Children's homes inspection – Interim

Inspection date	**22/03/2017**
Unique reference number	**SC005553**
Type of inspection	**Interim**
Provision subtype	**Children's home**
Registered provider	**Dalepeak Limited**
Registered provider address	**Richard House, 9 Winckley Square, Preston PR1 3HP**

Responsible individual	**Andrew O'Reilly**
Registered manager	**John Allen**
Inspectors	**Janine Shortman-Thomas** **Sarah Billett**

Inspection date	**22/03/2017**
Previous inspection judgement	**Good**
Enforcement action since last inspection	**None**

This inspection

The effectiveness of the home and the progress and experiences of children and young people since the most recent full inspection

This home was judged **good** at the full inspection. At this interim inspection, Ofsted judges that it has **declined in effectiveness**.

Although some good practice around improving young people's educational experiences is noted, evidence gathered at this inspection highlights that there has been a considerable amount of disruption in the home since the last inspection. This has undoubtedly had a negative impact on young people's progress, safety and well-being.

Staff make every effort to encourage and support young people to enhance their educational opportunities. The staff work closely with education professionals to develop appropriate strategies that improve young people's confidence and willingness to engage again within the school setting. Young people confirmed that they feel at ease and supported with their return back to a school environment, and are happy to be back in school after a sustained and prolonged period away.

The manager has taken suitable action to address three of the four recommendations. The manager now ensures that all incidents of discipline are subject to systems of regular scrutiny to ensure: that their use is fair; that young people are now being involved in devising their individual risk assessments and crisis management plans; and that systems are in place to support young people to add their views and comments to the record of restraint. That said, this system has not been tested, as there have not been any physical restraints used within this inspection period.

The manager has yet to suitably address the one requirement that was raised at the last inspection to improve risk management planning. Because of this, young people's safety, well-being and health are compromised. There are ongoing incidents of young people engaging in cannabis use. Although staff who were spoken to demonstrate a level of understanding about these behaviours, the risk management plans, which have not been reviewed or updated as required from the last inspection, still do not reflect young people's known and emerging vulnerabilities in any clear and concise way. Furthermore, the risk management plans do not provide the staff with any clear written guidance about how they will respond, monitor and supervise young people when they display any of their risk-taking behaviours, such as being under the influence of cannabis. As there is no

written, clear guidance for staff to refer to, and to follow, during these heightened times of risk, the staff's ability to manage such situations safely, consistently and effectively is unassessed and leaves young people at risk of harm.

The service does not consistently promote young people's physical safety. Staff do not ensure that appropriate medical advice and guidance is sought when young people require this. A young person who complained of being unwell and had vomited, after receiving a bang to the head and appearing to be under the influence of cannabis, was not taken to receive any medical assistance on their say so. The risk management plans do not direct staff to the course of action that they should follow in these instances, such as seeking medical advice from health services such as NHS Direct, nor do they identify how staff should monitor, check and supervise young people during these times. This practice is unsafe and leaves young people at risk of harm during precarious health situations.

Young people's safety and well-being are further compromised as staff do not understand their safeguarding roles and responsibilities. Staff have failed to identify and respond appropriately to a potential safeguarding concern that has been disclosed to them by one young person. Furthermore, the manager does not identify safeguarding concerns within his management oversight, and has failed to ensure that this significant information is passed on to the placing local authorities in a timely way. As such, an incident that was disclosed to a member of staff on 6 March 2017 has yet to be investigated by the necessary safeguarding agencies. Consequently, there has been a significant safeguarding concern raised within the inspection, which has not been identified or addressed suitably by the manager or the internal and external monitoring processes. Two young people reported information to members of staff on 6 March 2017, which would suggest that they have been placed at risk of harm. Both young people have alleged that they have been physically assaulted by each other, and one young person has alleged that they have been assaulted by an adult who provides them with cannabis while they are in this adult's home. Although this information has been recorded on an incident sheet and forwarded on to the placing social worker, the significance of the information included in the incident sheet was not highlighted within the email sent to the social worker, nor was a follow-up telephone call made to the social worker to highlight these concerns when no response was received for some time. The information was missed by the social worker, and at the time of the inspection these allegations had yet to be investigated thoroughly by the necessary safeguarding agencies to ensure that young people are safe. A social worker said, 'It would be helpful for me if the staff identified that the information was urgent or a safeguarding matter. It needs to be flagged. It should also be followed up with a phone call. There was also an assault with [name] in school and I didn't receive this information as I had been on holiday. I only gained this information when I went into school. The significance of incidents needs to be flagged and identified within the email and then followed up with a phone call.'

The manager has yet to take suitable action to address one of the four recommendations raised at the last inspection, although the manager has made

some efforts to improve the frequency of key-working sessions completed by the staff with young people to address their risk-taking behaviour. The frequency and quality of these individual sessions are poor and are ineffective in promoting any positive change for young people. Despite ongoing and frequent cannabis use, with over five reported incidents in March 2017, there have been no recorded key-working sessions held within that month to consider and address this with young people. Consequently, young people continue to engage in these behaviours that compromise their health and well-being, as they are unsupported to consider and reflect on their behaviours to make better and safer choices, and these behaviours go unchallenged.

