Inspection report for Children's Home

Unique reference number	SC358046
Inspection date	13/12/2010
Inspector	Rachel Ruth Britten
Type of inspection	Random

Date of last inspection	15/09/2009

About this inspection

The purpose of this inspection is to assure children and young people, parents, the public, local authorities and government of the quality and standard of the service provided. The inspection was carried out under the Care Standards Act 2000.

This report details the main strengths and any areas for improvement identified during the inspection. The judgements included in the report are made in relation to the outcomes for children set out in the Children Act 2004 and the relevant National Minimum Standards for the service.

The inspection judgements and what they mean

Outstanding:	this aspect of the provision is of exceptionally high quality
Good:	this aspect of the provision is strong
Satisfactory:	this aspect of the provision is sound
Inadequate:	this aspect of the provision is not good enough

Service information

Brief description of the service

This is a school that is a registered children's home. It accommodates young people for more than 295 days a year. The home is part of a larger organisation. It accommodates up to 56 young people with autism, Asperger's syndrome, or communication difficulties, between the ages of eight and 18 years. Children are accommodated in three residential houses. Acorn house and its annex presently provide the accommodation for up to ten young people who are looked after on 52 week per year placements. This inspection focussed on that house. Phoenix house is a unit within the main school and caters for 38 week students. This was closed for renovation. Children from there had moved temporarily into Acorn during building works. Pendleton, the third unit, also within the school building, also cares for children on 38 week placements.

Summary

The overall quality rating is inadequate - notice of action to improve.

This is an overview of what the inspector found during the inspection.

The purpose of this unannounced interim inspection was to follow up the action and seven recommendations made at the last full inspection on 31 October 2009. It was also to follow up nine actions raised following complaint visits by Ofsted in May and August 2010. The complaints visits highlighted safeguarding and organisational concerns. The inspection also reassessed staying safe and organisation. No other outcome areas were looked at during the inspection. The home's progress to meet previous shortfalls is inadequate overall. There is evidence of capacity to improve, but changes implemented are not having a consistent enough impact upon the quality of care practice. Organisation is inadequate because systems are not robust enough or consistently known and used by all staff and managers. Insufficient prompt action is taken to rectify the shortfalls identified by managers and others as a result of monitoring and complaints investigation. As a result, numerous national minimum standards and regulations are not being met, many of which directly impact upon young people's safety and well-being.

Improvements since the last inspection

The last inspection required the home to establish and keep an up-to-date daily log of events. This is being completed and used to assist staff to know and track events as they unfold each day and adapt their practice accordingly. The log is adequate, but it does not refer staff to records that have been made about events logged or give enough detail to promote a high quality handover and consistent care across shifts.

The last inspection recommended a record of meals as served. This is available and

generally shows what each young person has eaten. However, young people continue to comment that they would like more choices for snacks in the evening and more facility to shop for ingredients when they take part in cooking activities. Young people's physical and emotional health needs are now identified in their written plans and there is a clear, written health plan in place for each young person according to national minimum standard 12.1. These changes are satisfactory improvements.

The last inspection recommended that the record of the use of restraint be numbered and the time of the restraint always recorded as well as the reason the restraint took place. The restraint log is being adequately used and pages are numbered, but a number of restraints referring to different young people are listed on each page. Incidents involving restraints are not cross-referenced to the incident record sheets which give further detail. There is still little detail given about why restraints are used. It is not always clear whether it is to safeguard the young person rather than a method of control. In addition, the records are still not used effectively with young people to ensure that matters are promptly and positively addressed and the progress of the young person promoted. In particular, it is unclear if young people are offered the opportunity to be examined by a medical practitioner or to discuss and add their comments, views and signature to the records, endorsing their inclusion and the learning resulting from the restraint incident. The system in use now aims for this work to be completed through use of the incident record form, but these forms are put through to the central office for logging. Copies and logs do not arrive on the young person's file for up to three months afterwards. This misses the opportunity to maximise young people's progress and learning following an incident of restraint.

The last inspection recommended that the care plan for each child fully addresses their cultural, religious, language and racial needs and how they will be met. There are monthly care planning documents in place that aim to cover these needs and documentation can be added throughout each month to show how they are being met. The system is being used by staff with varying degrees of detail being given about, for example, meeting religious needs. Managers report that they remain concerned about the quality of staff interactions in relation to proactively meeting young people's cultural and racial needs.

The last inspection recommended that the home's staff, including where appropriate the child's key worker, contribute effectively to all reviews on the progress and any difficulties of the child in the placement. Managers state that they are working more closely with education and therapy staff, parents and local authorities to contribute effectively to reviews on the progress of young people in placement. Evidence to support the effectiveness of this was not requested during the inspection.

