

Children's homes inspection - Full

Inspection date	17/08/2015
Unique reference number	SC061232
Type of inspection	Full
Provision subtype	Children's home
Registered person	Bristol City Council
Registered person address	Bristol City Council, Director of Legal Services, City Hall, College Green, BRISTOL, BS1 5TR

Responsible individual	Karen Gazzard
Registered manager	Tracy Connolly
Inspector	Clare Davies

Inspection date	17/08/2015
Previous inspection judgement	N/A
Enforcement action since last inspection	A compliance notice was issued 23/10/2014. A subsequent monitoring visit on 20/11/2014 resulted in removal of the compliance notice with four requirements imposed.
This inspection	
The overall experiences and progress of children and young people living in the home are	Inadequate
There are serious and/or widespread failures that mean young people are not protected or their welfare is not promoted or safeguarded.	
how well children and young people are helped and protected	Inadequate
the impact and effectiveness of leaders and managers	Inadequate

SC061232

Summary of findings

The children's home provision is inadequate because:

- Managers fail to adequately monitor and review care practices and records. Routine checks that occur lack depth and analysis resulting in the manager and senior leaders being unaware of failings in day to day practice. The manager has failed to meet the requirements from the previous Ofsted visit, demonstrating limited progress for this home.
- Monthly visits by an independent person did not occur in March or May 2015. The visit to report on the way the home was managed during April 2015 occurred significantly later, in June. Inspections of the premises and the home's records by the independent person lack scrutiny and fail to review incidents effectively. Insufficient monitoring by the registered manager and the independent person hinders the development of this home.
- Young people are subject to inappropriate restrictions such as the front door routinely locked and being restrained on the floor. Calling the police to manage young people's behaviour and securing young people in their bedroom does not offer the care and support that young people need in order to feel safe and valued. Staff activate alarms on all bedroom doors every night to alert them if young people come out of their rooms. This restriction is applied routinely to all young people and not as a result of individual risk assessment.
- Risk management is poor. Written risk assessments fail to identify known risks to young people therefore staff are not fully equipped to recognise and be alert for any signs that indicate a young person is at risk of harm. The risk assessment of the young people living together as a residential group fails to consider the impact of each young person and their individual needs.
- Serious incidents are not always notified to Ofsted by managers, as required by children's homes regulations.

The children's home strengths

- Young people are regularly consulted about the home and their personal care plan. Staff engage young people through individual work, and group meetings, to seek their views and form activity plans and menus together. Most young people are making progress through their attendance at school and in their social development.
- The manager and staff actively support young people in maintaining contact with their family and friends. Social care professionals report positively on how the staff team work in partnership with them and other agencies. The police report that the staff report promptly any concerns they have if young people are late to return and possibly missing from care.
- Young people are supported well with their health and medical care. Good attention is given to ensuring young people attend health care services.
- There is a full complement of staff with skills and experience in residential care. Staff are supported in their roles through regular training and supervision.

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 with the given timescales.

Requirement	Due date
12: The protection of children standard In order to meet the protection of children standard with particular reference to risk management the registered person must ensure that staff: (2)(a)(i) 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. This relates specifically to the production of risk assessment documents to incorporate known risks and to consider the impact of such risks in the care and supervision of children in order to provide protection.	15/11/2015
13: The leadership and management standard In order to meet the leadership and management standard the registered person must ensure that robust monitoring of care practice occurs. In particular the registered person is required to enable, inspire and lead a culture in relation to the children's home to: *(1)(b) promotes children's welfare In particular, the standard in paragraph (1) requires the registered person to: *(2)(f) understand the impact that the quality of care provided in the home is having on the progress and experiences of each child	15/11/2015

and use this understanding to inform the development of the quality of care provided in the home *(2)(g) demonstrate that practice in the home is informed and improved by taking into account and acting on: (i) research and developments in relation to the ways in which the needs of children are best met *(2)(h) use monitoring and review systems to make continuous improvements in the quality of care provided in the home.	
20: Restraint and deprivation of liberty Ensure that restraint in relation to a child must be necessary and proportionate. This relates specifically to the use of restraint on the floor and restrictive practice such as securing children in a room. (Regulation 20(2))	15/11/2015
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. This relates specifically to the administration of any medicine to the child. (Regulation 36(1)(a))	15/11/2015
40: Notification of a serious event The registered person must notify HMCI and each other relevant person without delay if an incident requiring police involvement occurs in relation to a child which the registered person considers serious. (Regulation 40(4)(b))	15/11/2015
44: Independent person: visits and reports The registered person must ensure that an independent person visits the children's home at least once each month. (Regulation	15/11/2015

44(1)) The independent person must produce a report about a visit (the independent person's report) which sets out, in particular, the independent person's opinion as to whether children are effectively safeguarded. (Regulation 44(4)(a))	
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* These requirements are subject to statutory requirement notice.

