SC008488

Assurance visit

Information about this children's home

This is a private children's home registered for up to eight children or young people who may have emotional and/or behavioural difficulties.

The home offers education on site at a registered school.

The home is currently operating without a registered manager. The manager resigned following the assurance visit on 21 and 22 September 2020. A new manager has been recruited and is in the process of submitting their application to Ofsted to become registered.

Visit dates: 21 to 22 September 2020 and 13 to 16 November 2020

Previous inspection date: 20 February 2020

Previous inspection judgement: Good

Information about this visit

Due to COVID-19 (coronavirus), Ofsted suspended all routine inspections in March 2020. As part of a phased return to routine inspection, we are undertaking assurance visits to children's social care services that are inspected under the social care common inspection framework (SCCIF).

At these visits, inspectors evaluate the extent to which:

- children are well cared for
- children are safe
- leaders and managers are exercising strong leadership.

This visit was carried out under the Care Standards Act 2000, following the published guidance for assurance visits.

Her Majesty's Chief Inspector of Education, Children's Services and Skills is leading Ofsted's work into how England's social care system has delivered child-centred practice and care within the context of the restrictions placed on society during the COVID-19 pandemic.

Findings from the visit

We identified the following serious and widespread concerns in relation to the care or protection of children at this assurance visit:

- A serious safeguarding incident has taken place where a child sustained non-accidental injuries that are unexplained.
- A section 47 enquiry is taking place and there is an internal investigation being completed.
- Inspectors saw children seriously assaulting each other, and staff did not have the skills to be able to manage the behaviour.
- Serious incidents have taken place that have not been recorded.
- Staff have restrained children, using holds that they have not been trained to carry out safely.
- Significant shortfalls in basic child protection, safeguarding and first-aid training for staff.
- Lack of understanding of lines of accountability when reporting concerns about a child's safety, including the distinction between the roles of the manager and the designated safeguarding officer.
- Poor leadership and management oversight, resulting in managers being unaware about the significant shortfalls in practice.
- Managers not taking suitable action to address safeguarding concerns and an organisational culture that lacks transparency.

The care of children

The home was issued with two compliance notices at a monitoring visit on 13 August 2020, in relation to regulation 10, the health and well-being standard and regulation 14, the care planning standard. On 21 September 2020, Ofsted carried out a visit to assess the progress made by the provider in meeting the compliance notices. Inspectors found that although appropriate action had been taken to meet the steps in the compliance notices, on completion of the visit there were still serious shortfalls in relation to the health and safety of children.

In respect of the compliance notices, the home has made improvements to the monitoring of children's health needs and the recording of administration of medication. Staff have received additional training and guidance in this area and simplified medication administration records have been implemented. A thorough impact risk assessment has been developed, to ensure the safe matching of children moving into the home against any children in placement. This tool has not been tested as no children have been admitted since the compliance notice was served.

The registration of the home was suspended on 7 October 2020, following a serious safeguarding incident and children moved out of the home. Ofsted carried out a

further visit to the home on 13 November 2020, to consider actions taken in relation to the safeguarding incident and to consider progress made in relation to the suspension notice.

Direct work and debriefs with children to establish their views following incidents has not been robust. The home has not completed work with children to address their relationships with each other, nor has it evidenced key-work sessions in relation to discussing children's specific needs. Children said that they did not receive equal amounts of staff attention, especially when staff had to manage other children whose behaviour required additional adult support. As a result, children did not always have positive relationships with each other and any direct work that would support children in managing their behaviour was very limited.

Equally, direct work with children requested by therapists was not evidenced or recorded; because of this, children's progress in relation to their emotional well-being was difficult to evaluate.

Some children reported positively about their relationships with staff and said that they were happy living at the home. Social workers corroborated this and felt that children had made progress since living at the home. A social worker said, '[Name of child] has really good relationships with staff and staff are always there to support him.' Senior managers have recently introduced a three-monthly questionnaire, to gain feedback and views from social workers once there are children in placement.

The inside of the home required redecorating, personalising, and some areas refurbished to make it feel less institutionalised. This included children's bedrooms and the furniture in them. During the visit on 13 November 2020, inspectors found that there has been lots of improvement work to the environment; children's bedrooms are to a better standard, the kitchen and dining area has been refurbished and the layout of the home has been changed to meet children's day-to-day needs.

Children said that they were involved in setting their own consequences and had been involved in completing their own 'this is my consequence' booklet. However, children were not clear about how well they felt listened to in these circumstances. Consequences given to children are not proportionate or restorative in nature, to help children recognise the impact of their behaviour on themselves, other children and the staff caring for them. Children's views are rarely included, and many consequence records have no oversight or review by the manager.

