

1271998

Care 4 Children Residential Services Ltd

Monitoring visit

Inspected under the social care common inspection framework

Information about this children's home

The home is one of several homes operated by a private organisation. It is registered to provide care and accommodation for up to three children and young people who may have emotional or behavioural needs and/or a learning disability.

The current manager has been at the home since September 2020 and is awaiting formal registration with Ofsted.

Inspection date: 15 December 2020

This monitoring visit

This onsite monitoring visit was in response to a serious incident that took place in the home. The purpose of the visit was to ensure the safety of the children living in the home.

The incident involved a newly placed child setting a fire in his bedroom in the home. Ultimately, this resulted in him being arrested and notice being served on his placement. The child lived in the home for just six days. However, he had a negative impact on the home and on the other young people during his short stay.

Inspectors identified a failure to properly consider the needs of children and the risks relating to their care, prior to agreeing to admit them to the home. Furthermore, the manager failed to adequately assess the potential impact that proceeding with the placement of the child would have on existing residents. There was insufficient information and consideration of all known risks in the child's impact risk assessment. The information in the impact risk assessment did not support the decision to admit him to the home, and information about his previous behaviours and risks had been minimised. Additionally, neither the risk assessment or other records in the home demonstrate what additional information was taken into account to inform the decision-making regarding his placement.

Furthermore, staff did not have the skills and knowledge required to meet the needs of the child. The child had a diagnosis of autism, but no staff had received training in this condition. Training may have helped them adapt their approach to the child to better effect. This lack of robust placement planning resulted in the placement proceeding but lasting just a few days.

Staff did not meet the child prior to placement and he had no opportunity to visit the home. In fact, he arrived at the home by police escort, which is not the best start to a placement. Similarly, he was unaware of his discharge from the home until the morning that he was leaving. A breakdown in communication with the child's social worker then resulted in him being returned to his home area, but with no-one to meet him. Ultimately, this resulted in the child running off from the staff member and his whereabouts being unknown, putting him at further risk of harm. Such practice makes children distrustful of adult decision-making, which will have a negative impact on their investment in any future placement.

Shortfalls were evident in the standard of recording. For example, the daily record for one child indicated that he had gone to bed that evening and had settled without any concerns. However, other records in the home indicate that he was in another child's bedroom and later all three children left the home by exiting that child's bedroom window. Furthermore, information in the home's log book and visitors' book do not always correlate. This makes it difficult to work out what has actually taken place, since records do not always provide an accurate reflection of what has happened in the home.

Weaknesses in management oversight were also evident. For example, the manager had not produced a risk management plan or placement plan for the newly admitted child and was relying on those produced by the child's former residential home. She had not ensured that all staff working in the home were familiar with these documents, and only a limited number of staff had signed to say that they had read these documents.

The day-to-day arrangements for the child were unclear, such as the rules on the use of his mobile phone. There was no agreement about his use of this, or indeed his use of the house phone. The child set a fire in the home because his request to use the house phone was denied.. There was no clear guidance for staff or understanding by the child regarding his use of the phone. This leaves staff vulnerable to manipulation and children being frustrated by changing rules and expectations.

Shortfalls were evident in relation to the knowledge and skills of staff to meet the needs of children. Training records would also indicate a number of other deficits in relation to staff training, such as substance misuse and fire safety. Staff practice would also indicate that additional training is required in these areas. A debrief with one young person following an incident suggested that he should be discreet when smoking cannabis, rather than reminding the young person about the risks

associated with this practice and making it clear that the possession and use of cannabis is not permitted in the home.

Furthermore, staff did not respond in the correct manner when the fire was set in the home. Prior to taking action to put the fire out, they did not ensure that the other young person who was in the home had evacuated. Records would indicate that fire evacuation drills have not taken place since June 2020 and that not all staff have taken part in a drill. Similarly, despite this being part of the admission process for new children, practice drills have not been taking place. This potentially puts everyone in the home at risk of harm. Additionally, the home's fire risk assessment does not address the risk posed by children smoking in the home and potentially having lighters or matches on their person. There is no strategy to manage this, beyond simply stating that smoking is not permitted in the home. This lack of control measures leaves the home vulnerable to fire.

Not all the requirements and one recommendation made at the last assurance visit to the home were fully explored as part of this monitoring visit and, consequently, they are being repeated. This relates to notifications of serious incidents and reports under regulation 45. Following this monitoring visit, Ofsted made the decision to take compliance action in relation to care planning, and leadership and management. Ofsted will closely monitor the progress made by the home during this period.