Recommendations

- Ensure that action is taken to eradicate the use of institutional language with young people in residential care. For children's homes to be nurturing and supportive environments that meet the needs of their children, they will, in most cases, be homely, domestic environments. (The Guide to the Quality Standards, page 15 paragraph 3.9)

Full report

Information about this children's home

This children's home is registered to provide care and accommodation for up to five young people of either sex, with emotional and behavioural difficulties. It is operated by the local authority.

Recent inspection history

Inspection date	Inspection type	Inspection judgement
09/10/2014	CH - Interim	Declined in effectiveness
29/04/2014	CH - Full	Good
23/01/2014	CH - Interim	Satisfactory Progress

Inspection Judgements

	Judgement grade
The overall experiences and progress of children and young people living in the home are	inadequate
Young people report a variety of satisfaction levels with this home from, 'I would rather live somewhere else', to 'it's alright' and 'they have really helped me here'. Young people form good relationships with staff members, particularly those who have lived at this home for more than six months. Leaders and managers acknowledge that this children's home is not suitable for young people with significant special needs. An initial short term plan for a young person with a learning disability has extended beyond seven months as the local authority search for a more suitable placement. The individual needs of the current young people are considerably varied and different. Staff are aware of the need to adapt to each young person however this has an impact on group living. For example to ensure the safety of one young person the front door is always locked. Young people who want to go out are reliant on asking the staff to unlock the door or taking an alternative exit from the home. The impact risk assessment of young people living together is poor and fails to explore the strains on their compatibility. Difficulties arise amongst young people as they struggle to get along, resulting in young people making complaints about each other. One incident of two young people assaulting each other led to an informal meeting with a police officer to resolve their conflict. This was an effective intervention by the police as the young people discussed the incident and apologised to each other. There are times when young people are friendly and kind to each other and can show empathy. Young people understand why the front door remains locked and as one reports it can be 'annoying', most young people are in agreement with this restriction for reasons of safety. Young people regularly attend education and for those new in placement, there are discussions throughout the summer holidays to ensure that educational placements are ready for the autumn term. Teaching staff communicate difficulties in school to the staff team to enable a collaborative approach in supporting young people to re-engage with their learning. Young people's physical health care needs are met through regular visits to a dentist, optician and general practitioner. Medication is generally well managed with regular stock audits. This practice promotes the safe storage, administration and recording of medication. Medication records made in a bound book for the home are not recorded separately for the young person. Individual records are	

required to contribute to a full and accurate record for young people to have in their possession currently or in the future. Staff have regular consultation with a clinical psychologist and the Child and Adolescent Mental Health Service. Young people benefit from this input to meet their emotional health needs.

Young people enjoy activities in the home and in the local community. Regular trips to the park and swimming promotes physical activity. Young people enjoyed the opportunity to go camping during the summer holidays, staying by the coast.

This property is purpose built as a residential home. A positive aspect of this planning is that young people benefit from en-suite bathrooms. Less attractive is the use of design and layout with lockable areas of the home. Several fixtures detract from a homely environment such as the lighting and, the handles and metal plates on internal doors. The manager has made improvements to the environment and continues to order new furniture and decoration in consultation with young people.

	Judgement grade
How well children and young people are helped and protected	inadequate
Risk management is inadequate. Risks associated with young people offending, misusing drugs, self-harming, going missing or being sexually exploited are not always identified in written risk assessments. Chronologies and referral documents from social workers explicitly identify such risks. The manager has failed to ensure that this significant information transfers into individual risk assessments; a key document referred to daily by permanent and casual staff. Consequently staff lack full information to enable them to support young people to reduce and eliminate known risks. Restrictions imposed on young people are excessive at times. All young people have a door alarm activated on their bedroom at night. This practice is routine and without any assessment of risk to justify such a restriction. On at least three occasions, physical intervention has involved the restraint of young people on the floor. During physical intervention, there are times when young people are 'taken to their room', and on one occasion staff held the door handle to prevent a young person coming out of their bedroom. Incidents have occurred at least twice where physical intervention has not been effective and the staff have called the police to manage young people's behaviour. Following these incidents the manager has failed to monitor and review the records and techniques used, permitting repetition of poor practice. Staff receive regular training on de-escalation techniques and physical intervention.	

