Children's homes inspection – Full

Inspection date	**27/09/2016**
Unique reference number	**1183574**
Type of inspection	**Full**
Provision subtype	**Children's home**
Registered provider	**Cheshire West and Chester children's services**
Responsible individual	**Sophie Wales**
Registered manager	**Gillian Owen**
Inspectors	**Elaine Allison** **Michelle Edge**

Inspection date	**27/09/2016**
Previous inspection judgement	**Inadequate**
Enforcement action since last inspection	**None**
This inspection	
The overall experiences and progress of children and young people living in the home are	**Requires improvement**
The children's home is not yet delivering good help and care for children and young people. However, there are no serious or widespread failures that result in their welfare not being safeguarded or promoted.	
How well children and young people are helped and protected	**Requires improvement**
The impact and effectiveness of leaders and managers	**Requires improvement**

1183574

Summary of findings

The children's home provision requires improvement because:

- Educational engagement, attendance and outcomes are variable for young people living at the home.
- Young people's ability to build and maintain positive relationships has been affected by changes to the staffing arrangements at the home.
- Transition planning for young people moving on from the home does not adequately consider their emotional needs.
- Medication records are not consistently robust and on occasions fail to contain all required information. In addition, on one occasion, medication was unaccounted for.
- Managers do not have accurate information about the training and development needs of all staff working in the home. These circumstances bring into question the ability of staff to consistently meet the needs of young people living in the home.
- Measures of control, discipline and restraint are not consistently evaluated for effectiveness. Records do not provide sufficient detail of the measure used, nor do they include the young person's view. They are not, therefore, compliant with the Children's Homes Regulation 2015.

Children's home strengths

- Staff have developed and improved young people's health and education plans.
- The statement of purpose has been updated and clearly reflects the ethos and objectives of the home. Therefore, key stakeholders and young people have access to information that they need to know.
- Staff have taken appropriate action to support the individual needs of young people who have self-harmed.

What does the children's home need to do to improve?

Statutory Requirements

This section sets out the actions which must be taken so that the registered person(s) meets the Care Standards Act 2000, Children's Homes (England) Regulations 2015 and the 'Guide to the children's homes regulations including the quality standards'. The registered person(s) must comply within the given timescales.

Requirement	Due date
12: The protection of children standard In order to meet the protection of children standard the registered person must ensure that staff: (2)(a)(v) understand the roles and responsibilities in relation to protecting children that are assigned to them by the registered person; and (vii) are familiar with, and act in accordance with, the home's child protection policies.	11/11/2016
13: The leadership and management standard In order to meet the leadership and management standard the registered person must: (2)(c) ensure that staff have the experience, qualifications and skills to meet the needs of each child; and (e) ensure that the home's workforce provides continuity of care to each child.	11/11/2016
23: Medicines The registered person must make arrangements for the handling, recording, safekeeping, safe administration and disposal of medicines received into the children's home. They must also ensure that a record is kept of the administration of medicine to each child. (Regulation 23 (1)(2)(c))	11/11/2016
35: Behaviour management policies and records The registered person must ensure that within 24 hours of the use of a measure of control, discipline or restraint in relation to a child in the home, a record is made which includes the effectiveness and any consequences of the use of the measure and a description of any injury to the child or any other person, and any medical treatment administered, as a result of the measure. (Regulation 35 (3)(vii)(viii))	11/11/2016

35: Behaviour management policies and records The registered person must ensure that within 48 hours of the use of the measure, the registered person, or a person authorised by the registered person to do so ('the authorised person") has spoken to the user about the measure and has signed the record to confirm it is accurate, and within 5 days of the use of the measure, the registered person or the authorised person adds to the record confirmation that they have spoken to the child about the measure. (Regulation 35 (3)(b)(i)(ii)(c))	11/11/2016
36: Children's case records The registered person must maintain records ('case records') for each child which include the information and documents listed in Schedule 3 in relation to each child, are kept up to date and are signed and dated by the author of each entry. (Regulation 36 (1)(a)(b)(c))	11/11/2016
37: Other records The registered person must maintain the records in schedule 4 and ensure that the records are kept up to date. (Regulation 37 (2)(a)(b)) In particular, a copy of the staff roster of persons working at the home, and a record of the actual hours worked.	11/11/2016

Full report

Information about this children's home

This is a local authority home for four young people with emotional and behavioural difficulties.

Recent inspection history

Inspection date	Inspection type	Inspection judgement
15/06/2016	Full	Inadequate

Inspection judgements

	Judgement grade
The overall experiences and progress of children and young people living in the home are	**Requires improvement**

This is the second full inspection following an inadequate judgement on 15 June 2016 and a further monitoring visit on 23 August 2016.

