

SC020576

Registered provider: Castle Homes Care Ltd

Full inspection

Inspected under the social care common inspection framework

Information about this children's home

This children's home is operated by a large national provider. It is registered to provide care and accommodation for up to five male young people who have emotional and/or behavioural difficulties.

Inspection dates: 24 to 25 January 2018

Overall experiences and progress of children and young people, taking into account **inadequate**

How well children and young people are helped and protected **inadequate**

The effectiveness of leaders and managers **inadequate**

There are serious and/or widespread failures that mean children and young people are not protected or their welfare is not promoted or safeguarded.

Date of last inspection: 2 March 2017

Overall judgement at last inspection: sustained effectiveness

Enforcement action since last inspection: none

Key findings from this inspection

This children's home is inadequate because:

- The arrangements for young people's education are inadequate.
- Decision-making about young people's education indicates serious failings in

leadership and management within the organisation.

- The staff fail to effectively de-escalate incidents involving the young people.
- Restraint practice is not always proportionate and safely managed.
- The staff use restrictive practices which limit young people's access to parts of the home. For example, internal doors downstairs are locked at night. The reasons for this are not fully known or reviewed by staff.
- Managers and staff do not make sure that risk assessments and placement plans reflect young people's individual needs and circumstances.
- Young people do not understand why some rules and boundaries are not consistently applied.
- Some areas of the home have an institutional appearance.
- When young people return after being missing from home, they do not always have access to an interview with someone independent of the home.
- The home's statement of purpose is not up to date and does not accurately describe the children's education arrangements.

The children's home's strengths:

- Staff support young people's emotional and physical health needs well.
- Young people make some good progress in relation to their starting points.
- Young people enjoy a wide range of activities in the community.
- Managers make good matching decisions and thoroughly consider the compatibility of new young people with those already living at the home.

Recent inspection history

Inspection date	Inspection type	Inspection judgement
02/03/2017	Interim	Sustained effectiveness
12/10/2016	Full	Good
11/02/2016	Interim	Improved effectiveness
24/09/2015	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 quality and purpose of care standard requires the registered person to ensure that staff— provide personalised care that meets each child's needs, as recorded in the child's relevant plans, taking account of the child's background. (Regulation 6(2)(b)(iv))	10/03/2018
The education standard is that children make measurable progress towards achieving their educational potential and are helped to do so. In particular, ensure that staff— maintain regular contact with each child's education and training provider, including engaging with the provider and the placing authority to support the child's education and training and to maximise the child's achievement; help a child who is excluded from school, or who is of compulsory school age but not attending school, to access educational and training support throughout the period of non-attendance and to return to school as soon as possible. (Regulation 8 (1)(vi)(viii))	10/3/2018
The positive relationships standard is that children are helped to develop, and to benefit from, relationships based on mutual respect and trust. In particular, the standard in paragraph (1) requires the registered manager to ensure that staff— de-escalate confrontations with or between children, or potentially violent behaviour by children. (Regulation 11 (1)(2)(xi))	10/03/2018
The protection of children standard is that children are protected from harm and enabled to keep themselves safe. In particular, 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 and take effective action when there is a serious concern about a child's welfare. (Regulation 12 (2(a)(i)(vi))	10/03/2018

The leadership and management standard is that the registered person enables, inspires and leads a culture in the children's home that helps children aspire to fulfil their potential and promotes their welfare. (Regulation 13 (1)(a)(b))	10/03/2018
The registered person must keep the statement of purpose under review and, where appropriate, revise it. (Regulation 16 (3)(a))	10/03/2018
Restraint in relation to a child is only permitted for the purpose of preventing— injury to any person (including the child); serious damage to the property of any person (including the child). Restraint in relation to a child must be necessary and proportionate. (Regulation 20 (1)(a)(b)(2))	10/03/2018
The registered person must ensure that— children can access all appropriate areas of the children's home premises; and any limitation placed on a child's access to any part of the home's premises— is intended to safeguard each child accommodated in the home; is necessary and proportionate; is kept under review and, if necessary, revised; and allows children as much freedom as possible when balanced against the need to keep them safe. (Regulation 21 (b)(c)(i)(ii)(iii)(iv)) Specifically, this is with regard to the locking of internal doors.	10/03/2018

Recommendations

- Ensure that children's homes are nurturing and supportive environments that meet the needs of children. For them to be so, they will, in most cases, be homely, domestic environment. Children's homes must comply with relevant health and safety legislations (alarms, food hygiene,); however in doing so, homes should seek as far as possible to maintain a domestic rather than 'institutional' impression. ('Guide to the children's homes regulations including the quality standards', page 15, paragraph 3.9)
- Ensure that when a child returns to the home after being missing from care or away from the home without permission, the responsible local authority must provide an opportunity for the child to have an independent return to home interview. Homes should take account of information provided by such interviews when assessing risks and putting arrangements in place to protect each child. ('Guide to the children's homes regulations including the quality standards', page 45, paragraph 9.30)

Inspection judgements

Overall experiences and progress of children and young people: inadequate

Arrangements for young people's education are poor. None of the three school-aged young people attend school or receive full-time education. Placing authorities identified this home as suitable to meet the young people's needs because it offered young people education at the school operated by the provider. For reasons that are not clear, the school was de-registered at the end of the summer term 2017. Senior leaders within the organisation made this decision without sufficient planning and consideration for what the alternative education arrangements would be. This poor practice compromises young people's progress and experiences.