This includes a two day practical training event. Staff report that they are not provided with documents during or after this training for the theoretical approach and list of techniques they have learnt. Staff are referred to the manual held in the home for such guidance however, the manual held is out of date and refers to physical intervention techniques on the floor that are not appropriate to use with young people.

There is a reduction in the use of physical intervention with the last incident occurring two months prior to this inspection. Staff report how young people are better able to manage their upset and anger without hurting themselves or others.

Insufficient risk assessment contributes to blurred boundaries. Staff are inconsistent in their management of young people's behaviour. Underage membership for use of social media goes unchallenged. Similarly, young people access music and videos through the internet with explicit adult swearing without intervention from staff. Young people do receive guidance on e-safety but this is not reinforced in their day to day use of technology. Staff fail to regularly promote what is safe and acceptable through the internet and social media, this places young people at risk of exploitation from others.

An incident occurred when staff permitted a young person to stay out overnight without undertaking sufficient checks for their safety. This response demonstrated a lack of care, and curiosity, for the well-being and safety of young people. The manager addressed this poor practice and no further incidents have occurred. In fact, when young people fail to return on time staff actively try to locate them and report to the police. The police confirm that the manager and staff provide good communication about concerns for young people. The few times young people have been reported as missing, arrangements are made for return home interviews by the local authority.

The manager appropriately reports matters of safeguarding to the local authority and the police. The multi-agency risk management meetings promote good communication between the manager, staff and social care professionals.

	Judgement grade
The impact and effectiveness of leaders and managers	inadequate
Leaders and managers fail to effectively monitor the care practices in this home. The lack of oversight ensures that leaders and managers are not fully appraised of the strengths and weaknesses of the home. Therefore, leaders and managers do not take decisive action to remedy poor practice and address shortfalls.	

The registered manager has a system for weekly checks and monthly monitoring. This system lacks depth and fails to evaluate the information reviewed. Leaders and managers fail to recognise the extreme use of restraining young people on the floor and staff securing door handles when reviewing behaviour management records.

Leaders and managers fail to demonstrate progressive practice, unable to learn from inspection and enforcement action. Similar requirements imposed at the previous inspection feature again in this report. The lack of monitoring and review fails to ensure that Ofsted are notified of serious incidents. One omission noted is when the police were called to the home to manage young people's behaviour.

Monitoring by an independent person has not occurred at monthly intervals. In 2015, the four visits that occurred between January and June fail to report adequately on the quality of care provided. The Responsible Individual reports that the local authority have now secured arrangements for an independent person to visit each month.

Case records for young people vary in quality. There are good examples where young people are involved and consulted in completing records such as, 'my personal care plan', 'my behaviour plan' and incentive points. Failure to refer to a significant incident in a monthly summary report demonstrates a lack of understanding by staff for the collation and analysis of individual records. Poor monitoring fails to notice such omissions.

Staff openly report examples of progress for young people such as social interaction, communication skills and personal hygiene. It is unclear how progress and achievements, no matter how small, are celebrated and recorded.

The manager and staff develop effective relationships with family members and the friends of young people. They recognise the importance of these links and work well empowering parents with decision making where appropriate.

Staff receive supervision from line managers in the home and clinical supervision as a team with a psychologist. Staff report general levels of satisfaction with the training programme and management supervision to enable them to provide care and support to young people. The full complement of staff have many years of experience collectively and all are trained to the minimal level three for working in residential care.

Daily language used by the manager and staff reinforces to young people that they live in residential care. 'On shift', 'the unit' and 'shift plan' are institutional phrases failing to promote a nurturing homely environment.

The registered manager has been in post for five years with qualifications in management. She is currently enrolled for the Level 5 Diploma in Leadership and

Management for Residential Childcare. The manager liaises regularly with social workers and senior managers to challenge placement suitability. Records confirm that the manager has persistently requested alternative placements for young people when this home is unable to fully meet their needs.

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 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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