Inspection report for children's home

Unique reference number	SC361167
Inspection date	11/09/2013
Inspector	Joanne Vyas
Type of inspection	Full
Provision subtype	Residential special school (>295 days/year)

Date of last inspection	25/07/2013

Service information

Brief description of the service

This setting is an independent residential special school registered as a children's home. The school offers specialised education and care for up to 20 children on a full-time basis, and two children under short-break arrangements. The school cares for children who are diagnosed with an autistic spectrum disorder and associated complex needs.

The inspection judgements and what they mean

Outstanding: a service of exceptional quality that significantly exceeds minimum requirements
Good: a service of high quality that exceeds minimum requirements
Adequate: a service that only meets minimum requirements
Inadequate: a service that does not meet minimum requirements

Overall effectiveness

The overall effectiveness is judged to be **inadequate**.

Most young people make good progress at this home especially with regards to their health, behaviour and levels of communication. Staff know the young people well and young people enjoy the company of staff. Young people like living in this home. Staff receive a good induction and training package to enable them to better understand and care for the young people living in this home. Young people have access to an advocacy service that is now able to understand the ways in which they communicate.

After the last inspection, Ofsted took compliance action to drive forward improvement. The management team have made some improvements since then. In particular, attention to young people's health and their safety in the home is much improved, and completion of young people's records is also better. However, changes are not yet embedded in effective systems that can demonstrate improvement. There continues to be an inconsistent application of safeguarding procedures, particularly in relation to understanding of whistleblowing procedures. Furthermore, despite improved systems, there is a lack of robust investigation into allegations concerning staff practice. Care planning documents and records are cumbersome, making review of records of care delivery time consuming and difficult to monitor. Young people's documents do not coherently capture their holistic needs or provide a clear overview of their lives in the home. Staffing levels do not consistently meet the needs of the young people and care planning documents do not detail all the strategies used by staff to reduce challenging behaviour. The

registered person and the management team do not fully understand the concerns and they have not acted effectively to review the quality of care.

Areas for 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 person(s) must comply with the given timescales.

Reg.	Requirement	Due date
4 (2001)	ensure the written statement of purpose consists of a statement as to the matters listed in Schedule 1. This is specifically with reference to matters concerning staffing of the children's home (Regulation 4 (1))	18/10/2013
16 (2001)	ensure 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 and give consideration to the measures which may be necessary to protect children in the children's home following an allegation of abuse or neglect (Regulation 16(2)(b)(e))	18/10/2013
27 (2001)	ensure that all persons employed by him receive appropriate training, supervision and appraisal (Regulation 27 (4)(a))	18/10/2013
34 (2001)	establish and maintain a system for monitoring the matters set out in Schedule 6 at appropriate intervals and improving the quality of care provided in the children's home (Regulation 34 (1))	18/10/2013
11 (2001)	ensure that the children's home is conducted so as to promote and make proper provision for the welfare of children accommodated there (Regulation 11 (1)(a))	18/10/2013
25 (2001)	ensure that there is at all times, having regard to the need to safeguard and promote the health and welfare of the children accommodated in the home, a sufficient number of suitably qualified, competent and experienced persons working at the children's home (Regulation 25 (1))	18/10/2013
38 (2001)	give notice in writing to the HMCI as soon as it is practicable to do so if any of the following events take place or are proposed to take place: a person other than the registered person carries on or manages the children's home; a person ceases to carry on or manage the home. (Regulation 38 (a)(b))	18/10/2013

Recommendations

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

- ensure arrangements are in place to support the communication needs of children with disabilities, so that they are able to make their views known about the running of the home. This specifically refers to ensuring staff use the available resources when communicating with children (Volume 5, statutory guidance, paragraph 2.25)
- ensure all children and staff are given an opportunity to discuss incidents of restraint they have been involved in, witnessed or been affected by, with a relevant adult. (NMS 3.17)
- ensure an evaluation of the quality of practice is consistently carried out and recorded during visits conducted on behalf of the registered person to ensure the quality of care within the children's home (Volume 5, statutory guidance, paragraph 3.12 and 3.13)
- ensure all children communicate their views on all aspects of their care and support (NMS 1.3)
- ensure the home is clean, well maintained and decorated. (NMS 10.3)

Outcomes for children and young people

Outcomes for young people are **adequate**.

Young people like living at this home. A young person said, 'Love it here. Never want to leave.' Another confirmed that they like everything about it. Most young people make good progress, particularly about their behaviour, health and ability to communicate more effectively. However, young people become confused and anxious when there are not enough staff on duty to provide them with consistent care.