Young people have experienced inconsistency in their care because of a number of changes and vacancies to the staffing in the home. Agency staff, bank staff and staff from various homes in the organisation have covered the shortfalls in the rota. This has led to instability in relation to both the staff and care practices, meaning that young people are often unsure which staff members will be caring for them. This also limits young people's opportunities to make safe, protective and caring relationships with staff. One young person said, 'This is a kid's home and we are here to be looked after because the law states that. They (staff) should look after us and should be here to care for us, but they don't all care as they don't even know us.' Another young person said, 'How do you think it feels when someone you don't even know knocks on your door to tell you to get up.'

Transition plans for young people moving out of the home lack sufficient detail and fail to carefully consider the emotional needs of the young people involved. For example, on the morning of 16 September 2016, a meeting took place which included the interim manager, social work team manager and responsible individual. A decision was made to move a young person later on that day. In addition, the plan to tell the young person about the imminent move was not followed. The plan had stated '(name of young person) will be informed by RSW and SW and will be away from (name of home)'. However, there was limited consideration given to ensuring that there were sufficiently trained staff available to manage the impact of the decision situation for all young people. Staff were also unavailable to accompany the young person on her journey to her new home. Overall, this did not result in a positive ending to the placement for the young person.

Young people do not have a consistent voice in the home. During a meeting, staff decided that the 'rules' in the home would be changed and 'new rules' introduced. For example, during the meeting, staff decided that the home's kitchen would be locked from 10pm on weekdays and 10.30pm at weekends. This restricted young people's access to hot drinks and other hot snacks within their home. There was no discussion with young people to explain the reason why the changes have been implemented and although all young people expressed concerns about how the rules were 'unfair' and 'restricted access to rooms in their home', their views were not sought. This was discussed with the interim manager who took immediate action to speak to young people and to gain their views and he gave a commitment to the young people to review all of the 'rules' introduced within the home to

ensure that they are fair and reasonable. One young person said, 'I believe (name of manager) will now listen and he is taking this seriously.'

Educational engagement, attendance and outcomes are variable. While there has been a recent deterioration in attendance for some young people, staff are now taking a more proactive approach in actively encouraging young people to return to their education settings. Following training for all staff about the importance of education, they are clearer about their roles and responsibilities in supporting young people and promoting their engagement in education. Staff have developed plans for young people who do not currently attend education. This ensures that young people are encouraged to still get up at an agreed time and are provided with education and learning opportunities throughout school hours. Staff have also appropriately challenged education providers when they have failed to respond to concerns raised around anxieties that young people had about their education. One staff member said, 'Before the training, I did not really like to challenge schools, but not anymore. The training empowered me and I will challenge others if it means our young people only get the best they deserve.'

Staff have developed and improved young people's health plans. These now contain all relevant information. When issues are identified about health concerns these are now followed up and clear outcomes evidenced. For example, any outstanding hospital or medical appointments are addressed, ensuring that there is support, advice and guidance available to young people. This helps to promote young people's health and well-being.

Although the interim manager and staff have continued to update and improve all internal documents, including placement plans, risk assessments and behaviour management plans, these still do not fully capture the views and experiences of young people, the positive progress that they are making or the good work undertaken by staff to enable this progress. As a result, some young people's records do not present an accurate picture of their current situation or reflect their journey through care.

	Judgement grade
How well children and young people are helped and protected	**Requires improvement**

Since the last inspection, there have been incidents of physical intervention. The recording of these interventions is poor. They lack important information such as the details of the holds used, the times involved in the use of the holds and details of all staff involved. This is against the home's own policy and documentation, which clearly states that all information needs to be detailed and accurate. Furthermore, the effectiveness and consequences of the interventions used are not always recorded. This does not ensure that all staff are working appropriately within policies and procedures in the home. It is also a missed opportunity for the interim manager to carefully monitor practice issues and identify any common

themes and trends. Additionally, one recording omitted a full description of an injury or whether medical treatment was offered to the young person involved. Neither did the record indicate why a debrief had not taken place afterwards with the young person and staff. There is also not a single central record where all key information is recorded. This means that assurance cannot be given that procedures are followed correctly in a timely manner.

The home's behaviour management policy is implemented inconsistently. On occasions, responses to challenging behaviour do not provide a consistent, positive message to young people. Consequences can still be disproportionate, confusing and punitive, with no clear overview of why a decision was agreed. For example, one young person was upset as he was not allowed into the kitchen to get his supper. It was reported that he had continually kicked his bedroom door. No further detailed information was provided. The young person was then stopped from going to a planned activity five days later. There was no clear indication of why this measure was appropriate. Records did not show that the consequences given resulted in the young person learning from their actions. Although the interim manager had looked at some of the records and commented that they were not appropriate, this was not a consistent approach. This does not always help staff to evaluate and identify the effectiveness of the measure used in helping young people to make changes to their behaviours.

All permanent staff have now undertaken further refresher training in safeguarding. However, this was not mirrored in the training of agency staff who worked in the home. This does not ensure that all staff responsible for young people understand their roles and responsibilities around safeguarding and are sufficiently clear about procedures to follow if there are safeguarding concerns. This potentially leaves both young people and staff vulnerable. The interim manager cannot be assured that all staff will take effective action following any incidents in the home.

