Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Family Crosspoint

64 MOUNT EARL
BRIDGEND
CF31 3EY

Date Inspection Completed

21/10/2020

About Family Crosspoint

Type of care provided	Residential Family Centre
Registered Provider	Family Crosspoint Ltd
Registered places	35
Language of the service	English
Previous Care Inspectorate Wales inspection	01/05/2019
Does this service provide the Welsh Language active offer?	No

Summary

Family Crosspoint is a residential family centre located in a quiet residential area of Bridgend. The service is able to provide accommodation for up to twelve families where an assessment is required of parent's ability to care, promote and safeguard their children within a safe and supervised environment. The responsible individual (RI) is Gareth Morgan and a manager is appointed to oversee the daily running of the service who is registered with Social Care Wales.

Care Inspectorate Wales (CIW) undertook an inspection in response to concerns raised by social care and health professionals regarding the operation of the service. Serious safeguarding issues were identified prior to and during the course of the inspection which led to CIW issuing notices under our civil enforcement powers. We issued a notice to restrict admissions into the service and to prevent the extension of any existing placement arrangement without the consent of CIW. We also issued an improvement notice to the service provider on 17 November 2020 setting out the improvements required to evidence and demonstrate compliance with the regulations. Due to the seriousness of the concerns and potential risks to children local authority commissioners of the service sought alternative arrangements for families and all left the service by 6 November 2020.

Well-being

Parents who access this service require a high level of support, supervision and

monitoring to ensure their children are safe and protected. Limitations are imposed on parents during their stay, either voluntarily or directed through a court plan, and these are set out during an initial planning meeting on entering the service. This meeting identifies observation levels include arrangements for monitoring via closed-circuit television (CCVT) surveillance, additional support with parenting tasks and support in the community. As the assessment progresses, the level of observation is reviewed with social workers to reflect the parent's progress in line with the proposed care plan. Parents must accept and understand the purpose of the placement prior to their admission although this was not evident in our discussion with one parent and from records. Personal plans had not been drawn up with parent's to reflect their views and the level of support, supervision and observation levels agreed to help them achieve their personal outcomes and to keep children safe and protected from harm.

Families have access to health professionals to support and promote their physical, mental and emotional well-being. Health visiting arrangements are in place via local GP surgeries and parents and children register on their admission to the service. Issues have been raised by health services about health visitors not always being aware when children are discharged from the service, to ensure continued health monitoring of the child. The service supports and encourages parents and children to access community facilities with support from care staff where this is required. Unfortunately, access to activities such as soft play and playgroups have been limited during the Covid-19 pandemic, and trips into the community have been dependent on 'lockdown' restrictions.

Children are not always protected from harm and this has highlighted serious safeguarding concerns in the way in which the service operates. Not all care staff have received appropriate safeguarding training nor do all care staff have the level of experience and skill to manage situations of risk or potential risk to children. This has led to incidents where children's well-being and safety is compromised and they have been placed at serious risk of harm.

A resident's guide is available and contains the relevant information. The responsible individual has investigated complaints made by parents and recorded the outcomes although this approach has not been consistent with concerns raised by professionals or other relevant parties.

The service provides suitable living accommodation for families, which is clean and well equipped. Families live either in self-contained units or in smaller units with communal kitchen areas. CCTV surveillance is available in each room to enable close monitoring and observation.

Care and Support

The service provider has not identified the individual care and support needs of each children prior to, or following, their admission to the service. A viability assessment is

