Whitrigg House
Care Home Service

Bathgate

Type of inspection:
Unannounced

Completed on:
15 March 2023

Service provided by:
West Lothian Council

Service provider number:
SP2003002601

Service no:
CS2003011110

About the service

Whitrigg House is a care home for children and young people, in East Whitburn, West Lothian. It is one of two residential services for children and young people provided by West Lothian Council. The house was situated on the outskirts of Whitburn in a residential area, close to public transport links and local shops and amenities. This service was previously registered with the Care Commission and transferred its registration to the Care Inspectorate on 1 April 2011. The service operates as a small resource for young people, and they are registered to provide a care service for up to three young people.

The house is on two floors, with five bedrooms, one bathroom two communal living rooms, a kitchen, a downstairs cloakroom with shower and a small office. The house is detached, with a small front garden and outbuildings and parking to the rear. Plans are underway for a new build to replace Whitrigg House; this will be on the same site as their sister house (Torcroft). We were advised that work will be completed by 2025.

The aims and objectives for the service are currently under review. At this time, the 'Welcome to Whitrigg' information leaflet for young people, states that children and young people can expect to:

- 'Have fun making meaningful memories, and respect each other'.
- 'Enjoy spending time together'.
- 'Will be kept safe and happy'.
- 'Will be supported and advised in all aspects of their care'.
- 'Children and young people will be listened to'.

About the inspection

This was an unannounced inspection which took place on 7 and 8 March 2023. The inspection was carried out by one inspector from the Care Inspectorate. To prepare for the inspection, we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection. In making our evaluations of the service we:

- spoke with one young person using the service;
- spoke with eleven staff and management;
- observed practice and daily life;
- reviewed documents; and
- spoke with one social worker.

Key messages

- The service has worked hard to create a nurturing and trauma-informed culture.
- Young people were having very good outcomes.
- Staff and managers felt very well supported.
- Staff fully understood the young people, and had built trusting relationships.
- Managers and external managers of the service played a key role in monitoring young people's experiences and improving outcomes.
- The service need to improve their quality assurance at an operational level.
- The service should review care plans and risk assessments to ensure that these are up to date and reflect children and young people's views.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support children and young people's rights and wellbeing?	4 - Good

Further details on the particular areas inspected are provided at the end of this report.

How well do we support children and young people's rights and wellbeing?

4 - Good

Quality indicator 7.1: Children and young people are safe, feel loved and get the most out of life.

Since the last inspection, leaders within the service had continued to work hard to improve the culture and make Whitrigg House a more reflective and nurturing environment for children and young people. All staff that we spoke to, fully understood the importance of building supportive and trusting relationships with young people. They informed us that relevant training had been made available to them that improved their overall work practice and this, in turn, improved outcomes for young people. Staff informed us that levels of peer support and morale had vastly improved in the past year, mainly due to greater oversight of their work practice and clearer direction being provided by managers.

A staff member commented:

"During the pandemic and sickness, there were a lot of locums and agency staff, and the lack of consistency had an impact on the young people. Now, we are a much more settled staff group, we are all like-minded and staff know what they are doing."

It was encouraging to find that overall, staff that we spoke with were able to link young people's behaviours to earlier childhood adversity and experiences, and they took a calm and compassionate approach to dealing with young people. There had been no reports of restrictive practices within the house since the last inspection. However, if required, these approaches would only be used as a last resort and for safety reasons.

Since the last inspection, a new system for physical intervention had been introduced. All staff and managers spoke positively about this approach, and endorsed the principles underpinning the training, such as prevention, distraction and de-escalation, to avoid any form of restraint. We were pleased to see a strong input from West Lothian Council's Promise Worker during this training. 'The promise' is the Scottish Government's commitment to improve care for children and young people, and this involves being a nation that 'does not restrain children'. A clear and robust 'intervening safely policy' had been produced, and it was evident that the service had clear links with other organisations, all of which helped to assess, analyse and monitor improvements in practice in line with national guidance.

