Children's homes inspection - Full

Inspection date	**30/09/2015**
Unique reference number	**SC386505**
Type of inspection	**Full**
Provision subtype	**Children's home**
Registered person	**Keys Education Limited**
Registered person address	**Hurstwood Court, Laganwood House, New Hall Hey Road, ROSSENDALE, Lancashire, BB4 6HR**

Responsible individual	**Marc Murphy**
Registered manager	**Michael Merrison**
Inspector	**Chris Scully**

Inspection date	**30/09/2015**
Previous inspection judgement	**Adequate**
Enforcement action since last inspection	**None**
This inspection	
The overall experiences and progress of children and young people living in the home are	**Inadequate**
There are serious and 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**

SC386505

Summary of findings

The children's home provision is inadequate because:

- Young people's safety, health, emotional well-being and educational needs are not always recognised or adequately met.
- There are ineffective strategies to protect young people from a significant risk of being missing from care, self-harm and drug and alcohol misuse.
- Monitoring by the Registered Manager and independent person does not provide an accurate picture of how the home is operating and does not adequately identify and address shortfalls in practice to safeguard and support young people.
- Care planning and risk assessments are not robust or effectively reviewed to address the changing emotional and social needs of young people.
- Poor recording fails to provide a factual record of young people's care experience.
- Some young people do not have access to a full-time education limiting their progress and ability to reach their full potential.
- Not all staff are not sufficiently skilled or competent to meet the needs of young people.
- The matching process for the admission of young people to the home is ineffective, potentially leaving others at risk.

The children's home strengths

- One young person is making great strides with her education and has realistic aspirations of attending university.
- Young people said they enjoyed positive relationships with staff and felt that they could talk to them.

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
6: The quality and purpose of care standard 6. In order to meet the quality and purpose of care standard the registered person must; (2) (b) (ii) provide to children living in the home the physical necessities they need in order to live there comfortably. With particular regard to repairing the loose fitting carpet on the landing. The damage in the kitchen and replacing the bedroom furniture.	06/11/2015
10: The health and well-being standard 10. In order to meet the health and well-being standard the provider must ensure that: (1) (a) The health and well-being needs of children are met; (b) Children receive advice, services and support in relation to their health and well-being; and (c) Children are helped to lead healthy lifestyles. In particular all young people have an up-to-date health care plan that is regularly reviewed and updated, and that they receive individualised support and guidance with regards to their health care needs.	06/11/2015
8: The education standard 8. In order to meet the education standard the registered person must ensure that:	06/11/2015

(2)(a) (viii) they 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 exclusion or non-attendance and to return to school as soon as is possible; (x) help each child to attend education or training in accordance with the expectations in the child's relevant plans.	
12: The protection of children standard 12. In order to meet the protection of children standard the provider 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; (ii) help each child to understand how to keep safe; (iii) have the skills to identify and act upon signs that a child is at risk of harm; (iv) manage relationships between children to prevent them from harming each other; (v) understand the roles and responsibilities in relation to protecting children that are assigned to them by the registered person; (vi) take effective action whenever there is a serious concern about a child's welfare; and (b) 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; and (d) that the premises used for the purposes of the home are designed, furnished and maintained so as to protect each child from avoidable hazards to the child's health. With particular regard to the missing from care procedures, all young people's risk assessments, and behaviour management strategies.	06/11/2015
13: The leadership and management standard 13. In order to meet the leadership and management standard the registered person must ensure that they:	