The last inspection recommended that all staff receive one-to-one supervision from a senior member of staff each month and new staff receive one-to-one supervision at least fortnightly during the first six months of their employment. This standard is still not being consistently met and written records of supervision are not all available for inspection. There are adverse effects upon staff morale, skill levels and young

people's care as a result of this.

Similarly, it was recommended at the last inspection that there are systems in place to monitor the performance of the home against its Statement of Purpose as set out in Schedule 6 and that the registered person monitors and signs the home's records at least once a month, and produces a report of their review to identify any patterns or issues requiring action. There is documentary evidence that Regulation 33 monitoring is taking place, but that the issues and patterns noted are not being effectively and promptly dealt with. In addition, the manager monthly reports are not taking place regularly enough or being acted upon effectively and promptly. This means that young people's welfare is inadequately promoted because the organisation of the setting is inadequate.

The complaint visit in May 2010 required that young people's records contain all the information, documents and records specified in Schedule 3, in particular, young people's contact details for their dentist and details of any dental treatment. Documents checked show that this information is in place on files. This helps to properly support young people's health.

The complaint visit in May 2010 required that all staff have the qualifications, skills and experience necessary for the work they are to perform. This specifically relates to maintaining professional boundaries with the young people they work with. The visit also required a sufficient number of suitably qualified, competent and experienced persons working at the home. The same requirement was raised again at the August complaint visit. Staff observed on the day of the inspection maintained appropriate professional boundaries. Documents and discussion with managers provided evidence that staff have been re-located and have received additional training concerning positive behaviour management and key care skills. However, young people are experiencing a number of different care staff on shifts and state that they are 'between' key carers at present. Staff on duty on the day of inspection were suitably qualified and experienced, but were insufficient in number. In addition, investigations from managers indicate that staff morale and demonstrable skills are concerning. There is evidence that staff are not implementing care plans, strategies or handover information consistently. This means that they are not adequately or positively managing young people's behaviour to help them make progress.

The complaint visit in August required that young people must be treated by staff who have a suitable first aid qualification. The accident records indicate that this is now being met and staff rotas identify who on duty is suitably qualified. This supports children's health and safety in the event of accidents. This complaint visit also required the prompt referral to the local authority in whose area the children's home is situated, of any allegation of abuse or neglect affecting any child accommodated in the children's home. Documents, child protection training, and discussions with senior staff indicate that such notifications have now taken place and will take place in the future. Nevertheless, documents seen and discussions during this inspection show that staff do not always follow the notification requirements of Schedule 1, for example, when a young person has gone missing from care. As a result, young people are still not adequately safeguarded because of

inconsistent application of the children's homes regulations.

The complaint visit in August required that unnecessary risks to the health or safety of children accommodated in the home are identified and so far as possible eliminated. The home have reviewed young people's risk assessments and the risks in the home. Practice has been improved to better secure young people. However, inspection of risk assessments shows that they are still not effective enough in identifying the risks and how they will be managed and reduced. As a result, young people are still not adequately safeguarded.

The complaint visit in August required that the records specified in Schedule 4 be maintained and kept up to date. These are still not in place in relation to the register in respect of each young person accommodated in the home. There is no record of the statutory provision (if any) under which each young person is accommodated. This impacts on the safe running of the setting, including the correct notifications to relevant persons of notifiable events. Similarly, the complaint visit in August required that there should be, without delay, notification to the parent of any child accommodated in the home of any significant incident affecting the child's welfare unless to do so is not reasonably practicable or would place the child's welfare at risk. New incident recording forms have been introduced which do prompt for this and these are logged and audited centrally to ensure that notification has taken place. This change supports young people's welfare and safety if it continues to be effective in ensuring that notification to parents is prompt.

Overall, the action taken to improve the provision is inadequately securing young people's safety and well-being. A number of actions are still outstanding or are not met effectively enough.

Helping children to be healthy

The provision is not judged.

Protecting children from harm or neglect and helping them stay safe

The provision is inadequate.

Young people enjoy acceptable levels of privacy and confidentiality. They value the personal space of their bedrooms, for which they may have a key. Some young people choose to personalise their rooms and staff do not come in without knocking. Young people have access to a telephone and know how to complain and feel confident to do so to staff, managers or their social worker. However, they do not have contact details for contacting Ofsted. Records of some complaints do not show that young people have been kept informed of progress and fully responded to within 28 days. Care plans and records of incidents, absconding and restraint are rarely utilised positively with young people to help them to learn from difficult situations.

A number of young people participated in the inspection, both by completing questionnaires and by talking to inspectors. Their written and verbal comments are positive overall, indicating that they feel safe in the setting and can approach many staff who will deal with issues, such as bullying. Young people comment: 'yes I have been bullied and it was sorted out'; 'they teach you standard safety and the country code'; 'you are gone for good if you don't keep to the rules!'; 'you get in trouble, but some students get away with it'. Staff have been receiving training in empowerment and positive behaviour support. However, managers remain concerned that staff morale and commitment is a barrier to better behaviour and care management for individual young people.