completed on receipt of a referral from those commissioning the service, which sets out basic information and expectations of the service to be provided. An initial care-planning meeting is held on the date of admission to consider the arrangements for the placement, assessment and to set out the level of observation and supervision required. From the records provided, the care staff shift lead undertakes the initial care-planning meeting. Compatibility assessments are completed once the family has been admitted into the service; however, they did not indicate the service provider had determined the service was suitable. There was no consideration given to the impact of a new admission on families already using the service nor the risks / potential risks to those moving in. Assessments were completed by staff who were unqualified, inexperienced and had not received training to assist them in their role. The examples we saw were incomplete and unsigned and did not evidence management oversight or consideration of the information provided prior to or on admission.
Personal plans were not in place for children and parents. The documents developed by the service do not demonstrate individuals were able to contribute and identify their personal wishes, aspirations and outcomes. Children's care and support needs were not identified and there was no clear guidance for care staff on how to assist families. Provider assessments lacked any clear understanding of the requirement of the regulation. Care staff completing assessments do not have the skills, knowledge and training to undertake this task and there was no management oversight to evidence how the provider would meet individual's needs. The risk management system implemented by the service was not effective in identifying risk and the action for care staff to take to safeguard and protect children. Parents have the opportunity to engage in workshops to develop and improve their parenting and their attendance is encouraged during the period of assessment. Care staff delivering workshops told us they work from a training pack and shadow other care staff but we found no evidence they had received training in some workshop subjects despite delivering these to parents.

Children are not always safe and protected from harm, abuse and neglect. Families using the service have a high level of complex support needs. Observation of parents and children take place via 24-hour CCTV surveillance and, where requested, care staff provide direct support and supervision. Care staff with responsibilities to monitor families via the service's CCTV surveillance system, have not received adequate training to identify safeguarding risks and use the procedure to alert other care staff to take action. This has led to a failure by care staff to consistently identify, intervene and protect children, and has led to children being harmed or placed at risk of harm.

Leadership and Management

The governance and management arrangements in place have not ensured the service operates with sufficient care, competence and skill in accordance with its statement of purpose. Not all children have receive a service that provides for their care and support needs, promotes their well-being and protects them from harm. Policies and procedures

are not embedded in practice and the service provider has failed to ensure CIW have been notified of incidents as required by the regulation.

Quality assurance processes are in place and the responsible individual visits the service to consult with care staff and parents on the experiences of working in or using the service. A review of the quality of care has been completed at six monthly intervals and identifies service developments. However, it does not provide analysis of data in relation to notifiable incidents, safeguarding matters, whistleblowing, concerns and complaints. The opportunity for greater scrutiny to review and improve standards of care and compliance with the regulations has been overlooked. The responsible individual has not considered confidentiality when including information in reports from and about commissioners and individuals.

Care staff recruited to the service do not all have the qualifications, experience, competency and understanding of the complex risks posed to children from their parents. Recruitment processes did not evidence gaps in employment history were accounted for or references verified. Care staff's induction training does not support newly employed care staff to develop an understanding of the service or equip them with skills to be confident in their role. Some care staff had completed the All Wales Induction Framework, but the implementation of this framework was not consistent across the team. Information from the care staff training matrix does not confirm the current care staff team have received training as set out in the service statement of purpose. Not all care staff have received safeguarding training nor do they all have the skills, experience, knowledge and confidence in their role to protect vulnerable children. Care staff's training on the CCTV surveillance system has not been consistent and not all care staff have been confident in recognising signs of abuse to take immediate action when children are at risk. This has resulted in a number of incidents where parents have not appropriately supervised children or where children have suffered harm.

Safeguarding reports have not been made as required by the Wales Safeguarding Procedures and the manager, as the designated safeguarding lead for the service, has not shown due diligence in ensuring concerns or incidents have been reported. The service has not completed notifications to CIW as required by regulation and this has resulted in lack of oversight of the functioning of the service where there have been significant safeguarding concerns.

Environment

The site visit was time limited due to the Covid-19 pandemic and did not allow for a full inspection of the premises.

Overall, the service provides children and their parents with suitable accommodation in a location and within an environment with facilities and equipment suitable for their care and support needs. We had the opportunity to view a ground floor 'bedsit' which was

clean, spacious and well equipped with furnishings to a good standard. There is a large car park to the front of the property and families are able to access a rear garden, which also has a designated smoking area, and care staff are able to observe via CCTV surveillance.

Systems are in place for monitoring families via CCTV surveillance. Care staff observe families on screens linked to each room and communal areas, including the service foyer/entrance area. The layout of the observation room has recently been re-designed to reduce staff numbers and 'traffic' in the CCTV room, prevent distractions to staff operating equipment and increase the number of staff in the adjacent staff office. Despite these improvements, a serious incident occurred during the inspection period where a parent and child were able to leave the premises via the main entrance without care staff intervening, leading to a significant safeguarding concern. The CCTV equipment is fit for purpose but care staff failed to respond and take action to safeguard the child.