(2)(h) use monitoring and review systems to make continuous improvement in the quality of care provided in the home.	
14: The care planning standard 14. In order to meet the care planning standard the provider must ensure: (2) (a) that children are admitted to the home only if their needs are within the range of needs of children for whom it is intended that the home is to provide care and accommodation, as set out in the home's statement of purpose; in particular the home's impact risk assessment. (e) that the child's placing authority is contacted and a review of that child's relevant plans is requested, if (i) the registered person considers that the child is at risk of harm	06/11/2015
The registered person must maintain all of the records which include the information and documents listed in Schedule 3 in relation to each child, in particular that records are sufficiently detailed, and are up-to date and are signed and dated by the author of each entry, records are held in a secure place when the young person has ceased to be accommodated. In particular reference to the recording of daily living plans, key worker sessions, incident reports, accident and first aid logs, contact arrangements, physical intervention records and young people's health care needs. (Regulation 36 (1) (a) (b) (c) (2)(d)) Schedule 3 (14,15,16,17,22 & 26)	06/11/2015
Maintain in the home the records in Schedule 4 in particular the staff rotas. (Regulation 37 (2) (a)(b)) Schedule 4 (3)	06/11/2015
The registered person must notify HMCI and each other relevant person without delay in particular if— (a) a child is involved in or subject to, or is suspected of being involved in or subject to, sexual exploitation; (b) an incident requiring police involvement occurs in relation to a child which the registered person considers to be serious; (c) there is an allegation of abuse against the home or a person working there; (d) a child protection enquiry involving a child — is instigated;	06/11/2015

or concludes (in which case, the notification must include the outcome of the child protection enquiry); or (e) there is any other incident relating to a child which the registered person considers to be serious. (Regulation 40 (4) (a) (b) (c) (d))	
The registered person must ensure produce a report about a visit ("the independent person's report") which sets out, in particular, the independent person's opinion as to whether - (a) children are effectively safeguarded: and (b) the conduct of the home promotes children's well-being (Regulation 44 (4) (a) (b))	06/11/2015
The registered person must complete a review of the quality of care provided for children ("a quality of care review") at least once every 6 months. (2)In order to complete a quality of care review the registered person must establish and maintain a system for monitoring, reviewing and evaluating – (a) the quality of care provided for children; (b) the feedback and opinions of children about the children's home, its facilities and the quality of care they receive in it; and (c) any actions that the registered person considers necessary in order to improve or maintain the quality of care provided for children. (Regulation 45 (1) (2) (a) (b) (c))	06/11/2015

Recommendations

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

- Ensure the staffing structure has the necessary experience and qualifications to enable the delivery of the homes Statement of Purpose in particular, training with regards to record keeping, self-harm, drug and alcohol misuse and sexually harmful behaviours. (The Guide to the Quality Standards, page 53, paragraph 10.8)

Full report

Information about this children's home

This service is a private children's home, registered to care for up to three children with emotional and/or behavioural.

Recent inspection history

Inspection date	Inspection type	Inspection judgement
05/03/2015	CH - Full	Adequate
27/08/2014	CH - Interim	declined in effectiveness
05/02/2014	CH - Full	Outstanding
31/07/2013	CH - Interim	Good Progress

Inspection Judgements

	Judgement grade
The overall experiences and progress of children and young people living in the home are	**inadequate**

Care planning in the home is poor. Daily living plans are not up-to-date and do not reflect the ever-changing needs of young people, such as increasing incidences of self-harm. Plans do not provide clear guidance to staff about how to respond. For example, staff failed to take effective action when a young person began to draw on their arm with a safety pin.

Poor recording within health care plans significantly impacts upon the care provided to young people. For one young person there was no health plan in place and in another, there is no reference to the recent increase in concern over their emotional health due to self-harming behaviours. Accident forms and incident reports are not consistently completed. This fails to demonstrate how young people's health care needs are addressed.

Both young people have very specific health care needs that require ongoing support in relation to self-harm and potential drug and alcohol misuse. However, risk assessments do not identify all of the known risks or the action to minimise these. Also both young people smoke; one said he wanted to take part in 'stoptober' to give up but staff failed to seize the opportunity to engage him in a full and frank discussion about this, to aid his chances of success.

Overall, plans lack detailed analysis of young people's experiences or consider what positive impact there has been on their lives because of the care they receive. There is very little written evidence to show how young people are supported on a daily basis and how effectively they are being looked after in line with their plan. Consequently, the Registered Manager has little information to measure young people's progress and help to develop a better understanding of how to promote their welfare.