Liaison is taking place with the Local Safeguarding Children Board to ensure that closer working relationships are developed. Safer recruitment processes have been introduced alongside an internal safeguarding team. Visitors are properly monitored. This helps to ensure that young people are safeguarded from abuse. However, the management of episodes of absence without authority does not adequately safeguard young people in these instances. Records are not always completed or the correct notifications made. Risk assessments do not explain clearly enough how young people are safeguarded and risks managed and minimised in situations when their behaviour may expose them to harm. In addition, lack of clear records showing young people's legal care status holds back staff in making timely and correct notifications when events, such as young people going missing, have happened.

Young people report that staff take care of their safety and manage risks such as the recent snow, by gritting the paths to the school buildings and supervising movements on foot around the grounds. Vehicles were not used while the snow and ice were assessed as being too dangerous for busses and cars to be used. Young people have some opportunities to increase their independence, for example, by being supported to use public transport and interact appropriately in shops. Records of daily checks in the home demonstrate that these are undertaken, although the upstairs corridor and access to the stairs in Acorns was blocked by the vacuum cleaner and bags of rubbish when the inspector was shown around. Records of boiler and specialist equipment servicing was not available in the house office, although this is stated to be available in the central office. Fire drills are undertaken as required and there is a new maintenance logging system, aiming to ensure that issues are dealt with more quickly. Bathrooms and washing facilities are clean, safe and suitable.

Helping children achieve well and enjoy what they do

The provision is not judged.

Helping children make a positive contribution

The provision is not judged.

Achieving economic wellbeing

The provision is not judged.

Organisation

The organisation is inadequate.

The management systems in the home do not work well enough to ensure that young people are adequately safeguarded. The new care manager for the home has not yet submitted to vetting by Ofsted. The monitoring systems in the home are not effective enough. For example, the monthly monitoring of records and reports made by managers are not being promptly acted upon by house managers and their staff. The same is true of Regulation 33 reports. As a result, full and consistent use of records is not happening to meet young people's needs. There are continuing concerns from managers that staff are not well prepared for their shifts because they are not accessing or utilising full details of individual young people's recent activities and care. Many staff have been in receipt of training and have moved to new roles. Nevertheless, ongoing issues in the organisation of the setting hold back improvements because not all staff are aware and committed to them.

What must be done to secure future improvement?

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 Regulations 2001 and the National Minimum Standards. The Registered Provider(s) must comply with the given timescales.

Std.	Action	Due date
34	ensure that notice is given to Ofsted forthwith of the person appointed to manage the home and the date of their appointment (Regulation 7 (2))	14/01/2011
33	ensure that there is a register of each child accommodated in the home which includes all the matters listed in Schedule 4.1, in particular, the statutory provision (if any) under which they are accommodated (Regulation 29(1))	14/01/2011

33	ensure that matters identified in monthly monitoring visits are acted upon to improve the quality of care provided (Regulations 33 and 34)	14/01/2011
33	ensure that action is taken on recommendations and issues of concern raised in Regulation 33 and 34 monitoring reports (NMS 32.3 and 33.1)	14/01/2011
20	ensure that events in column 1 of Schedule 1 are notified to those specified in column 2, in particular, to placing authorities when there has been absconding by a child accommodated in the home (Regulation 30(1)).	14/01/2011

Recommendations

To improve the quality and standards of care further the registered person should take account of the following recommendation(s):

- improve the effectiveness of the record of restraint, giving full detail of the behaviour requiring the restraint and ensure that the record shows that children have been offered the opportunity to be examined by a medical practitioner and to write or have their views recorded, including signing their name against the confidential record (NMS 22.9, 22.13 and 22.14)
- ensure that records of incidents regarding behaviour, including sanctions and restraint records, are clearly cross-referenced, confidentially kept, promptly available to and used by care staff to support consistent and constructive responses to inappropriate behaviour (NMS 22.2)
- ensure that risk assessments effectively identify the risks in the home and actions to be taken to reduce and manage those risks to an acceptable level (NMS 26.2)
- ensure that written records are made of the circumstances of all incidents of absconding, all actions taken by staff and the reasons for the absconding (NMS 19.6). Ensure that the procedure for children who are absent without authority takes into account the looked after legal status of the child (NMS 19.3)
- ensure that complaints procedures and information include the right and means for children, parents, staff and others to make complaints to Ofsted (NMS 16.5)
- ensure that all complaints are responded to within agreed timescales and that complainants are kept informed of the progress of their complaints (NMS 16.3 and 16.1).