Measures for reducing the risk of cross-infection are in place. The service provider has a hygiene control and infection policy and a risk assessment specific to Covid-19 home to minimise risks to children, their parents and care staff. There is a Covid-19 protocol for visitors to the service. The manager needs to ensure the information obtained is stored securely on completion. The manager told us Personal Protection Equipment (PPE) is available to all care staff and we saw they were wearing facemasks during our visit.

Areas for improvement and action at the previous inspection		
The service provider must ensure the service is provided with sufficient care, competence and skill having regard to the statement of purpose.	Regulation 6	Not achieved.
The service provider must not employ a person under a contract of employment to work at the service unless person is fit to do so.	Regulation 35(1)(a)	Not achieved.
A provider assessment needs to be established within seven days of the commencement of the placement.	Regulation 18(1)	Not achieved.
The residents guide should be dated and contain information about advocacy services and information of the active offer of the Welsh language.	Regulation 19(3) and 19(2)(a)	Achieved.
Parents should be provided with a signed service agreement relation to care and support and other services provided.	Regulation 20(1)(a) and 20(1)(b)	Not achieved.
The provider should not retain referral information where families have not accessed the service.	Regulation 59(1)	Achieved.
People who use the service have access to their records and are aware of their rights to access this information	Regulation 59(3)(h)(i) and (h)(ii)).	Achieved.
A system is in place to record incidents and complaints.	Regulation 64(2)(d)).	Not achieved.

Areas where immediate action is required	
The service provider has not ensured the service operates as described in the statement of purpose and has failed to ensure	Regulation 6

the service is provided with sufficient care, competence and skill.	
The service provider has not determined the care and support needs of children and their parents to ensure that the service is suitable and able to support them to achieve their personal outcomes. The assessment required has not been completed by an appropriate person.	Regulation 14(5)
The service provider has not prepared personal plans for children and their parents to identify how their individual care and support needs are to be met as required by the regulation and the actions to be taken to mitigate any identified risk.	Regulation 15(1)(a) 15(1)(b) 15(1)(c) 15(1)(d)
The service provider has not completed a provider assessment for children and their parents on how their care and support needs are to be met by the service and how they are to be supported to achieve their personal outcomes. The service provider has not ensured that assessments undertaken are completed by a person who has the skills, knowledge and competence to carry out this role.	Regulation 18(1) 18(3) 18(4)
The service provider has not operated the service in a way that has ensured that children are protected from harm, neglect and abuse.	Regulation 26
The service provider has not ensured that all staff recruited have been subject of a rigorous selection and vetting procedure and checks have been undertaken to ensure their veracity. Care staff recruited have not had the qualifications, skills and experience for the role they are employed to undertake.	Regulation 35(1) 35(2)(b)
The service provider has not ensured care staff receive an induction appropriate to their role, are supported, and receive training appropriate to the work to be carried out to support their understanding of the complexities and risks posed to children by their parents.	Regulation 36(2)
The service provider has not notified the service regulator of the events specified in Parts 1 and 2 of Schedule 3.	Regulation 60(1)
The responsible individual has not had sufficient oversight of the management, quality, safety and effectiveness of the service.	Regulation 66
The responsible individual has not ensured that the arrangements in place for monitoring, reviewing and improving the quality of care and support provided by the service consider the outcome of engagement with staff and people using the service, analyse data and consider the outcome of any audit of the accuracy and completeness of records.	Regulation 80(3)

We found poor outcomes and identified risks to the well-being of children. An improvement notice has been issued to the service provider alongside a non-compliance notice.