Impact risk assessments for young people who are moving into the home are ineffective. A generic document is used which does not adequately recognise the known risks associated with the young person and how these will affect the other young people living in the home. Consequently, the failure to sufficiently assess compatibility of placements meant a young person was inappropriately placed in the home. This resulted in a number of assaults on staff, high levels of disruption in the home and this led to the placement breaking down. Ultimately, the welfare, health and safety of all young people was compromised.

Staff are not sufficiently proactive in securing appropriate advice and guidance

from medical professionals when required. For example, records indicate that they failed to administer first aid or seek advice for a young person who had cleaning liquid sprayed in their face. On another occasion, they failed to make regular checks on a young person when she returned home from hospital, having been suspected of being under the influence of an unknown substance. As a result, staff failed to safeguard her.

Young people said they have positive relationships with staff and can talk to them about anything. One young person wrote to the inspector about her experiences at the home. She said, 'the staff are just brilliant; they support you in every given way.' However, this was not apparent within the records to show what work is being undertaken to support young people's progress and development.

One young person is building upon her previous educational success prior to moving in to the home. She aspires to attend university to study law or criminology. She said a member of staff is to help her with her university application and she is looking forward to visiting some universities on their open days. This approach supports the young person's aspirations for their future.

The other young person is still not receiving 25 hours education a week. He was originally placed on a two week placement in April 2015. Until very recently he has been completing online education at the home. He feels insecure about his future and this is affecting his emotional well-being and resilience. He understands that the placing authority is looking for an alternative placement and that the Registered Manager and staff are liaising with their social worker and virtual head to secure this. However, there have been ongoing delays in securing this and he feels that no one is listening to his wishes about his preferred school placement as he wants to be in a 'proper school' rather than an alternative provision. Consequently, the lack of an educational placement is affecting his ability to reach his full educational potential.

Young people are working towards independence. One said she does her own laundry and loves to cook in the home. She particularly enjoys making stir-fry's. She said she is now confident to travel to and from college each day.

	Judgement grade
How well children and young people are helped and protected	**inadequate**
Poor safeguarding practice is leaving young people at risk of harm in particular, missing from care risk assessments are ineffective. They do not identify issues, such as young people's potential to self-harm, their exposure to criminality and ongoing drug and alcohol misuse. They also fail to identify where a young person	

may go, whom they may be with or the addresses and contact details for people with whom they are known to associate with. This significantly hinders staff's ability to conduct a focussed search for them.

The lack of clear risk identification and planning does not help staff understand the risks associated with each young person. Neither does it provide effective guidance to manage these safely. For example, clear guidance to staff on what steps to take when young people return home and retire to bed who are thought to be under the influence of a substance. In addition, documentation is not routinely updated following serious incidents, changes in young people's behaviour or after reviews. This means practice is not based on the most up to date information.

Staff failed to recognise the serious risks to a young person during an incident when staff had attended another home to collect them. The young person appeared to be under the influence of a substance and stated their intention to leave and not return at the appointed time or even at all. The staff let her leave and did not appear to take steps to counsel her to return with them to seek medical attention. This was further exacerbated due to the on call manger instructing staff to return to the home without the young person or seeking immediate further assistance to try to locate her. This left the young person in a very vulnerable position where her welfare was not effectively safeguarded and resulted in her later that night independently seeking hospital attention.

The incidents of missing from care have increased for one young person. Police missing from care coordinators said this was partly due to them being out of education and wanting to see their girlfriend. They said the Registered Manager is generally quick to report any incidents of missing to them. Staff do go looking for young people, but admit this is problematic as they are not familiar with areas where they are looking. Young people said they know staff look for them when they are missing and that staff try to ring them. They admitted to turning their phones of so they do not have to talk to them. Key worker sessions do not reflect the work undertaken with young people to discuss the importance of answering the phone to them when they are away from home and why it is important that staff know they are safe.

Ofsted were not notified of a significant event resulting in child protection meetings to support a young person. The home also failed to update his care plans, risk assessment and health care plan as a result of the meeting. The quality of recording in other notifications is poor and does not provide an accurate account of the actual events, the antecedent or outcomes for young people. This does not demonstrate the action the home is taking to help keep young people safe.