Young people's views are not always taken account of. This may mean they become frustrated and their behaviour may deteriorate as a result. A parent described her son's distress at moving from one residential house to another. She said this upset him and he drew many pictures of the old house, demonstrating his wish to return there. The parent felt this was a very unsettled time for her son and that his views had been ignored. Furthermore, young people do not regularly contribute to their records. The management team say they are planning to address these issues but new systems are not yet fully implemented or embedded into practice. However, young people do have access to an advocacy service, which now have the information required to enable them to communicate more effectively with young people.

Young people enjoy a wide range of activities including: walks in the local area; games; laser quest; the cinema and attending local clubs. For example, some young people attend local youth clubs which enables them to integrate with the local community and build friendships with young people outside the home.

Young people benefit from good health. They regularly attend routine health checks and have access to a range of healthcare professionals such as nurses, an education psychologist, speech and language therapist and physiotherapist who are based at the home. Furthermore, they have regular support for, and review of their mental health needs from a visiting consultant psychiatrist.

Young people eat healthy foods and expand their dietary repertoire. For example, a young person who would previously only eat a limited diet and consequently was underweight now eats a range of food, including fruit. This young person has put on healthy weight and now has more energy.

Young people benefit from having their school on the same site as where they live. This ensures their regular attendance at school and consequently their educational achievement.

Quality of care

The quality of the care is **inadequate**.

Young people have positive relationships with most of the staff who work with them. They enjoy their company and say they would talk to staff if they have a problem. However, staff do not always use the available communication resources, such as symbols, to communicate with young people who cannot verbalise their views and feelings. Furthermore, young people's views are not consistently reflected in their records. This means that not all young people's views may be taken into consideration when making decisions about their care and the day-to-day running of the home. Additionally, parents do not always feel that staff communicate and work with them about their child's care.

There is an immense amount of care planning documentation and within it, staff have access to some good information about young people which helps to inform their practice.

However, the quantity of documentation and different recording systems do not coherently capture young people's holistic needs or provide a clear overview of their lives in the home. Staff find the documentation cumbersome and some have developed their own ways of working with young people which are not reflected in the care planning documents. This means that strategies for managing complex behaviours for some young people may not be applied consistently across all staff teams. This may lead to confusion, frustration and further challenges from young people as they are not always cared for as set out in their care plan.

Staff now complete the vast number of records well, but consequently spend time doing this rather than talking to young people. It is questionable whether some records are required for some young people due to their age and understanding. For example, there is a standard record of intimate personal matters for each young person, regardless of individual need. This may be an invasion of privacy for young people who are soon to be leaving the home and are moving towards independence.

There are insufficient staff to allow for proper one-to-one time with young people, as staff are called away to assist with other young people and get meals ready. This means that there is a lack of continuity for young people, which can cause confusion, frustration and lead to further unnecessary challenges because of changes in familiar staff.

There is now an improved handover of information between day and night staff and education and day staff. Senior staff provide a handover of information to all staff working the next shift. However, the handover provided by day staff to night staff is not comprehensive as it does not always include accurate information about each young person's day and is repeated once staff go into the houses. For example, young people's mood is not always accurately reported in the handover session. This means important information may not be passed on and more time is spent away from the young people.

Staff promote the health of young people. Young people have access to a range of healthcare professionals who include a nursing team. The nursing team work shifts with staff to ensure they are available for young people. Young people attend routine health appointments. Staff meticulously plan these appointments for young people to ensure each young person receives an optimum service. For example, social stories are used to help prepare young people for their health appointments and, for opticians appointments, staff model glasses made out of felt to encourage young people to wear them. There are good systems in place to effectively manage the safe handling of medication that include regular rigorous audits and good staff training.

Young people benefit from individual en suite bedrooms which are adapted to meet their individual needs in most cases. Flooring in all the bedrooms is a hard-wearing vinyl-type material. Although this is practical for some young people, rooms appear bare and some young people said they would like their rooms carpeted. The maintenance of the home has significantly improved and plans are in place to ensure further improvements take place. However, some areas such as flooring and décor remain shabby and grimy.

Safeguarding children and young people

The service is **inadequate** at keeping children and young people safe and feeling safe.

Young people say they feel safe. All staff have been involved in further training for safeguarding children and appear knowledgeable. However, leaders and managers continue to be inconsistent in their application of safeguarding procedures, particularly in relation to staff understanding of whistleblowing procedures. Furthermore, despite improved systems, there remains a lack of robust investigation into allegations concerning staff practice towards young people. This means that staff who may not be suitable to work with young people, continue to do so, unchallenged.

While there are behaviour support plans, some staff have devised their own strategies which are not recorded within the behaviour support plans and therefore may not be consistently used across all staff teams. Some of these ad-hoc strategies involve punitive or restrictive measures, such as removal of electronic equipment or locking doors to prevent young people's free movement between areas. While there is anecdotal evidence that these may have had some success in de-escalating challenging behaviour, they have not been documented or agreed by placing authorities. Furthermore, staff appear de-sensitised to some behaviours young people exhibit, such as spitting, because these are not always reported. Consequently, staff may not apply behaviour management strategies consistently, which may mean young people become frustrated and confused, leading to further challenges.