Date Published 11/02/2021

Care Inspectorate Wales

Regulation and Inspection of Social Care (Wales) Act 2016

Non Compliance Notice

Residential Family Centre

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

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

Further advice and information is available on our website
www.careinspectorate.wales

Family Crosspoint

64 MOUNT EARL
BRIDGEND
CF31 3EY

Date of publication: **02/02/2020**

Leadership and Management	Our Ref: NONCO-00009746-JSGC
Non-compliance identified at this inspection	
Timescale for completion	**01/02/2021**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider is not compliant with regulation 6 of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.	6

Evidence

The service provider has not ensured the service operates as described in the statement of purpose and has failed to ensure the service is provided with sufficient care, competence and skill.

Evidence:

- The statement of purpose states, “Family Crosspoint acknowledges the duty of care to safeguard and promote the welfare of children and adults and is fully committed to developing robust policies and procedures that minimise the risk to children and adults in a Residential Family Centre.” The service has failed to do this by not taking sufficient action to safeguard all children from the risk of harm.
- Policies and procedures are not embedded in practice and care staff are not provided with the support and guidance that enables them to carry out their role effectively. The service’s Closed-circuit television (CCTV) surveillance policy and procedure has not been effective and has failed to protect children.
- There have been a number of incidents where children have been placed at risk of harm. For example, on 21 May 2020 a parent left the service on foot with a child when care staff were present and no concerted attempt was made by care staff to pursue or locate them. On the 28 August 2020, a father held his hand over his child’s mouth for approximately 11 seconds. The father was observed to roughly handle the child before putting him on the bed and then placing his hand over the child’s mouth. He then appeared to put his finger into the child’s mouth, again quite roughly. This incident was observed by care staff on CCTV who failed to take immediate action, intervene and call a ‘code red’ alert in line with the service’s CCTV surveillance policy. The child was taken to the Princess of Wales Hospital in Bridgend that day for extensive medical examinations. Health professionals reported that if this incident continued for a few more

seconds then this could have resulted in death. During further medical examinations of the child, a historic fracture was identified which the hospital reported was likely to have occured during the time the family were at the service. To date there has been no explanation of this injury despite the service having 24-hour surveillance in place to ensure children are protected at all times from significant harm. On the 28 October 2020, a parent and child left the service in a taxi without being challenged by care staff despite an agreement of 24-hour surveillance and a known history of absconding or fleeing from services.

- The service provider has failed to ensure care staff are trained appropriately in the use of the CCTV monitoring system and to react immediately when observing parents present with behaviours that pose a risk to their child. This failure has resulted in a number of concerning incidents where children have suffered harm and been placed at risk of harm.
- The conclusion of the internal investigation undertaken by the service provider in relation to concerns raised at a safeguarding meeting on 10 September 2020 was to dismiss the member of care staff who had been operating CCTV equipment at the time of the incident on 28 August 2020. However, the member of care staff had continued to work and operate CCTV equipment following this serious safeguarding incident until their dismissal on 10 September 2020. The investigation did not identify any failings in the actions of other care staff on duty at the time of the incident to act to protect the child; however, they were also implicit in these failings.
- The service provider has failed to ensure care staff are provided with appropriate support and supervision, to ensure they are effectively supported in their role and as set out in the statement of purpose.
- The staff training matrix provided by the provider does not confirm the current staff team have received training in line with the service as set out in their statement of purpose.

The impact on the children living at the service is that the service provider has failed to ensure the service is provided with sufficient care, competence and skill, having regard to the statement of purpose. This has led to children being placed at risk, and because of these failings a child has suffered significant harm.

Care and Support	Our Ref: NONCO-00009794-RBDG
Non-compliance identified at this inspection	
Timescale for completion	**01/02/2021**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider is not compliant with regulation 14(5) of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.	14(5)

Evidence

The service provider has not determined the care and support needs of children and their parents to ensure that the service is suitable and able to support them to achieve their personal outcomes. The assessment required has not been completed by an appropriate person.

Evidence:

- Case records provided to CIW for two families (Family B1 and Family B2) contained compatibility assessments that did not evidence that consideration had been given to the compatibility of families using the service or identify any impact on the admission of a new family on those already receiving a service. Care staff undertaking assessments did not have the required skills, knowledge and training to carry out this role and records of the assessment were not fit for purpose.
- Case records provided to CIW for one family (Family C) did not contain a compatibility assessment for these risks to be considered.