The external and internal monitoring systems are poor and ineffective. External scrutiny, undertaken by the independent person, is not rigorous, nor does it support the manager in highlighting areas of risk and areas for continued development. The manager's internal monitoring does not provide any update on his previous action plan, but focuses on the detail of the events that have occurred rather than providing any evaluation on the progress and the quality of care that is provided for young people. Although the manager has identified some areas for progression for the young people within the home, the potential for drift is possible, as the manager has not identified by whom, when and how these actions will be taken forward. In addition, these areas for progress focus around the young people's individual needs and not on what the manager and the staff team are proposing to do to meet these needs, and develop the service further as a whole. Furthermore, the manager has failed to establish and maintain a system for ascertaining and considering the opinions of children, their parents, placing authorities and staff within his review. As such, the manager is not clear about what areas of the home are working well and what areas require further consideration and development.

The home has recently introduced an electronic system for recording and storing young people's case records. This system runs alongside the paper-based records. As yet, the manager has not ensured that there is an effective system in place to ensure that the documents which inform staff's care of young people are clearly updated, easily accessible, and maintain the appropriate level of detail and information. Consequently, young people's records are cumbersome and poorly organised. This has a direct impact on the quality of care that each young person receives, as care planning is not effective and it is difficult to locate pertinent information.

The manager and responsible individual accepted and acknowledged the findings and shortfalls raised in this inspection. The senior management team has identified and is now implementing an action plan to secure improvements and address the shortfalls identified by this inspection.

Information about this children's home

The home is run by a limited company and it provides care and accommodation for up to five young people with emotional and/or behavioural difficulties.

Recent inspection history

Inspection date	Inspection type	Inspection judgement
29/11/2016	Full	Good
07/03/2016	Interim	Sustained effectiveness
11/08/2015	Full	Outstanding
26/02/2015	Interim	Declined in effectiveness

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
10: The health and well-being standard (1) In order to meet the health and well-being standard, the registered person must ensure: (b) that children receive advice, services and support in relation to their health and well-being. This is with particular regard to ensuring that children receive the correct level of medical advice and support from an appropriate health professional following any significant incident.	28/04/2017
12: The protection of children standard (1) In order to meet the protection of children standard, the registered person must ensure that children are protected from harm. (2) In particular, the standard requires the registered person to ensure that: (b) 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. This is with particular regard to ensuring that the risk management plans clearly identify young people's individual and known risks and how the staff will support, manage, supervise and monitor young people during these times.	28/04/2017
12: The protection of children standard (1) In order to meet the protection of children standard the registered person must ensure that children are protected from harm. (2) In particular, the standard requires the registered person to ensure: (a) that staff: (iii) have the skills to identify and act upon signs that a child is at risk of harm;	28/04/2017

(vi) take effective action wherever there is a serious concern about a child's welfare. This is with particular regard to ensuring that the staff have the knowledge, understanding and skills to recognise and respond to significant safeguarding information that young people share with them. The manager must ensure that any safeguarding concerns that are identified to himself or the staff team are responded to quickly and transparently. All relevant safeguarding agencies must be notified and an effective process must be in place to escalate the safeguarding concerns when placing authorities do not respond to these concerns within their safeguarding timescale.	
The independent person must produce a report about a visit and in particular set out the independent person's opinion as to how children are effectively safeguarded. (Regulation 44 (4))	28/04/2017
The independent person's report may recommend actions that the registered person may take in relation to the home and timescales within which the registered person must consider whether or not to take those actions. (Regulation 44 (5))	28/04/2017
The registered person must complete a review of the quality of care provided for children (a quality of care review) at least once every six months. In order to complete the quality of care review the registered person must establish and maintain a system for monitoring, reviewing and evaluating the quality of care for children. This system must provide for ascertaining and considering the opinions of children, their parents, placing authorities and staff. (Regulation 45 (5))	28/04/2017

Recommendations

To improve the quality and standards of care further, the service should take account of the following recommendations:

- Staff should support children to be aware of and manage their own safety both inside and outside the home to the extent that any good parent would. In order to achieve this the staff should complete meaningful direct work with children which enables them to understand how to protect themselves, feel protected and be protected from significant harm. ('Guide to the children's homes regulations including the quality standards', page 43, paragraph 9.9)

- Staff should be familiar with the home's policies on record keeping and

understand the importance of careful, objective and clear recording. This is with particular regard to ensuring that the staff record a full account of their work with young people and any subsequent actions taken from this work. ('Guide to the children's homes regulations including the quality standards', page 62, paragraph 14.4)

What the inspection judgements mean

At the interim inspection we make a judgement on whether the home has improved in effectiveness, sustained effectiveness, or declined in effectiveness since the previous full inspection. This is in line with the 'Inspection of children's homes: framework for inspection'.

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 that 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 focused on the effectiveness of the home and the progress and experiences of children and young people since the most recent full inspection.

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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