The manager and the placing authorities were not consulted by the provider prior to the closure of the school. One social worker commented, 'I had no idea the school was closing... The children haven't been given any consideration in this decision.' Another social worker said, 'It's not good enough. It is [the young person's] last year in education and they should be doing their GCSEs.' A lack of consultation with key personnel by senior leaders within the organisation shows deficiencies in the leadership and management of the service. These weaknesses had a significant impact on young people's learning opportunities.

During the autumn term, the young people continued to receive education for 20 hours a week at an unregistered school. The young people now receive education at home from a qualified teacher each morning. Young people receive education in the open-plan kitchen and dining area of the home. Two housekeepers carry out their duties around the young people who are trying to receive education. This arrangement does not provide a satisfactory learning environment. Furthermore, the home is not registered as a school.

On most afternoons, no educational activity takes place and the young people play on games consoles. The lack of adequate education has a significant impact on young people's learning. Two of the young people are in their GCSE year, and so the loss of education is having a particularly serious impact on their ability to gain qualifications.

Young people's care plans do not contain clear aims and objectives for each young person. Plans are not targeted and do not detail the steps the young people need to take to earn trust and maximise their independence. This does not fully support young people's progress.

Managers and staff do not sufficiently explain to young people why rules and boundaries are different at the home compared to when they go to visit their family. For example, when one young person visits his family he has a mobile phone and is allowed out into the community on his own. However, he is not allowed to have a mobile phone at the home or to go out into the community unaccompanied. The young person said, 'It is silly, that at home I can go out on my own and have a phone, but when I am here, I can't go out or have a phone.' This inconsistency does not support the young person's

understanding about their care plan. Furthermore, this inconsistent practice does not help young people to enjoy age-appropriate freedoms safely.

One young person, who will shortly be leaving the home, is on a transition programme. The social worker said, 'This is a bit late in the day. I had to nudge them [the staff] to start helping him to become more independent, like going out on his own.' Following the intervention from the local authority, this young person is now making good progress with building his independence skills. He is now going out of the home on his own, is preparing and cooking meals and applying for apprenticeships.

The young people enjoy a wide range of activities, including Scouts, bowling, go-karting and visits to the cinema. As a result, young people have positive leisure experiences, enabling them to develop social skills and build confidence.

Staff meet young people's health needs well. The staff have supported one young person to receive the medication he needs, which has had a positive impact on his behaviour. The young people benefit from regular therapeutic sessions with a suitably qualified therapist. The therapist provides strategies for the staff to follow, which supports young people. Workshops take place three times a week for the young people as part of their therapeutic programme. The staff discuss topics with young people, for example sexual health care, the dangers of smoking and taking drugs.

Young people do make some good progress. For example, incidents of self-injurious behaviour have reduced, and young people understand that their general well-being has improved. One young person said, 'I have learned good skills here, I have learned a lot. I have got better at not being angry and at saying my feelings and thoughts.'

Serious shortfalls in education and failings in the help and protection of children contribute to the inadequate judgement.

How well children and young people are helped and protected: inadequate

Physical intervention records do not contain sufficient detail about what strategies the staff use to stop potentially challenging situations from escalating. As a result, the manager cannot fully assess whether the incident could have been avoided or whether alternative actions could have been taken. Young people told the inspector that not all staff are consistent in their approach. They said that although some staff give young people the chance to calm down others do not. One young person said, 'Staff aren't really consistent. Some are more lenient than others.' There have been incidents in which the young people have caused damage to the home and assaulted the staff. Another young person said, 'The staff aren't good at calming me down.' As a result, young people do not receive consistent support at challenging times. This does not help them to manage aspects of their behaviour appropriately.

Trained staff use front ground restraint techniques, which involve staff holding a young person face down on the floor. This has happened on three occasions. On one occasion,

the young person felt dizzy, vomited and needed hospital treatment following a ground hold restraint. On another occasion, the same young person was taken to hospital following a ground restraint and was found to have a graze on their shoulder and a mark on their head. The review of restraint incidents does not consider whether other action could have been taken to avoid the use of this technique.

Managers do not ensure that young people who witness a restraint receive a debrief by someone independent of the incident. As a result, young people do not have the opportunity to seek reassurance about what happened or raise concerns. One young person said, 'I don't understand why three or four adults need to jump on one kid.' This inspection found that incidents of physical intervention have reduced. Nevertheless, when restraint incidents happen, they are not always managed proportionately or safely.

