

Netherton Farm Care Home Service

Netherton Farm
Blackford
AUCHTERARDER
PH4 1QU

Telephone: 0141 4046765

Type of inspection:
Unannounced

Completed on:
8 March 2024

Service provided by:
Greenleaf House Co Ltd

Service provider number:
SP2018013227

Service no:
CS2021000344

About the service

Netherton Farm is a care home service provided by Greenleaf House Co Ltd. It is registered to care for two young people.

The service is based in Blackford in Perth and Kinross.

The house is spacious, offering accommodation over two floors. The house can be split into two separate areas: one that accommodates 24/7 support on a one-to-one staffing ratio, and another that accommodates 24/7 support on a two-to-one staffing ratio. The door to these two areas can be closed, creating separate living arrangements, or left open for young people to live in one house.

There is lots of indoor and outdoor space for the young people to relax and spend time with staff and the people who are important to them.

The house is in close proximity to local amenities and public transport.

At the time of our inspection, two young people were living in Netherton Farm.

About the inspection

This was an unannounced inspection which took place on 27 February 2024 between 09:30 and 17:00. 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 two young people using the service and one of their family members
- spoke with staff and management
- observed practice and daily life
- reviewed documents
- spoke with visiting professionals.

Key messages

- We saw that the young people who were currently living in the service were kept safe.
- We spent time observing staff and young people together and we could see good evidence of the staff building relationships with young people.
- Arrivals and matching were managed and planned well. The manager and staff had been to visit young people and they told us this made a difference.
- There were good examples of young people recovering as a result of the therapeutic care from staff.
- At a strategic level, the quality assurance processes were failing to provide stability. The oversight of the service was not aligned to a clear model of care, or a set of principles, or standards that helped drive processes.

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? | 3 - Adequate |
|--|--------------|

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?

3 - Adequate

We saw that the young people who were currently living in the service were kept safe. Their needs were matched against the skills and training of the staff and manager. This meant that young people were supported to be safe and their emotional health was supported as well.

Young people were supported emotionally. When young people felt distressed there was effective support to offer them emotional containment. There was limited use of restraint because people were able to use their relationships to manage distress.

The service was able to offer a level of therapeutic care. We found that this was reflected in warm interactions and relationship building that facilitated trust building, and young people were enabled to talk to the staff about their historical experiences.

Young people's mental health was prioritised, and if they needed support, the staff and manager were proactive in seeking this support. We found that the manager and staff had a developed understanding of the resources available to them in the local community and were clearer about how effective the mental health supports were for their young people.

We spent time observing staff and young people together and we could see good evidence of the staff building relationships with young people. There was good humour, use of tactility when appropriate, and lots of fun. Staff could reflect on the needs of individual young people and how they needed to adjust their style of support accordingly. One social worker told us, "They have come on leaps and bounds. They go over and above and they make my job significantly easier. They manage family time and have a good relationship with the school. They advocate well, promote independence, and everything is centred around the young person." This meant that young people got the support they needed.

We found that medication was safely managed and the previous area for improvement had been met.

Advocacy was in place for the young people. For young people who had moved to the service from across a border, the service had made a concerted effort to ensure advocacy was available.

Arrivals and matching were managed and planned well. The manager and staff had been to visit young people and they told us this made a difference, "I don't think Greenleaf could have done anything differently. I feel like everyone was very welcoming and when people come in they are always welcoming." This meant that when arrivals could be matched in advance and with space to plan, young people arrived at the service in a positive way.

When young people had access to mainstream education this worked well and the outcomes were very positive. For young people who arrived from far away, we found less clarity on their education plans. Whilst the organisation takes a broad and individualised approach to education, the service has to be clear about staff working within their given skill set. Strong links with an oversight by educators will ensure young people's learning opportunities are optimised. **(See Area for Improvement 1)**

We saw young people involved in lots of physical activity. When young people lived in the service for a while they became involved in local clubs. The staff ensured young people were busy and did the things that they wanted to do. This meant that young people had a big say in how they were cared for and supported.

Family connections were nurtured for some young people. For young people who lived far away, the service also made sure that they had as much access to the people that were important to them as possible.

Young people ate with staff and appeared to be encouraged to eat a varied and balanced diet. We would encourage the service to make sure young people are having lots of fresh home cooked meals, and that they are involved in selecting nutritional and balanced choices.

Leaders were focused on creating a positive culture and a clear model of care. However, the strategic leadership of the service had lacked stability and clear direction.

The external managers had been unable to embed processes and systems that ensured young people were protected from harm, particularly in relation to allegations of abuse and investigation of complaints. Whilst they had very good relationships with young people and modelled relationship building, they had failed to ensure the service had stable and embedded systems to explore complaints and protect young people. **(See Requirement 1)**

Recruitment and staff retention was a live challenge, but the service was managing to bring in new staff when others departed. The mix, experience and skills of staff was meeting young people's needs. The managers of the service knew their staff and knew how to upskill them and identify necessary training.