Case files contain inconsistent information in relation to children's health needs and risks. There are gaps in weekly reports sent to social workers and some children did not have placement plans on file. Since the initial visit, a key-worker toolkit has been introduced to support key workers to keep their child's records and files up to date. This has not been used, as there are no children in placement.

The safety of children

A serious safeguarding incident has taken place where a child sustained non-accidental injuries that are unexplained. As a result of this, a section 47 enquiry is being conducted and a police investigation has taken place. An internal investigation is also being completed in relation to concerns raised about staff practice.

As a result of the company's internal investigations, it has been identified that staff have used unauthorised holds to restrain children. Some records of restraint have not been completed or records have not reflected a true written account of the restraint used. Children's debriefs do not help them to develop a greater understanding of their behaviour and do not help to reduce the level of restraint. As a result, physical intervention remained high in the home.

Staff recording of bruising and injuries to children on body maps is not clear and action taken to seek medical treatment is not evidenced on accident reports. Senior managers have now scheduled staff to receive further training associated with recording of incidents, restraints and the completion of body maps.

Significant shortfalls have been identified in relation to staff's understanding of allegation management, whistle-blowing procedures and escalating their concerns. This has had a negative effect on the safety of children living in the home. Staff are being retrained to understand lines of accountability when reporting concerns about a child's safety, including the roles of the manager and the designated safeguarding officer. During the visit on 13 November 2020, staff demonstrated to inspectors that they understood lines of authority for reporting a safeguarding incident and where to escalate this information when action to keep children safe was not being taken.

Inspectors observed children's negative behaviour escalating very quickly during the initial visit on 21 September 2020, resulting in a child being hurt. Staff were not well prepared to respond to children in crisis. Staff were not provided with the skills and training to manage some behaviours that children present. As a result of this, staff lacked guidance and support to manage children's behaviour effectively and prevent them becoming hurt by other children. In addition, when the inspectors returned on 13 November 2020, there was no evidence of a written report to reflect a serious incident.

There are significant gaps in mandatory training completed by staff, specifically first aid, child protection and basic safeguarding training. Training specific to children's needs has not been completed by staff, which hinders the team's ability to support children's needs effectively in areas such as attachment and developmental trauma.

Leaders and managers

There are serious shortfalls in the leadership and management of the home. Management oversight has not been sufficiently rigorous, and as a result, poor practice has not been challenged.

The staff team did not operate with a transparent and open culture. Staff reported that although they had support in some areas of practice, they felt that they had not been supported adequately by managers when children had assaulted them. Some staff have not received regular practice-related supervisions and as a result, they have not had enough direction and guidance to practise safely. In recent weeks, a senior management restructure has taken place. Staff now report that they feel there is a greater level of transparency and they can talk to senior management about concerns or support they require.

The oversight of behaviour management and records is inconsistent. The manager has failed to identify gaps or shortfalls in records. When there are debriefs with staff, these are not effective in developing staff practice or identifying lessons learned to improve strategies to manage children's behaviour and reduce the level of restraint. Senior managers have since developed a staff debrief tool. It is intended that this will be used at the end of every shift and after serious incidents to promote regular reflective practice from staff.

Staff reported concerns about the lack of sleep afforded on long shifts, leaving them unable to work to their full capacity. Staff sleeping arrangements were not conducive to staff obtaining a good night's sleep. For example, staff slept on an airbed in the communal lounge or in the office where door buzzers sounded during the night, despite waking night staff being present. Senior management are in the process of changing the layout of the home to create space for two separate staff bedrooms.

Senior managers have taken appropriate steps in relation to protective action following serious safeguarding concerns being raised. Inspectors were shown improvements to the templates for supervision records and team meeting agendas. Both documents included standard agenda items in relation to addressing whistle-blowing, safeguarding and policy review routinely. Senior managers have evidenced a structured plan for future team meetings to improve the staff team's understanding of safeguarding and the protection of children.

The location risk assessment has been adapted to include risks in the local area that may impact on the safety of children, such as the main road near the home. However, it does not evidence consultation with other agencies in relation to the support other professionals can offer to provide better care for children should they be placed at the home.

The review of the quality of care report does not meet regulatory requirements. It does not evidence or consider feedback in relation to the quality of care that children are receiving in the home, from local authorities, staff, parents and children to support the changes necessary to improve outcomes.

The provider has recently changed its monthly independent visitor. The independent visitor's reports are now more robust and consider feedback from children and staff. The reports are proportionate and make suitable recommendations to help managers address any shortfalls to improve the quality of care.