Both young people are on a one to one support, but their behaviours can quickly escalate. There have been a number of incidents of the young people physically fighting and being disruptive in the home. This has resulted in staff physically intervening. Incident records and the physical interventions log do not provide

clear insight into these incidents. They fail to reflect the severity of the incident or the action taken by staff to try and resolve or deescalate the situation. They also fail to routinely include a discussion with young people about what happened. This does not promote transparency or provide young people the opportunity to reflect upon their behaviour and consider different ways of managing their feelings. Staff and the Registered Manager said they are 'fire-fighting' now due to the unpredictable and the volatile nature of the young people. This impacts upon their ability to manage challenging situations and to learn from the events in order to inform future strategies about how best to respond to and manage young people's behaviour.

However, staff do report that progress is being made; citing an example whereby when one young person may damage items in the kitchen, they are now increasingly able remove themselves from the escalating situation. They are more able to reflect upon their behaviour, and show a willingness to acknowledge their actions and to apologise and help to clear up. Young people said the sanctions are fair and the house rules are 'ok.' Young people are consulted on their incentives. A young person said he is working towards getting Fifa 16 game, if he did not go missing for two weeks.

The home is adequately maintained. The Registered Manager is quick to replace broken crockery and to seek repairs by the maintenance department. A new carpet is to be ordered for the stairs and landing. However, the carpet this is lifting by one of the young people's bedrooms and is a tripping hazard. The wardrobe doors in one bedroom are damaged and one is coming away from the frame. The flooring in this room does not cover the whole floor. There is graffiti on the ceiling on the ground floor. A vacant bedroom has not been cleaned since the young person left the home. These issues affect the safety of young people and detract from the homely environment staff are striving to achieve.

	Judgement grade
The impact and effectiveness of leaders and managers	**inadequate**

Young people live in a home that is not effectively managed. The Registered Manager and senior managers have failed to identify the shortfalls in recording and practice. This has led to little or no action being taken to address the issues. For example, why staff returned home when a young person failed to meet them when suspected of being under the influence of a substance. As a result of these failings the health, safety and well-being of young people is compromised.

The manager has been in post since July 2014 and holds an NVQ 5 in Leadership and management as well as relevant childcare qualifications. He is also the Registered Manager of a second one bed home that has recently opened. The homes deputy has recently left and this position is yet to be filled. Staff said they

felt the lack of a deputy had compounded some of the issues identified, in particular addressing the poor recording and the need to reflect better the work that is undertaken with young people.

The lack of information about young people in the documentation means agency staff have little up-to-date, information upon which to base their care practice. A recruitment programme has taken place with staff being appointed subject to suitable checks being received. The home seeks to provide a continuity of care by using the same agency staff in the interim period.

The home seeks to work collaboratively with placing authorities. A social worker said communication between them and the home was good. The home keeps them regularly apprised of all situations and they felt they managed young people's need well.

Staff have adequate training opportunities, but not all staff have received training in important relevant areas such as self-harm, sexually harmful behaviours, drug and alcohol misuse and record keeping. This impacts upon their ability to provide consistent, effective care.

One of the two previous requirements has been met. Arrangements for supervision of staff have improved. However, the home has failed to act upon the requirement to address young people's known and risk-taking behaviour and the potential for harm to them and others. The manager's monitoring does not identify any concerns about specific incidents or any patterns or trends with particular emphasis on reviewing serious incidents and any barriers to young people's progress. This impacts upon the homes ability to demonstrate continuous improvement.

The internal monitoring of the home and visits by the independent person are ineffective and are failing to identify weaknesses. For example, ineffective recording of incidents, key worker sessions, accidents and first aid offered to young people. The independent person has also not routinely recorded young people's comments and did not identify the lack of appropriate health care planning documents to support young people's needs. Consequently, monitoring does not ensure that action is taken to address shortfalls and that the safety and well-being of young person is promoted at all times.

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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