At the last inspection, young people told us that they had not always felt safe living in Whitrigg House, particularly when other young people had been inappropriately placed. This had lead to a lot of disruption for staff and young people. During this inspection, improvements had been made in this area. For example, a framework was currently being developed and implemented to fully consider the needs of existing residents when admissions were being considered. It was also very encouraging to observe more sensitive and respectful discussions taking place between staff and young people, around a planned admission during this inspection. This type of thorough approach can prevent placements becoming fragile and stressful for young people, and also ensure that young people feel safe and protected from harm.

Young people's views and preferences were taken into account when personalising their bedrooms. A young person invited us into his bedroom and was proud of the layout and décor he had chosen. Overall, the house had a welcoming and homely atmosphere. An effective maintenance log was now being monitored to

ensure that that any minor repair work around the house was being reported and completed in a timely fashion.

Information about the service was available to the young people in a child friendly format, so that they knew what they should expect. This included information about their rights, who could help them and how they could complain if they were unhappy about their care. The leaflet provided the young person with details of an independent advocacy worker, that they could speak with should they need to talk to a supportive adult outwith the service. At feedback, we suggested that stronger links with the advocacy service would be beneficial for young people. We were informed that plans were already in place for a participation worker to start this work within the residential services. We will look again at this area during the next service inspection.

Young people were receiving individually tailored support to maximise attainment and to help them participate in education. Staff and managers strongly advocated for young people, and had close links with local schools. This collaborative approach had enabled some young people to attend school following long periods of disengagement. It was also commendable that, in one particular case, extensive and time consuming efforts were made to understand and engage with a young person who had complex needs. These very positive outcomes provided clear evidence of a high level of commitment by staff. They also demonstrated that the young person's voice was always heard, and that they were able to participate meaningfully in the planning process.

Young people's personal plans were linked to GIRFEC (Getting it right for every child) indicators and these had identified some strengths and areas where additional support may be required. We could see that staff were being encouraged to develop the completion of all young people's records, in line with the aims of 'The Promise'. For example, more emphasis was being placed on avoiding the use of jargon and writing in the first person from the child's perspective.

Whilst we could see more appropriate and reflective language was being used in daily recordings, this was much less evident within personal plans. The goals and outcomes for some young people were not SMART (specific, measurable, achievable, realistic and timebound). These read more like objectives to be achieved by staff and we provided managers with advice at feedback regarding the importance of ensuring that young people's needs and desired outcomes were always clearly identified. (See area for improvement 1.)

Risk assessments were completed for each young person admitted to the service and most of these contained appropriate information. A new format had recently been introduced, which was designed to be an improvement, and this was at the initial stages of implementation. We noted, however, inconsistencies in the quality regarding some of the content and language, and one risk assessment did not have important up-to-date information about a young person. (See area for improvement 2.)

Quality indicator 7.2: Leaders and staff have the capacity and resources to meet and champion children and young people's needs and rights.

At the last inspection, there had been changes within the provider's residential leadership structure. New management had put in place systems of audit, and the external manager had established a strong overview of the service to monitor the quality of the care being provided. The culture of the service was now more empowering and managers were successfully modelling high standards of practice. Young people knew all managers and senior staff by their first names, and it was clear that there was a strong and helpful managerial presence within Whitrigg House.

During this inspection, it was clear that managers had continued to strengthen the staff team as well as the overall service. Regular team meetings and management meetings were now being held, these were well attended and always included senior managers. Minutes we examined, were reflective, inclusive and captured the views of staff. There was a strong emphasis on collaboration with staff, which was important given that there had been a high level of operational change. It was also encouraging to see that some areas we identified for improvement during this inspection, had also already been highlighted by the service.

The staff team received regular training and formal supervision, and had benefitted from leaders being present for informal supervision at times of need. Staffing levels were stable, there were no vacancies, and this had helped young people to develop and enjoy secure and trusting relationships. Managers had an efficient staffing schedule in place that enabled them to ensure, whenever possible, that the right number of staff with the right skills and knowledge were available to meet the needs of the young people. This was particularly useful as the staff team worked across two residential houses, and careful consideration was required when planning staff deployment.

Staff members commented:

"We are a very strong team, with a mix of skills and experience. I can request any training during supervision, and it will always be considered."

