important training, such as safeguarding children or adults.

Preventing and controlling infection

At our last inspection we recommended the provider considers ways to make sure that all areas, including the living quarters at The Willow, are kept clean, in line with the provider's policies and procedures. The provider had made some improvements.

● During our inspection, we took time to inspect the living quarters of the young person living at The Willow, finding that all areas were visibly clean. This included the bathroom, which we found to be visibly dirty during the last inspection.
● However, on reviewing guidelines that were in place for staff to follow, it was still unclear when staff were expected to support the young person with cleaning, particularly at times when the young person had disengaged from this activity. This meant that there was an increased risk that the young person would not always be supported to do this appropriately and that improvements made would not be sustained.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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 effective key question at this inspection.

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- During the inspection we identified concerns that the provider had not taken all reasonable steps to support the young person living at The Willow in a way that met their individual needs. For example, the written records did not provide sufficient information to help staff in supporting the young persons needs regarding their diagnosis of autism.
- Although the young persons care plan that was written on admission contained important information, such as not using raised voices when supporting the young person, this had not been made clear in the records that staff used on a day-to-day basis.
- Importantly, we observed one occasion during the inspection of a member of staff raising their voice at the young person, leading to an incident of escalated behaviour. We also observed another occasion when a member of staff communicated with the young person in a way that was increasingly frustrating for them.

Systems had not been established to do everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be. This was because the needs of the service user, particularly relating to their diagnosis of autism had not been met. This placed people at risk of harm. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- We took time to review training records for staff who worked at The Willow. Although the provider had made some improvements to the way that oversight of training completion had been kept, we had concerns that the provider was unable to provide evidence that staff had completed all training that had been required.
- For example, during the inspection, the provider was unable to provide evidence that staff had completed the Care Certificate at the start of their employment (The Care Certificate is an agreed set of standards that define the knowledge,
skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the

15 minimum standards that should form part of a robust induction programme).
● Following the inspection, the provider shared information that only three members of staff had completed this, which was not in line with the provider's training policy and procedure.
● In addition, we found that staff had not completed all elements of other training that had been required. For example, evidence of safeguarding training for adults and children was limited, as well as only two out of ten members of staff having completed required first aid training.
● We also had concerns that the provider had not made sure that agency staff who worked at The Willow had completed all training that was needed for them to undertake their roles safely and effectively. For example, on reviewing records for agency staff, there was no evidence of any of them having completed safeguarding training for adults and children. This was important as there had been one occasion in August 2023 when agency staff had supported the young person overnight without a member of permanent staff being present.
● The provider was unable to provide evidence of training for all members of the senior management Team. For example, we did not see any evidence that the unit manager had completed all training, which included key information like safeguarding children and safeguarding adults, as well as restraint training. Importantly the unit manager was part of the on-call rota and was responsible for giving advice to staff on actions to keep children safe in the event of an emergency.

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.

Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection we recommended that the provider consider ways in which to better support the young person living at The Willow to manage and maintain a better-balanced diet. The provider had not made improvements.

● During this inspection we identified continued concerns that the dietary needs of the young person who lived at The Willow had not been met. We found that there was a lack of documented evidence to support staff to make sure that meals had been planned with the young person. For example, although meal planning documents had been available, there was no evidence that these had been used.
● In addition, we were informed that the young person had a list of 'safe foods' that they were happy eating. However, records did not clearly indicate what these were, meaning that there was a lack of clear information for staff to follow to support the young person effectively.
● The young person and their family who we spoke with during the inspection informed us that they did not feel that enough support had been given by staff at The Willow.
● We noted that there had been a recent incident when the young person had needed to attend a local emergency department. Despite advice being given on discharge to improve the young person's diet and fluid intake, the provider had taken some actions. However, the provider was unable to evidence clear strategies that had been put in place for staff to follow, meaning that effective improvements had not been made.

Systems had not been established to do everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be. This was because enough support had not been provided for service users to maintain a healthy diet. This was a breach of regulation 9(1) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support

At our last inspection we recommended that the provider consider ways in making sure that all important documentation, such as health plans are readily available, reducing the risk of individual needs not being met. The provider had not made improvements.

● During this inspection, we found that the provider had not made sure that staff had access to the most up to date health plans for the young person. Although we noted that a specialist nurse had recently visited The Willow to undertake a yearly health assessment, there was no documented record of this and staff who we spoke with were unaware of whether any immediate recommendations had been made to better support the young person.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Although staff understood court of protection orders that were in place, including what they meant and that they should be applied in the least restrictive way possible, this had not always been followed.
● During the inspection, we observed one occasion when restraint was used inappropriately. Although the young person's behaviour had escalated, they were restrained by three members of staff despite not presenting an immediate threat to themselves or others.

Systems had not been established to safeguard service users from abuse and improper treatment as restraint had not always been used only when needed. This placed people at risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We also found that all belongings, including toiletries and clothes had been removed from the young person following a recent incident of self-harm. On the day of inspection, we found that there was no written documentation justifying why all the items had needed to be removed, particularly as some did not pose an immediate risk to the young person.
● Importantly, the provider had also not planned when these items should be reintroduced to the young person. The young person informed us that they had been unable to wash for two days because of this. This was particularly important as the young person had recently suffered from an illness and access to personal hygiene items was essential to prevent reinfection.