Recent inspection history

Inspection date	Inspection type	Inspection judgement
15/10/2019	Full	Good
17/10/2018	Full	Good

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

Statutory Requirements

This section sets out the actions that the registered person(s) must take to meet 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
The protection of children standard is that children are protected from harm and enabled to keep themselves safe. In particular, the standard in paragraph (1) requires the registered person to ensure that staff have the skills to identify and act on signs that a child is at risk of harm; understand the roles and responsibilities in relation to protecting children that are assigned to them by the registered person; take effective action whenever there is a serious concern about a child's welfare; and are familiar with, and act in accordance with, the home's child protection policies; that the home's day-to-day care is arranged and delivered so as to keep each child safe and to protect each child effectively from harm. (Regulation 12 (1)(2)(a)(iii)(v)(vi)(vii)(b))	22 January 2021
*The leadership and management standard is that the registered person enables, inspires and leads a culture in relation to the children's home that helps children aspire to fulfil their potential; and promotes their welfare. In particular, the standard in paragraph (1) requires the registered person to lead and manage the home in a way that is consistent with the approach and ethos, and delivers the outcomes, set out in the home's statement of purpose; ensure that staff have the experience, qualifications and skills to meet the needs of each child;	22 January 2021

understand the impact that the quality of care provided in the home is having on the progress and experiences of each child and use this understanding to inform the development of the quality of care provided in the home; and use monitoring and review systems to make continuous improvements in the quality of care provided in the home. (Regulation 13 (1)(a)(b)(2)(a)(c)(f)(h))	
*The care planning standard is that children— receive effectively planned care in or through the children’s home; and have a positive experience of arriving at or moving on from the home. In particular, the standard in paragraph (1) requires the registered person to ensure— that children are admitted to the home only if their needs are within the range of needs of children for whom it is intended that the home is to provide care and accommodation, as set out in the home’s statement of purpose; that arrangements are in place to— ensure the effective induction of each child into the home; and plan for, and help, each child to prepare to leave the home or to move into adult care in a way that is consistent with arrangements agreed with the child’s placing authority. (Regulation 14 (1)(a)(b)(2)(a)(b)(i)(iii))	22 January 2021
After consultation with the fire and rescue authority, the registered person must— make arrangements for persons working at the home to receive suitable training in fire prevention; and ensure, by means of fire drills and practices at suitable intervals, that persons working at the home and, so far as reasonably practicable, children are aware of the procedure to be followed in case of fire.	22 January 2021

(Regulation 25 (1)(c)(d))	
The registered person must notify HMCI and each other relevant person without delay if there is any other incident relating to a child which the registered person considers to be serious. A notification made under this regulation must include details of the matter; the other persons, bodies or organisations (if any) who or which have been notified; and any actions taken by the registered person as a result of the matter and must be made or confirmed in writing. (Regulation 40 (4)(e)(5)(a)(i)(ii)(iii)(b))	22 January 2021

*These requirements are subject to a compliance notice.

Recommendations

- Regulation 45 sets out requirements for the registered person to have a system in place which allows them to monitor the matters set out in the regulation at least once every six months. The registered person should undertake a review that focuses on the quality of the care provided by the home, the experiences of children living there and the impact the care is having on outcomes and improvements for the children. The review should enable the registered person to identify areas of strength and possible weakness in the home's care, which will be captured in the written report. The report should clearly identify any actions required for the next 6 months of delivery within the home and how those actions will be addressed. The whole review process and the resulting report should be used as a tool for continuous improvement in the home. ('Guide to the children's homes regulations including the quality standards', page 64, paragraph 15.2).

Information about this inspection

The purpose of this visit was to monitor the action taken and the progress made by the children's home since its last Ofsted inspection.

This inspection was carried out under the Care Standards Act 2000.

Children's home details

Unique reference number: 1271998

Provision sub-type: Children's home

Registered provider: Care 4 Children Residential Services Ltd

Registered provider address: Care 4 Children, 1 Stuart Road, Bredbury Park Industrial Estate, Bredbury, Stockport SK6 2SR

Responsible individual: Stephanie Hewitt

Registered manager: Post vacant

Inspectors

Mandy Williams, social care inspector

Jessica Forshaw, social care inspector

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