The impact for children and their parents is that the service has not considered the care and support needs of children and their parents and the impact of these on others using the service. Assessments undertaken did not inform personal plans and risk assessments and the care staff completing assessments were not competent to do so.

Care and Support	Our Ref: NONCO-00009795-RKBG
Non-compliance identified at this inspection	
Timescale for completion	**01/02/2021**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider is not compliant with regulation 15 (1) (a)(b)(c)(d) of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.	15(1)(a) 15(1)(b) 15(1)(c) 15(1)(d)
Evidence	

The service provider has not prepared personal plans for children and their parents to identify how their individual care and support needs are to be met as required by the regulation and the actions to be taken to mitigate any identified risk.

Evidence:

- Following the inspection of 21 October 2020, CIW requested copies of personal plans for Family B1, Family B2 and Family C. These were not provided and were not contained in the case records requested. Initial care planning documentation did not meet the requirements of the regulation.
- Risk assessments did not provide specific and detailed guidance for care staff on how to respond or what action to take to minimise or prevent children being placed at risk.
- CIW found no evidence that a representative of the service provider had completed assessments in line with the regulation.

The impact for children and their parents is there is no effective mechanism in place to identify their individual care and support needs and personal outcomes and provide guidance to care staff on how to provide support and take action to reduce or eliminate risks to children.

Care and Support	Our Ref: NONCO-00009796-HKYJ
Non-compliance identified at this inspection	
Timescale for completion	**01/02/2021**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider is not compliant with regulation 18 (1) 18(3) and 18(4) of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.	18(1) 18(3) 18(4)

Evidence

The service provider has not completed a provider assessment for children and their parents on how their care and support needs are to be met by the service and how they are to be supported to achieve their personal outcomes. The service provider has not ensured that assessments undertaken are completed by a person who has the skills, knowledge and competence to carry out this role.

Evidence:

- Following the inspection of 21 October 2020, CIW requested copies of the provider assessments for Family B1, Family B2 and Family C. The assessments provided did not comply with regulatory requirements, as they were not an assessment of how the child and parent's identified care and support needs were to be met by the provider.
- The assessment lacked detail, analysis and did not identify risk or how to keep people safe. They did not take account of any other assessments and were undertaken by members of care staff who had not received training in carrying out assessments or were competent in undertaking such a task. The assessment documents were hand written notes that were incomplete and were representative of a questionnaire and not fit for purpose.

The impact for children and their parents is that the service provider had not assessed how individual's care and support needs could be met by the service.

Well-being	Our Ref: NONCO-00009747-VWXB
Non-compliance identified at this inspection	
Timescale for completion	**01/02/2021**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider is not compliant with regulation 26 of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.	26

Evidence

The service provider has not operated the service in a way that has ensured that children are consistently protected from harm, neglect and abuse.

Evidence:

- The leadership of the service does not evidence a clear understanding of their role to safeguard children by ensuring that safeguarding concerns are reported and that action is taken by care staff as outlined in the service safeguarding policy and Wales Safeguarding Procedures.
- Incidents at the home had not been referred to the local safeguarding team as required by the Wales Safeguarding Procedures. This included admissions of children to hospital where there had been concerns regarding an injury or presentation of marks which parents were unable to provide an account for. Neither had they been notified to CIW as required.
- The risk management system implemented in the service does not appropriately identify risks and the evasive action, to be taken by care staff to safeguard children from harm.
- Information shared by the Local Heath Board advised of a vulnerable family discharged with no communication with the health visitor; a birth visit undertaken outside of the Healthy Child Wales Programme Timeline as the health visitor had not been informed the baby had been admitted to the service; non-referral of a baby with bruising to the Paediatric Assessment Unit as per their policy; a two day delay in referral to medics in relation to a child with bruising on their genitalia.
- Staff failed to intervene promptly in a potentially dangerous situation as reported by a parent to their social worker where one to one support was being provided.
- The incident of the 28 August 2020, when a father appeared to impede their child's

breathing and further medical examination found a fracture to the seventh rib.

- A report to CIW from Cwm Taf Morgannwg University Health Board of concerns that several babies have been recently admitted from the service and their ability to deal appropriately with concerns.
- Two incidents of parents leaving the service with their children, one returned within an hour by Police and the other missing for seven days.

