SC400355

Registered provider: Social Care Services (Clayton) Limited

Full inspection

Inspected under the social care common inspection framework

Information about this children's home

This is a privately run children's home that provides care and accommodation for up to three young people who may have emotional and/or behavioural difficulties.

Inspection dates: 24 to 25 May 2017

Overall experiences and progress of children and young people, taking into account	**requires improvement to be good**
How well children and young people are helped and protected	requires improvement to be good
The effectiveness of leaders and managers	requires improvement to be good

The children's home is not yet delivering good help and care for children and young people. However, there are no serious or widespread failures that result in their welfare not being safeguarded or promoted.

Date of last inspection: 31 January 2017

Overall judgement at last inspection: Declined in effectiveness

Enforcement action since last inspection

None

Key findings from this inspection

This children's home requires improvement to be good because

- The behaviour management strategies used within the home are often ineffective in managing young people's aggressive and harmful behaviours. As a result, young people continue to display behaviours which compromise the safety and well-being of themselves and others.
- Staff understand and have the skills to manage incidents of bullying. However, interventions have not always been effective. As a result, young people have not always been able to build and maintain positive relationships with one another.
- The manager has implemented an impact risk assessment for new admissions. Despite this, the process of making suitable placements are not sufficiently robust. Consequently, the admission of some young people has significant impact on the group dynamics within the home.
- Procedures are in place to ensure that relevant professionals and agencies are informed of significant events. However, this system is not robust. The manager has failed to notify partner agencies and HMCI of information pertaining to the protection of children within the required timescales.
- There are some repeated issues in the quality of record keeping. Physical intervention and missing from home records are not sufficiently robust.

The children's home's strengths

- Leaders and managers recognise weaknesses in areas of practice and are working hard to address them.
- Some progress has been made in addressing shortfalls identified at the last inspection. Risk assessments are now updated regularly and provide relevant information regarding the needs and vulnerabilities of young people.
- Staff offer a range of activities within the home and community to encourage young people to develop self-confidence and to have fun.
- Staff spoken with during the inspection recognise that the home has had a period of instability and crisis. Nevertheless, they continue to express commitment and enthusiasm for their role and have genuine aspirations for young people in their care.
- The staff team reports good levels of support from each other and the manager. This provides team members with emotional resilience to provide effective care.

Recent inspection history

Inspection date	Inspection type	Inspection judgement
31/01/2017	Interim	Declined in effectiveness
09/08/2016	Full	Good
30/03/2016	Interim	Sustained effectiveness
13/05/2015	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 with the given timescales.

Requirement	Due date
11: The positive relationships standard In order to meet the positive relationship standard, the registered person must ensure that staff — (2)(a)(i) meet each child's behavioural and emotional needs, as set out in the child's relevant plans; (ii) help each child to develop socially aware behaviour; (iii) encourage each child to take responsibility for the child's behaviour, in accordance with the child's age and understanding; (vii) help children develop the understanding and skills to recognise and withdraw from damaging or harmful behaviour; (xii) understand and communicate to children that bullying is unacceptable; (xiii) have the skills to recognise incidents or indications of bullying and how to deal with; and (b) that each child is encouraged to build and maintain positive relationships with others. This is with particular regard to ensuring more robust behaviour management strategies and responding effectively to harmful behaviour such as bullying.	30/06/2017
12: The protection of children standard In order to meet the protection of children standard the registered person must ensure that — (2)(b) 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. This is with particular regard to ensuring more robust matching and effective risk management practices.	30/06/2017
The procedures to be followed in the event of an allegation of abuse or neglect must provide records to be kept of an allegation of abuse or neglect, and the action taken in response. (Regulation 34(2)(d)).	30/06/2017

This is with particular reference to leaders' and managers' responses to safeguarding concerns such as allegations of abuse.	
The registered person must maintain records ("case records") for each child which include information and documents listed in Schedule 3 in relation to each child. Specifically, the date and circumstances of all incidents where a child goes missing from the home, including any information relating to the child's whereabouts during the period of absence. (Regulation 36(1)(a)(14))	30/06/2017
The registered person must notify HMCI and each other relevant person without delay if there is an allegation of abuse against the home or a person working there. (Regulation 40(4)(c))	30/06/2017

Recommendations

- All children's case records must be kept up to date and stored securely whilst they remain in the home. ('Guide to the Children's homes regulations including the quality standards', page 62, paragraph 14.3) This is with particular regard to the monitoring of case records.