Systems had not been established to safeguard service users from abuse and improper treatment as the provider had not evidenced that the least restrictive option had been used when removing risk items and had not made plans for them to be introduced as soon as possible when safe to do so. This placed people at risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although there was some evidence that the provider had worked to get the balance right between ensuring young people's privacy with safety, this had not always been achieved. For example, there was no evidence that the provider had sought consent from the young person living at The Willow before adding audio to the CCTV that was available in the communal areas.

Systems had not been established to make sure that the privacy of service users had been always maintained as consent had not been sought from the service user following changes that had been made to the way in which CCTV was used. This placed people at risk of harm. This was a breach of regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we recommended that the provider consider ways to make sure that all staff fully understand Gillick Competence. The provider had not made enough improvement.

● Although managers informed us that they had worked with staff to understand Gillick Competence, staff who we spoke with were unclear about this. Gillick Competence is a term used to determine whether a young person aged under 16-years has sufficient maturity and understanding to consent to their own treatment and care.

At our last inspection we recommended that the provider consider ways to make sure that the young person living at The Willow has access to an independent mental capacity advocate and as well as an independent visitor when needed. The provider had made some improvements.

● Managers informed us that meetings with an independent visitor had been arranged with the young person since the last inspection, providing an opportunity for them to address any concerns or worries that they may have.

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 if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Since our last inspection, the provider had made changes to the policies and processes relating to whistleblowing. This was important as having routes to support staff, including routes in which anonymity can be maintained is important as it supports staff in raising concerns about poor care safely when needed.
- However, some staff who we spoke with during and after the inspection had not always felt that concerns that had been raised had been listened to, and sometimes felt that that there was no point in raising concerns at all.
- The young person who lived at The Willow also informed us that they sometimes had felt like there was no point in raising concerns as their concerns would not always be listened to. Or taken seriously.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Although the provider had informed the Commission of actions that had been taken since our last inspection, we found that these had not always been effective, or implemented in a way in which improvements had been sustained.

At our last inspection we found that roles and responsibilities of managers were unclear. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Although the provider had taken steps to improve the roles and responsibilities of managers, including the registered manager and the nominated individual, we found that the changes had not been fully effective in maintaining oversight of the regulated activities that were provided at The Willow.
- Since our last inspection, the provider had recognised the need to add additional capacity to the

management team and had recruited a manager who was responsible for maintaining oversight of The Willow on a day-to-day basis. However, we found that most of the unit manager's focus had been directed towards another registered location owned by the provider, and subsequently, all improvements that had been needed at The Willow had not yet been made. This was acknowledged by managers during the inspection.
● Following the inspection, we were informed that two key members of the provider's management team had left, meaning that we had further concerns that the provider would be unable to make further sustainable improvements to the services provided.

At our last inspection we found that systems had not always been effective in monitoring the services provided. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider had some systems in place to monitor the services provided at The Willow, 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 managers to recognise other areas of poor performance.
● For example, the provider had not recognised that the risk assessments that were immediately available to staff were out of date and that there had been several examples of when individual risk assessments and care plans had not had sufficient, up to date information contained within them to support staff in providing safe and effective care.

At our last inspection we found that the provider had not operated an effective system to make sure all policies and procedures needed to support staff were available, contained clear and accurate information and reflected the most up to date best practice guidance. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider had done a lot of work to update all of the policies and procedures that they had since the last inspection. Although most policies and procedures better reflected the services that were provided at The Willow, we had continued concerns that the provider would not continue to make changes to these as and when needed.
● For example, we found one occasion when the way in which CCTV was used within The Willow, but the policy and process for this had not been amended to reflect this. This meant the most up to date information was not available in how the use of CCTV should be managed.

At our last inspection we found that the provider did not operate an effective system to identify, manage and reduce organisational risks as much as practicably possible. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Although the provider had introduced systems to better manage organisational risks since our last

inspection, we found that these improvements had not been sustained. During the inspection, managers were unable to tell us about any organisational risks that the service currently faced, and more importantly whether any actions had been taken to reduce these as much as practicably possible.

Continuous learning and improving care

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

● On occasions when incidents had been reported by staff who had been involved in incidents, we found that the provider had made improvements to the way in these had been documented, including what actions had been taken to reduce the risk of similar incidents happening again.

● However, we identified concerns that not all incidents had been reported in line with the provider's policy. For example, we found incidents that had happened which had been reported as safeguarding concerns but had not been reported as incidents. This meant that it was unclear what actions managers had taken to better understand what had caused these incidents, but more importantly, what actions had been taken to make improvements.

● On reviewing incident reports that had been completed, we found that important information had not always been captured by staff who had written the report. For example, on one occasion, the completed report had failed to mention the correct numbers of staff were not present to support the young person. This was important as the young person had subsequently absconded.

● Although the provider's incident reporting policy indicated that incident reports should be written by staff who had been involved in an incident, we found that this had not always been the case. For example, we observed that a manager had written an incident report that had involved other members of staff, meaning that we had concerns that the incident report would not accurately reflect what happened during the time that the incident had taken place.

● In addition, the provider had not operated a system to make sure that original incident reports had been kept. This meant that we could not be assured that all aspects of incidents had been captured, meaning that there was an increased risk that all necessary actions had not been taken to make improvements.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service as incidents had not always been reported, investigated and managed in line with the provider's policy and had not always captured important information relating to incidents. 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.