Leadership and Management	Our Ref: NONCO-00009797-LWKR

Non-compliance identified at this inspection

Timescale for completion	01/02/2021

Description of non-compliance/Action to be taken	Regulation number
The service provider is not compliant with regulation 35(1) and 35(2)(b) of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.	35(1) 35(2)(b)

Evidence

The service provider has not ensured that all staff recruited have been subject of a rigorous selection and vetting procedure and checks have been undertaken to ensure their veracity. Care staff recruited have not had the qualifications, skills and experience for the role they are employed to undertake.

Evidence

- Examination of five staff members recruitment records indicated that the provider had not sought to verify references once received and gaps in employment history had not been accounted for.
- The qualifications, skills and experience for care staff delivering workshops to families was not evident or connected to their qualification or experience.
- The safeguarding lead for Bridgend County Borough Council informed CIW of their concerns about staff expertise and knowledge and the service recruitment procedure in an email of 19 October 2020. Specifically, that a social worker had advised them they had been offered employment at the service, without completing an application form or attending an interview. They had been asked to sign a contract by 21 October 2020, without any checks being undertaken or to ensure that the person concerned had the experience or was suitable for the position.
- On 22 October 2020, CIW received an email from an operational manager of Cardiff

County Council raising concerns about the staffing of the service following a Professional Strategy Meeting held on 20 October 2020. Specifically, that a member of staff "… was very young and inexperienced and there was clearly a lack of support and training. Her previous experience raises concerns about their recruitment process and I would have expected much more regular supervision, support and oversight for this worker and a long period of induction. It was also worrying to hear that they accepted the safeguarding training a worker had done elsewhere rather than ensuring this was updated in their induction. This raises significant questions about the other staff they have there and if they are qualified and experienced to undertake the role and if they have the right support and management oversight in place."

- A member of care staff informed us during our consultation with them on 2 November 2020 that they had delivered workshops on a range of issues, including substance abuse. They had no qualification, previous experience or training on this area of safeguarding and had not received training to deliver workshops. This would render this work ineffective in working with parents to inform their understanding of the impact and exposure to risk.
- Not all care staff appointed as a 'keyworker' had experience of working with vulnerable families with complex needs and where child protection concerns had been identified. Despite a lack of experience, care staff were appointed following a telephone discussion with no evidence of further scrutiny by the manager at the point of induction. On 2 November 2020, a member of care staff we interviewed told us that they had been recruited to their positon, and was appointed by the manager following a telephone interview. They had previously worked in a nursery and an adult care home, had no qualifications or experience in working with vulnerable families, and had not attended safeguarding training. They told CIW they had been employed since 28 September 2020 and had assisted a parent with a nappy change on their first day on shift, had worked on CCTV monitoring for the previous two weeks and had been escorting families into the community.

The impact on children and their parents is that not all care staff recruited by the service provider have been subject of rigorous recruitment checks and scrutiny prior to their appointment. Their qualifications, skills and experience are not always adequate or sufficient to meet the complex and diverse needs of those using the service.

Leadership and Management	Our Ref: NONCO-00009748-FBPS
Non-compliance identified at this inspection	
Timescale for completion	**01/02/2021**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider is not compliant with Regulation 36(2) of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.	36(2)

Evidence

The service provider has not ensured care staff receive an induction appropriate to their role, are supported, and receive training appropriate to the work to be carried out to support their understanding of the complexities and risks posed to children by their parents.