The staff manage young people's behaviour through restrictive practices. Internal doors are locked at night. The reasons for this are not clear, and this practice is not risk assessed. The inspector found that some of these doors had not been opened promptly in the morning. Locking internal doors imposes external controls on young people and does not allow them access to appropriate areas of their home.

Risk assessments are not individualised. For example, none of the young people are allowed to use aerosol deodorants or have use of the internet in the home. Three young people are not allowed to have mobile phones or free time out of the home without the staff being with them. Blanket rules do not ensure that young people receive personalised care. Restrictive practice that is not sufficiently risk assessed and reviewed is an infringement of young people's rights. Furthermore, it means that young people do not receive the right support to help them to learn how to manage their behaviour safely.

Young people do not often go missing from the home. When they do, staff take steps to locate them and return them quickly and safely. After one incident of going missing, young people did not have a return interview with someone independent of the home. This does not help staff to gather information that may be useful in safeguarding young people. Furthermore, it is not clear what arrangements are in place to facilitate independent return home interviews for those young people who live a long way from their family home.

All of the young people could identify a member of staff they could speak with if they felt unsafe or worried. There are no incidents of bullying in the home.

Staff use incentives and praise to reward and encourage positive behaviour. Young people have individual targets and can earn money when they do things well. Young people said that this is an effective way to help them behave well and that they like earning money. The registered manager monitors the effectiveness of sanctions and rewards.

The registered manager ensures that only suitable people are employed at the home.

Prospective staff are requested to pass comprehensive checks and reference requests to evidence their suitability.

The effectiveness of leaders and managers: inadequate

Senior leaders in the organisation made the decision to close the educational provision linked to the home. This was done without fully consulting the manager or placing authorities. Although the manager made repeated efforts to challenge this decision, her challenge was not effective. The decision to close the school, and the manner in which this decision was made, indicate serious failings in the organisation's leadership. These failings are having a significant impact on young people's educational progress and experiences.

Managers and staff have made some improvements to the home environment. The lounge has recently been redecorated, and photos on display show some of the positive experiences that children have enjoyed. However, some areas of the home continue to have an institutional feel. For example, there are an excessive number of signs and noticeboards on display around the home. The upstairs landing contains a large mirror on the ceiling so that the waking night staff can see if a young person comes out of their room. This measure is in place despite other risk-reduction strategies, such as bedroom door alarms and the presence of waking night staff. The use of the mirror has not been reviewed by the manager to assess whether this continues to be necessary. Furthermore, the staff sometimes use institutional language, such as referring to the landing as 'the landing zone' and to the home as a 'unit' and 'on and off-site'. When combined, these issues influence how young people feel about their home. One young person said, 'This is not a normal house... it doesn't look like a normal house.'

Young people's routines do not reflect their age and stage of development. Young people said that some rules are fair, but others are not. For example, young people are expected to be in their bedrooms at 10pm, despite one young person being almost 18 years old. When the inspector asked about this, the registered manager said, 'This is the time that staff go off shift.' A young person said, 'To have to go to my room at 10pm is far too early at my age.' Decisions about day-to-day routines are not child-led, and young people are not fully consulted about all aspects of their day-to-day lives.

The manager has completed a development plan for the home. It outlines how the home will meet regulations but does not contain details about how the home will continue to develop the quality of care, how the young people will be involved in this and in what timescales improvements will be achieved. The strengths and areas for improvement in the home are not detailed, and there is no evidence of learning from incidents that have happened.

The statement of purpose for the home contains inaccuracies and is not up to date. It states that education is provided at the school operated by the provider. This is no longer correct.

There is a stable and consistent staff team in place at the home. Staff turnover is very low. The experienced and qualified registered manager is supported by a deputy manager, who takes charge of the home in her absence. The staff commented positively on the support they receive from the managers and confirmed that they receive regular, good-quality supervision and training.

The manager carefully assesses the impact of a new young person on the young people already living at the home. The young people are kept fully informed if a new young person is arriving at the home. If possible, the young person visits the home prior to their admission and the staff give them a written guide to the home. The young people are well matched and get on well.

Information about this inspection

Inspectors have looked closely at the experiences and progress of children and young people. Inspectors considered the quality of work and the differences made to the lives of children and young people. They watched how professional staff work with children and young people and each other and discussed the effectiveness of help and care provided. Wherever possible, they talked to children and 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 whom it is trying to help, protect and look after.

Using the 'Social care common inspection framework', this inspection was carried out under the Care Standards Act 2000 to assess the effectiveness of the service, how it meets the core functions of the service as set out in legislation, 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'.

Children's home details

Unique reference number: SC020576

Provision sub-type: Children's home

Registered provider: Castle Homes Care Ltd

Registered provider address: 80 Hammersmith Road, London W14 8UD

Responsible individual: Shelley Whiting

Registered manager: Deborah Bassett

Inspector

Tina Maddison, social care inspector

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