- Where the registered person considers that a child is at serious risk of harm, due to their escalating violence and aggression or an increase in their risk-taking behaviours such as being persistently missing from their placement, they must contact the local authority to request a review of the child's care plan. Where a review does not take place, the registered person must escalate this concern under regulation 5 (engaging with the wider system to ensure children's needs are met). ('Guide to the Children's homes regulations including the quality standards', page 57, paragraph 11.12)

- Records of restraint must be kept and should enable the registered person and staff to review the use of control, discipline and restraint to identify effective practice and respond promptly where any issues or trends of concern emerge. These records should provide a clear account of the debriefs that occur following the events. ('Guide to the Children's homes regulations including the quality standards', page 49, paragraph 9.59)

Inspection judgements

Overall experiences and progress of children and young people: requires improvement to be good

This home requires improvement to be good. The period since the last inspection has been characterised by increased risk-taking behaviours. The relationships between young people and some of the staff have broken down, and behaviour management has

not been effective. This has left some young people vulnerable and at risk of harm. There have been a number of serious incidents which have had a detrimental impact on young people. Examples include aggressive and intimidating behaviour, young people barricading themselves in their bedrooms, and unauthorised absences from the home. These ongoing risk-taking behaviours compromise the safety and well-being of the young people and the staff, and impact negatively on the experiences and progress that young people make.

More positively, most young people are engaged in education and are able to reflect on the progress that they have made. One young person said, 'One of the things that has gone well for me here is my education. I'm now back in school and I like it.' However, attainment for others is variable. When young people are reluctant to engage in their education staff maintain their commitment and offer support, encouragement, advice and additional opportunities to try to re-engage them in positive education. Staff work in partnership with schools and placing authorities to make sure that tailor-made education packages are provided. This gives young people the best opportunity to progress in their education.

Staff support contact between young people and their families when it is safe to do so, and in line with their care plan. Staff supervise contact when needed and try to make contact a positive experience, especially when young people have contact with siblings. Staff are aware of the emotional impact that contact can have upon young people and sensitively support them at these times. This support from staff ensures that young people's contact with those who are important to them is managed in a safe, enjoyable, and positive way.

Staff spoken with during the inspection demonstrate a good awareness of bullying and promote a culture where this is not tolerated. However, there is little evidence of qualitative work undertaken with young people to help them rebuild and maintain positive relationships with each other. Furthermore, there is no clear system in place for the recording and monitoring of bullying. This means that staff are not able to effectively monitor any emerging patterns in bullying and intervene accordingly.

Staff encourage young people's individual interests and ensure that they have access to community facilities. For some this has been very successful and they have clearly identified hobbies and interests in the community. For example, one young person enjoys swimming two or three times a week. Young people's engagement in activities greatly broadens their outlook on life, improves their social skills and fully integrates them into community life and wider society.

The manager ensures that young people are registered with doctors, dentists and opticians. They attend their routine health appointments with support and encouragement from staff. Young people also have access to the services that they need to promote their physical, emotional and psychological well-being. This ensures that young people's holistic health needs are met.

Communication between staff and partner agencies is adequate. Social workers confirm

that staff share information verbally. However, not all social workers receive written weekly updates as agreed at point of placement. This is something that the manager has identified, and they are in the process of reviewing recording practice within the home to ensure that all case records are updated regularly. More positively, there is evidence to suggest that staff challenge partners when they feel necessary, in the young people's best interests. This demonstrates that staff advocate effectively on behalf of young people when required.

How well children and young people are helped and protected: requires improvement to be good

Staff spoken with during this inspection demonstrated an understanding of the difficult emotions being expressed when young people are challenging or engage in harmful behaviour. Staff are very honest and direct with young people and will say if behaviour is unacceptable, particularly if their behaviour is having an impact upon another young person. However, despite the staff team's best efforts, interventions have often proved ineffective. In recent weeks the home has seen an increase in challenging and harmful behaviour, such as violence and aggression, physical assaults on staff and bullying. This cannot fail to have a negative effect on young people's day-to-day experiences of living in the home.

There are clear risk-management procedures in place, and the quality of risk assessments has improved since the last inspection. However, staff do not ensure that these are consistently followed on a day-to-day basis. For example, the inspector identified a pattern of behaviour of young people entering the staff office to retrieve confiscated items such as cigarettes. On one occasion during the inspection, a young person was able to gain access to the office and located the vehicle keys. This resulted in two young people gaining entry into the car and initially refusing to hand the keys back to staff. This does not demonstrate robust safeguarding practice, and leaves young people vulnerable to risk of harm.

The behaviour management protocols and records are unclear and confusing. It is not clear how young people are being supported and encouraged to maintain positive behaviour and what staff are doing to assist young people with improving their known risk-taking behaviours. For example, staff do not make use of incentive systems to promote more socially acceptable behaviour. Records relating to behaviour management lack clarity and, therefore, the manager is unable to thoroughly review effective interventions in promoting positive behaviour.