Staff are trained to de-escalate, distract and, as a last resort, provide physical intervention. Staff carry out physical intervention in an appropriate manner and complete accurate and clear records. However, records of physical intervention do not include the views of the young people involved. Furthermore, there is a lack of management oversight on records of incidents; for example, a significant incident lasting some hours had not been read and signed by the manager.

There is now improved attention to health and safety within the home. Risk assessments ensure hazards within the environment are eliminated or reduced. In theory, the health and safety committee reviews records such as accidents in order to strategize to reduce the number of accidents. For example at the last meeting the number of staff injuries were discussed and ways of reducing this. However, they did not review a large number of accident records for young people after the summer holidays, to consider any remedial action.

Leadership and management

The leadership and management of the children's home are **inadequate**.

The quality of care has not improved because there are inconsistent managerial arrangements. The service has not had strong or permanent leadership. The children's home has not had a consistent, permanent manager since the 25 July 2013 and lines of accountability have not been clear, to children, staff, parents, and to Ofsted.

The Statement of Purpose does not reflect all the information required by regulation such as staffing ratios, qualifications and experience. This means placing authorities do not have a clear view of staffing within the home and whether or not staff have the skills necessary to ensure the health, well-being and safety of young people they may wish to place. The young person's guide, however, is individual to their specific communication needs. This means it is more meaningful to each young person and, therefore, young people have an understanding of what they can expect while living at the home.

A development plan has been implemented but lacks sufficient detail to ensure

managers can effectively drive forward improvement in this home. Some progress has been made towards meeting the compliance notices, requirements and recommendations set at the previous inspection in July 2013. For example, staff have received further training, particularly with regards to safeguarding. Records for young people are fully completed providing an improved picture of the child's life. A new system has been put in place to ensure staff know who to notify in the event of an incident occurring. This is yet to be tested. The home is maintained to a better standard and avoidable hazards are better managed. Furthermore, there is proper attention to fire safety now. Handover of information from one team to another is also improved. However, there is little evidence that improvements have been embedded into practice yet.

There is a lack of a wholly effective developmental focus and monitoring systems continue to be inadequate. Furthermore, there is an inadequacy of staff due to high levels of sickness and the competence of some staff, including those at team leader level, has not been guaranteed. There is little governance with regards to safeguarding children and issues around health and safety.

The newly appointed manager has not been apprised of historical and more recent safeguarding incidents within this home. This means her ability to inform the development of the home is diminished.

Managers do not ensure effective management oversight to support the development of staff in their roles. The system in place for review of performance and development of staff has not been effective in identifying, or improving poor practice. Supervision of staff has not been robust, sufficiently frequent, nor has it addressed incidents of concern. While residential leaders have recently had training, this is not yet embedded in effective supervision. Records do not evidence supervision at the required frequency, nor are sessions reflective or sufficiently challenging. They do not serve as a record of professional accountability for decisions.

There is a lack of competence in team leaders in their ability to lead appropriately and develop staff. For example, a number of team leaders have been implicated in allegations of poor practice or abuse. Furthermore, where other staff have passed on their concerns to their supervisor, these have not been acted on, nor have safeguarding implications been referred. This means that staff who may not be suitable to work with young people, continue to do so, unchallenged.

While the registered person has made some efforts to improve the sufficiency and competency of staff, there continue to be shortfalls. Rationale for staff deployment is unclear: the staffing of shifts seems to bear no correlation to the number of young people in residence. High staff sickness means that some staff work continuously with only a few days off. A complete picture of staff coverage is not clear in the two separate rotas that show day and night staffing.

There are ineffective management monitoring systems that do not identify weaknesses, address issues or track patterns and trends. The new management

monitoring format has not yet been implemented but appears process driven and not focused sufficiently on improving the quality of care. There is no specific evaluation of how effectively young people are safeguarded or whether staff understand and are following child protection processes. Previous management monitoring systems result in a collation of data but lack evaluation, analysis or a link to the service development plan.

A senior member of the organisation visits the home to review the conduct of the home on a monthly basis. The subsequent report provides good challenge to the home particularly with regards to record keeping. However, the report focuses on processes rather than the quality of care.

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 to assess the effectiveness of the service and to consider how well it complies with the relevant regulations and meets the national minimum standards.

The report details the main strengths, any areas for improvement, including any breaches of regulation, and any failure to meet national minimum standards. The judgements included in the report are made against the *Inspections of children's homes – framework for inspection* and the evaluation schedule for the inspection of children's homes.