Evidence:

- The staff training matrix detailed that not all of the 35 members of care staff had completed Child Protection Level 2 training.
- Examination of the staff training records and the information contained in the action plan submitted by the provider, informed that the induction was not sufficiently robust for care staff, working with the complex needs of the children and families placed at the service.
- Training for care staff to deliver workshops to families was not evidenced on the training matrix and staff members told us they had not received any training but had shadowed other care staff, who had delivered the workshops. There was no management overview of the effectiveness of the workshops.
- Our observation of a workshop on child development, during our inspection of the 21 October 2020 was that it was not adapted to the parent's needs and understanding and was not effective in achieving its aims.
- A staff member informed us during our consultation with staff on 2 November 2020, their induction had been for approximately one and a half hours and they had shadowed care staff prior to being able to support parents. We were told that they had no previous experience of working with vulnerable families and had not received training to support their understanding of the complex needs of families using the service.
- Care staff had not received appropriate levels of training in the use of the CCTV

surveillance equipment and were not confident in implementing the risk based ‘traffic light’ system, to raise concerns and take immediate action. Therefore, care staff failed to act or respond to incidents where children were subject to significant harm whilst in the care of their parents.

- The ‘traffic light’ system in place is not fit for purpose and has failed to protect children despite a review following an incident where a child had been harmed.

The impact on children and their parents is that not all staff members employed have the skills, experience and knowledge to respond to their needs and care staff are not provided with the advice and guidance they need to effectively meet families’ complex needs. The failure of the service provider to ensure that care staff were equipped with appropriate, relevant training resulted in children being placed at risk, and suffering significant harm.

Leadership and Management	Our Ref: NONCO-00009749-WTFS
Non-compliance identified at this inspection	
Timescale for completion	**01/02/2021**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider is not complied with regulation 60(1) of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.	60(1)

Evidence

The service provider has not notified the service regulator of the events specified in Parts 1 and 2 of Schedule 3.

Evidence:

- The service provider has not notified CIW of incidents when children have been taken to hospital with injuries sustained at the service.
- The service provider failed to notify CIW and to make child protection referrals/reports in line with the requirements of the All Wales Procedures.
- The service provider has failed to notify CIW of incidents when the Police have been called to the service to manage situations. We examined the service complaint records and found that an incident had been reported by a parent to the police on 13 August 2020. The police had attended the service as part of their investigation. CIW were not notified of this incident as required by the regulation.
- CIW has received information from the Local Health Board of hospital attendance for children living in the service, which had not been notified to CIW.
- A serious safeguarding allegation from a placing authority in relation to the care provided by a parent and mismanagement of medication resulting in a police investigation was not reported to CIW.

The impact for children and their parents is that CIW has not been able to conduct their regulatory role effectively and respond to incidents where there have been significant safeguarding concerns. As the service provider had failed in its duty to inform CIW of events, there were no opportunities for protective measures to be considered or implemented to prevent or reduce the risk of subsequent incidents.

Leadership and Management	Our Ref: NONCO-00009750-VMSL
Non-compliance identified at this inspection	
Timescale for completion	**01/02/2021**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider is not compliant with regulation 66 of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.	66

Evidence

The responsible individual has not had sufficient oversight of the management, quality, safety and effectiveness of the service.

Evidence:

- Incident reports were not consistently reviewed by the manager and actions taken by care staff were not analysed to ensure they were appropriate and in line with the service policies and procedures.
- The responsible individual had not identified the failings of the manager to consistently review actions taken by staff, nor had they identified a failing to make notifications to CIW or make safeguarding referrals.
- On our inspection on 21 October 2020, the manager was unable to identify the names of families using the service and the name of their placing authority.
- The responsible individual had not ensured that all complaints and concerns raised by placing authorities are recorded in accordance with the service complaint's policy and regulation.

The impact for children and their parents and those that commission the service is that they are not assured that the service is safe, well run and complies with regulations.

Leadership and Management	Our Ref: NONCO-00009848-XVFT
Non-compliance identified at this inspection	
Timescale for completion	**01/02/2021**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider is not compliant with regulation 80(3) of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.	80(3)
Evidence	

The responsible individual has not ensured that the arrangements in place for monitoring, reviewing and improving the quality of care and support provided by the service consider the outcome of engagement with staff and people using the service, analyse data and consider the outcome of any audit of the accuracy and completeness of records.

Evidence:

- The quality of care review reports dated 24/10/2019 and 20/04/2020 completed by the responsible individual did not evidence compliance with the regulation.

The impact on people using the service is that the responsible individual has not shown sufficient oversight to provide assurance that the service provides high quality care, achieves the best possible outcomes for individuals and improves their well-being.