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, the 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 quality and purpose of care standard is that children receive care from staff who— understand the children's home's overall aims and the outcomes it seeks to achieve for children; use this understanding to deliver care that meets children's needs and supports them to fulfil their potential. In particular, the standard in paragraph (1) requires the registered person to— ensure that the premises used for the purposes of the home are designed and furnished so as to— meet the needs of each child; and enable each child to participate in the daily life of the home. (Regulation 6 (1)(a)(b) (2)(c)(i)(ii))	12 January 2021
The positive relationships standard is that children are helped to develop, and to benefit from, relationships based on— mutual respect and trust; an understanding about acceptable behaviour; and positive responses to other children and adults. In particular, the standard in paragraph (1) requires the registered person to ensure— that staff—	12 January 2021

meet each child's behavioural and emotional needs, as set out in the child's relevant plans; help each child to develop socially aware behaviour; encourage each child to take responsibility for the child's behaviour, in accordance with the child's age and understanding; help each child to develop and practise skills to resolve conflicts positively and without harm to anyone; communicate to each child expectations about the child's behaviour and ensure that the child understands those expectations in accordance with the child's age and understanding; are provided with supervision and support to enable them to understand and manage their own feelings and responses to the behaviour and emotions of children, and to help children to do the same; de-escalate confrontations with or between children, or potentially violent behaviour by children; that each child is encouraged to build and maintain positive relationships with others. (Regulation 11 (1)(a)(b)(c) (2)(a)(i)(ii)(iii)(iv)(v)(x)(xi)(b)) Specifically, evidencing direct work with children following incidents, engaging children in key-work sessions to address children's relationships with each other and children's specific needs. Ensure that key-work sessions are structured, appropriately timed and completed regularly.	
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— assess whether each child is at risk of harm, taking into account information in the child's relevant plans, and, if necessary, make arrangements to reduce the risk of any harm to the child;	12 January 2021

help each child to understand how to keep safe; have the skills to identify and act upon signs that a child is at risk of harm; manage relationships between children to prevent them from harming each other; 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)(i)(ii)(iii)(iv)(v)(vi)(vii)(b)) Specifically, ensure that physical restraints and serious incidents are recorded and records reflect the full duration of the incident; staff use authorised and trained restraints only; body maps are recorded clearly and reflect detailed accounts of any bruising or injuries to children; staff are trained in safeguarding, child protection and first aid.	
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;	12 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; 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)) In particular, the management oversight of the home should be more robust. Debriefs and lessons learned should be used to support staff to manage children's aggressive behaviour towards others living in the home in an effective manner, to prevent children being hurt. Staff should have suitable sleeping arrangements while completing their overnight shift. The oversight of the review of quality of care report and locality risk assessment should ensure that both documents meet regulatory requirements. Managers should ensure that all staff, including probationary staff, receive regular practice-related supervisions.	
No measure of control or discipline which is excessive, unreasonable or contrary to paragraph (2) may be used in relation to any child. (Regulation 19 (1)) Specifically, that the managers' oversight of consequences is robust. Consequences should be discussed with children, should be proportionate and restorative in nature, and help children recognise the impact of their behaviour on themselves, other children and the staff caring for them.	12 January 2021
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 name of the child; details of the child's behaviour leading to the use of the measure; the date, time and location of the use of the measure;	12 January 2021

a description of the measure and its duration; details of any methods used or steps taken to avoid the need to use the measure; the name of the person who used the measure ("the user"), and of any other person present when the measure was used; 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; within 48 hours of the use of the measure, the registered person, or a person who is 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)(a)(i)(ii)(iii)(iv)(v)(vi)(vii)(viii)(b)(i)(ii)(c)) Specifically, restraint records should meet regulatory requirements and demonstrate suitable oversight by the manager. Records should include full and reflective debriefs with both children and staff involved in the incident, to help reduce the level of restraint in the home.	
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))	12 January 2021

Specifically, that all children have a current placement plan on file, the home provides regular written reports to children's placing authorities and that children's individual documents contain consistent information in relation to health and risks.	

Recommendations

- Staff should be familiar with the home's policies on record keeping and understand the importance of careful, objective, and clear recording. Staff should record information on individual children in a non-stigmatising way that distinguishes between fact, opinion and third-party information. Information about the child must always be recorded in a way that will be helpful to the child. ('Guide to children's homes regulations including the quality standards', page 62, paragraph 14.4)

  In particular, that staff record the work they complete with children as requested by therapists, so that children's progress is maximised.

Children's home details

Unique reference number: SC008488

Registered provider: Halliwell Homes

Registered provider address: The Curtis Partnership, 1 Tape Street, Cheadle, Stoke-on-Trent ST10 1BB

Responsible individual: Karen Mitchell-Mellor

Registered manager: Post vacant

Inspectors

Cheryl Field, Social Care Inspector
Charlie Bamber, Social Care Inspector

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