The right number of staff were working in the service. In times of staff absence, we saw that the team pulled together to cover absence. This meant that the managers covered shifts and worked alongside their team. This didn't impact on managers undertaking their role.

There were good examples of young people recovering as a result of the therapeutic care from staff. One social worker told us, that the care their young person had, had been transformational in terms of the young person's self-care and self-confidence. This meant that staff did have an understanding of the therapeutic role.

Within the service there were quality assurance processes in place. These helped the house function. We were pleased to see systems focused on developing the care and support planning process. The service had altered its care planning to ensure young people understood what was being asked of them. As a result, young people were fully involved in their care and support.

At a strategic level, the quality assurance processes were failing to provide stability. The oversight of the service was not aligned to a clear model of care, or a set of principles, or standards that helped drive processes. Senior managers failed to ensure issues of quality were robustly investigated and action plans put in place to improve performance.

Requirements

1. By 30 August 2024, the provider must ensure that there are robust and effective processes and systems in place for investigating allegations and complaints.

In particular:

- a) ensure that the details of all allegations have been notified to the lead agency and the Care Inspectorate;
- b) ensure any young people who have made allegations of abuse are assured of their safety and understand that protection procedures are being followed;
- c) undertake regular quality assurance audits of complaints, allegations, child protection procedures, safeguarding and staff training within the service and act on any findings. This must include a review to ensure the provider is aware of all incidents where there has been a possible risk of harm, and that all necessary safeguarding actions have been taken;
- d) ensure that any new information leads to an exploration of historical allegations and concerns raised; and
- e) notify the Care Inspectorate on all actions taken and the findings of the quality assurance audit.

This is in order to comply with Regulation 4(1)(a) and Regulation 7(2)(c) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

Areas for improvement

1. Young people who live at Netherton farm achieve their potential because their educational needs are met. The service has ready made access to a variance of educational resources that nurture achievement and lead to no delays in access to education provision.

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

'I am supported to achieve my potential in education and employment if this is right for me' (HSCS 1.27).

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

Young people experience an arrivals process that is founded in their rights and wellbeing from the outset the service becomes involved. The organisation advocates against practice that minimises or breaches their human rights.

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

'If possible, I can visit services and meet the people who would provide my care and support before deciding if it is right for me' (HSCS 4.5)

and

'My care and support is provided in a planned and safe way, including if there is an emergency or unexpected event' (HSCS 4.14).

This area for improvement was made on 14 July 2023.

Action taken since then

The service had taken a much more proactive approach to advocacy and ensuring young people's rights were met from prior to arrival right through their time living in Netherton Farm.

This area for improvement is met.

Previous area for improvement 2

Young people experience care and support from people who are well recruited. This is because the recruitment process ensures they have the correct values and skills to undertake the caring role.

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

'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (HSCS 3.14)

and

'I am confident that people who support and care for me have been appropriately and safely recruited' (HSCS 4.24).

This area for improvement was made on 14 July 2023.

Action taken since then

Staff retention and recruitment were a live issue, but the people we met who were working in the service had the correct values and experience to be working with the young people.

This area for improvement is met.

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? | 3 - Adequate |
| 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 | 3 - Adequate |

To find out more

This inspection report is published by the Care Inspectorate. You can download this report and others from our website.

Care services in Scotland cannot operate unless they are registered with the Care Inspectorate. We inspect, award grades and help services to improve. We also investigate complaints about care services and can take action when things aren't good enough.

Please get in touch with us if you would like more information or have any concerns about a care service.

You can also read more about our work online at www.careinspectorate.com

Contact us

Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY

enquiries@careinspectorate.com

0345 600 9527

Find us on Facebook

Twitter: @careinspect

Other languages and formats

This report is available in other languages and formats on request.

Tha am foillseachadh seo ri fhaighinn ann an cruthannan is cànan eile ma nithear iartras.

অনুরোধসাপেক্ষে এই প্রকাশনাটি অন্য ফরম্যাট এবং অন্যান্য ভাষায় পাওয়া যায়।

یہ اشاعت درخواست کرنے پر دیگر شکلوں اور دیگر زبانوں میں فراہم کی جاسکتی ہے۔

ਬੇਨਤੀ 'ਤੇ ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਉਪਲਬਧ ਹੈ।

هذه الوثيقة متوفرة بلغات ونماذج أخرى عند الطلب

本出版品有其他格式和其他語言備索。

Na życzenie niniejsza publikacja dostępna jest także w innych formatach oraz językach.