Staff spoken with during the inspection confirmed that behaviour management strategies have been tested in recent months. Staff said, 'The behaviour of some young people has been difficult to manage and staff have been assaulted on almost a daily basis.' Another staff member said, 'The combination of these young people together isn't positive. It has been a really challenging time.' Despite the challenges, staff presented as resilient and demonstrate a commitment to getting things back on track, and action has been taken to address some of these issues. However, the increase in incidents cannot fail to impact

on the safety and well-being of young people.

Following a requirement raised at the last inspection, the manager has implemented an impact assessment for new admissions. However, matching processes continue to be ineffective. For example, there is no evidence to show how the admission of young people may impact on the risky behaviour of others. Furthermore, the manager failed to reflect and learn following previous disruptions. Consequently, leaders and managers have not made well-informed decisions about admissions.

More positively during the inspection, the manager escalated his concerns appropriately with placing authorities, having concluded that the home can no longer ensure the safety of some young people. However, more robust and timely decisions with regards to recent behaviours could have improved the safeguarding of young people.

Incidents of physical restraint occur only when there is clear risk of harm or the safety of others is compromised. There have been five recorded restraints since the last inspection. Records for these restraints are not completed with sufficient rigor. Records are brief and do not provide sufficient detail. For example, there is limited evidence that debriefs occur following incidents. There is little evidence that young people are given the opportunity to reflect on the incident and express any negative feelings that they have about being restrained. A recommendation has been made to ensure that all restraint records are more robust.

Missing from home incidents continue to be a concerning feature. Some young people's missing episodes have decreased significantly while others have increased. Records confirm that when young people go missing staff take action and attempt to locate young people as quickly as possible. While good practice is noted in relation to staff action, missing records are less robust and are not completed with sufficient rigor. Overall, records lack clarity in relation to what action has been taken, where young people were located and the circumstances of their return.

Safeguarding concerns, such as allegations, are not subject to immediate referral to the placing or residing authority. For example, on at least one occasion the provider failed to notify the local authority's designated officer within the required timescales. This omission leaves professionals without key information and signifies poor safeguarding practice.

Safeguarding investigation records are not sufficiently detailed. Records are poorly organised, and the outcome of any investigation is not thoroughly recorded. Records made in this way do not stand up to scrutiny in the event of a further complaint. Nor does this demonstrate the manager's ability to promote best practice.

The effectiveness of leaders and managers: requires improvement to be good

The manager is not registered with Ofsted. There are some weaknesses in the effectiveness of leadership and management that require improvement. However, the

manager has expressed a desire to improve the service. This is demonstrated in the fact that three out of the four requirements raised at the last inspection have been met. However, there is some way to go, particularly in relation to the robustness of matching and safeguarding practice.

Over the last three months, the service has experienced a period of instability and crisis. The staff team's ability to keep all young people safe has been hindered by poor matching of young people's needs. The manager has acknowledged that the home has experienced considerable upheaval following recent admissions of young people and has taken some steps to stabilise the home. However, change and effective resolutions have been slow. This cannot fail to impact negatively on the welfare and safety of young people.

In response to recent challenges, the manager has implemented increased staffing in an attempt to support young people's individual needs and behaviour and to safeguard all within the home. There has been a period of staff turnover, and a number of new staff have joined the home. However, the staff team is suitably diverse and there is a good mix of experience. A large proportion of the staff team have acquired the required Level 3 childcare qualification, with sufficient arrangements in place for the remaining staff to achieve this within the required timeframe.

Staff routinely undertake mandatory training, including safeguarding, child sexual exploitation and first aid. The manager also ensures that further opportunities for additional training are identified in response to young people's needs.

The staff team receives regular supervision, and staff members' performance is annually appraised. Supervision records reflect a good level of discussion, and staff spoken with during the inspection confirmed that they feel supported by the manager and colleagues.

The manager has taken suitable action to address the requirement raised under regulation 45. The manager has updated the six-monthly template that reviews the quality of care and has submitted the report to Ofsted within the required timescales. However, the manager recognises the need to further develop the home's quality assurance systems. In particular, this is in relation to the quality and adequacy of record keeping.

External monitoring remains consistent. These visits enable the manager to understand the home's strengths and weaknesses. Where possible, the visitor consults with young people, social workers and relatives during the visits to ascertain their views. This ensures that the independent visitor can provide an opinion as to whether young people are being cared for in a safe manner.

Procedures to ensure that relevant professionals and agencies are informed in the event of serious incident are not robust. For example, the manager has failed to notify HMCI of information pertaining to allegations of abuse. This hinders the regulator from effectively carrying out its safeguarding responsibilities to ensure that young people are protected from harm.

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 difference 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 who 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: SC400355

Provision sub-type: Children's home

Registered provider: Social Care Services (Clayton) Limited

Registered provider address: 31 Shaw Road, Stockport, Cheshire SK4 4AG

Responsible individual: Stephen Davitt

Registered manager: Post vacant

Inspector(s)

Ceri Evans, social care regulatory inspector

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