Medication records are still not fully completed. In some records, the date and time that medication had been administered were not accurately recorded and signatures had been missed. Although the newly introduced audit system had identified these errors, it had failed to identify a discrepancy in the amount given to a young person and the amount left in stock. This still does not adequately demonstrate the safe handling, administration or the recording of all medication within the home.

Staff have taken appropriate action to support the individual needs of young people who have self-harmed. For example, locating a young person at risk in the community and seeking immediate medical advice, while updating all relevant professionals. This ensured that the young person received the medical attention and support that they required at that time.

Since the last inspection, a young person has made an allegation against a staff member working in the home. Both the interim manager and staff on shift followed child protection procedures and reported their concerns immediately to all safeguarding professionals, including the local authority designated officer. The initial fact finding investigation was conducted in a transparent manner and a

notification was provided to Ofsted to ensure that we were fully aware of the safeguarding concerns.

	Judgement grade
The impact and effectiveness of leaders and managers	**Requires improvement**

The registered manager remains unavailable for work. The interim manager is still in post, undertaking this management role in an acting capacity. However, as well as working as an interim manager, he has continued to complete both sleep in and late shifts at the home. This has affected the time available to carry out all of his managerial responsibilities in an effective way.

Staff members report that the interim manager is 'extremely supportive', 'has made sure he has spent time individually with all of us' and 'is really trying to improve practices in the home'. However, staff also commented that they were, 'Worried about the amount of work he is trying to do, as he is still working on shift, on call and trying to make changes for the better in the home.' Staff were concerned that this may impact on his health in the long term. This was discussed with the interim manager who acknowledged this and stated, 'It has been a difficult few weeks and I have spoken to the responsible individual about the hours involved, but hopefully it will settle down more as we continue to make improvements and get enough staff in place to fill the rotas.'

On occasions, staff duty rosters fail to accurately reflect the actual staff on duty, and lack transparency. This prevents a clear audit trail of who is working within the setting, when and where. In addition, staff had not always signed the daily handover sheets to indicate clearly who was on shift. Consequently, the home's own records do not provide sufficient information and it was therefore difficult to establish which staff were always on duty. The lack of transparency of who is on duty potentially places young people at risk and compromises the continuity of care.

Staff have continued to attend regular team meetings and have received monthly supervision. Staff said that this has continued to help to improve practices in the home and provided an opportunity to talk about what is working well and what needs to change. Furthermore, the local authority has also requested the support of two registered managers from neighbouring local authority children's homes, to work with staff, in improving practices and paperwork within the home. Staff said that this has been 'really helpful' and 'I feel I now understand what my role is and how I can support young people to get the best outcomes in all areas of their lives'.

The interim manager and responsible individual have recently updated the statement of purpose. This now includes all relevant details. In addition, in team meetings and supervision sessions, discussions have taken place with staff about the vision and ethos of the home. Staff said, 'We spent time reading it on our own

and then agreed its content as a group.' And, 'It's the first time I have really looked at it, but now I understand what we are trying to achieve.'

The home has regular internal and external monitoring processes, which ensure that managers are aware and committed to improvement. They have focused on shortfalls highlighted at the previous full inspection and monitoring visit. However, these systems have not always picked up staff inconsistencies in following some of the procedures and the quality of some of young people's individual records. For example, key worker documents and daily observation records do not always include the exact date of entries and the author of the record. This prevents a complete record of young people's time at the home, although it has not affected their welfare. The interim manager has recognised and identified internal monitoring systems as an area for further development. In addition, the local authority has developed a detailed improvement development plan, which will continue to be kept under review.

What the inspection judgements mean

The experiences and progress of children and young people are at the centre of the inspection. Inspectors will use their professional judgement to determine the weight and significance of their findings in this respect. The judgements included in the report are made against 'Inspection of children's homes: framework for inspection'.

An **outstanding** children's home provides highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** children's home provides effective services that help, protect and care for children and young people and have their welfare safeguarded and promoted.

In a children's home that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place. However, the children's home is not yet delivering good protection, help and care for children and young people.

A children's home that is **inadequate** is providing services where there are widespread or serious failures that create or leave children and young people being harmed or at risk of harm or that result in children looked after not having their welfare safeguarded and promoted.

Information about this inspection

Inspectors have looked closely at the experiences and progress of children and young people living in the children's home. Inspectors considered the quality of work and the difference adults make to the lives of children and young people. They read case files, watched how professional staff work with children, young people and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the children's home knows about how well it is performing, how well it is doing and what difference it is making for the children and young people who it is trying to help, protect and look after.

This inspection was carried out under the Care Standards Act 2000 to assess the effectiveness of the service and to consider how well it complies with the Children's Homes (England) Regulations 2015 and the 'Guide to the children's homes regulations including the quality standards'.

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