"I have regular supervision with my manager. I am very happy with that, but I can go at any time and speak to managers, I know they would all be supportive. The external manager is heavily involved in the service, she attends team meetings. I wouldn't hesitate to speak with her."

Evidence provided to us showed that the service were safely recruiting staff. For example, relevant safety checks and references were being obtained for all new recruits. A member of staff who was recently appointed, informed us that managers and staff were very welcoming, and that helpful arrangements were being made to enable access to electronic systems. This would allow essential core training to be prioritised and policies and procedures to be read as part on an overall induction. The member of staff was also given opportunities to shadow staff practice, and start to build positive relationships with young people during the induction period.

Managers of the service played a key role as champions for young people, monitoring their experiences and safeguarding and improving outcomes. The missing young person's meeting was a very good example of a social work led, strategic, multidisciplinary forum. At this meeting, up-to-date relevant statistical information was analysed and this assisted partners working jointly in helping to reduce risks associated with missing young people, trafficking and exploitation. We were informed of some innovative approaches towards gathering important information from personnel involved in the transport services. We were also impressed by the bespoke training staff were being provided with on the subject. The breadth of this overall approach made the safeguarding arrangements stronger.

The development plan for Whitrigg House was a useful working document which provided a coherent picture of the service's priorities, and showed good oversight of desired outcomes and what was required. We discussed with managers at feedback some improvements that could be made to strengthen their overall plan. For example, more detail is required on 'how' the plan would be monitored and that review dates and end dates should be specified. Managers were receptive to our suggestions and we will look at this again during our next service inspection.

The provider supported the professional development of staff, and staff were motivated to take opportunities to enhance their knowledge and career prospects. Staff who were engaged in self-directed learning, were also given protected time to study. This meant that for periods of time, some staff could be on placement outwith the service. We were assured by managers that arrangements were in place to ensure that this would not impact on staffing levels, or have any adverse impact on young people.

At the last inspection, different technological systems that were in place for quality assurance resulted in a number of records being held in different places. Potentially, this could lead to some information going missing, and the process was time consuming for staff and managers. During this inspection, a new system was about to be launched that should improve matters, and be much less onerous for staff. We will look at this area during the next service inspection.

At an operational level, we found some weaknesses in quality assurance. Children's documents within the electronic files were not always being checked for accuracy and it was difficult to know if these documents had been reviewed regularly. (See area for improvement 3.)

We also identified that not all notifiable incidents had been submitted to the Care Inspectorate. Managers had made some improvements in this area prior to the inspection ending, and we will look at this area during the next service inspection.

Areas for improvement

1. The provider should ensure that all risk assessments are updated regularly, and as children and young people's circumstances, needs and desired outcomes change.

This is in order to ensure that the quality of care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'I am helped to understand the impact and consequence of risky and unsafe behaviour and decisions' (HSCS 2.25).

2. The provider should ensure that young people are involved in directing and leading their own care and support and ensure that young people's needs and desired outcomes are clearly identified within their personal plans.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15); and
'My needs, as agreed in my personal plan, are fully met and my wishes and choices are respected' (HSCS 1.23).

3. The provider should ensure that appropriate systems are in place to support quality assurance and improvement within the service. Quality assurance processes should always include care planning for children and young people, risk assessments and monitoring of notifications to the Care Inspectorate.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19); and
'I experience high quality care and support based on relevant evidence, guidance and best practice' (HSCS 4.11).

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

The Care Inspectorate had not been notified about an incident which had occurred two weeks ago. In accordance with legislation, a provider must notify the Care Inspectorate of all accidents, incidents or injuries to a person using a care service. This is to ensure that care and support is consistent with Health and Social Care Standards (HSCS) which state that 'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

This area for improvement was made on 18 March 2022.

Action taken since then

Some improvements had been made prior to the inspection ending. We will look at this area during the next service inspection.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support children and young people's rights and wellbeing?	4 - Good
7.1 Children and young people are safe, feel loved and get the most out of life	4 - Good
7.2 Leaders and staff have the capacity and resources to meet and champion children and young people's needs and rights	5 - Very Good

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