1234163

Registered provider: Jamores Limited

Full inspection

Inspected under the social care common inspection framework

Information about this children's home

The home is privately owned. It is registered to provide care and accommodation for up to four young people who have emotional and/or behavioural difficulties. The home is also registered to provide care and accommodation to young people with learning difficulties.

Inspection dates: 9 June 2017

Overall experiences and progress of children and young people, taking into account	**inadequate**
How well children and young people are helped and protected	inadequate
The effectiveness of leaders and managers	inadequate

There are serious and/or widespread failures that mean children and young people are not protected or their welfare is not promoted or safeguarded and/or the care and experiences of children and young people are poor and they are not making progress.

Date of last inspection: 6 March 2017

Overall judgement at last inspection: inadequate

Enforcement action since last inspection

Four compliance notices were issued on 21 March 2017.

Key findings from this inspection

This children's home is inadequate because

- The home has failed to protect young people who go missing. Young people are not reported as missing according to their individual 'missing' plans, and the reporting of some 'missing' incidents to the police is delayed. Record keeping of 'missing' behaviour is inaccurate and is ineffectively monitored.
- The reporting of allegations against staff is deficient. There are delays in reporting to the local authority designated officer (LADO), and one allegation against an agency member of staff remains unreported. Insufficient record keeping means that the home lacks full written records of allegations and the action taken in response.
- Complaints are poorly recorded. The home lacks a clear record of the investigation of some complaints.
- New staff lack sufficient induction into their role. The new deputy manager's induction did not take place to timescale and lacked sufficient detail. As a result, he lacks essential information to provide care safely and according to young people's individual plans.
- Health and safety monitoring in the home is insufficient, and it fails to explore all health and safety risks. This does not ensure that the home provides a safe environment for young people.
- Staff in the home do not consistently work according to young people's behaviour management plans or the rules of the home. This fails to provide safe and consistent care to young people.

The children's home's strengths

- The home has taken disciplinary action against staff with poor practice. These staff are no longer in the employment of the home.
- Managers are taking action to recruit the required new staff.

Recent inspection history

Inspection date	Inspection type	Inspection judgement
06/03/2017	Full	Inadequate

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 within the given timescales.

Requirement	Due date
6: The quality and purpose of care standard In order to meet the quality and purpose of care standard, the registered person must: 6(2)(b)(iv) provide personalised care that meets each child's needs, as recorded in the child's relevant plans, taking account of their background. This is a repeat requirement.	18/08/2017
12: The protection of children standard In order to meet the protection of children standard, the registered person must: 12(2)(a)(iv)(v) ensure that staff understand the roles and responsibilities in relation to protecting children that are assigned to them by the registered person; and take effective action whenever there is a serious concern about a child's welfare.	18/08/2017
12: The protection of children standard In order to meet the protection of children standard, the registered person must: 12(2)(e) ensure that the effectiveness of the home's child protection policies is monitored regularly. In particular that the policy provides clear timescales for the reporting of concerns and guides staff to keep records of the concern and action taken in response. This is a repeat requirement.	18/08/2017
13: The leadership and management standard In order to meet the leadership and management standard, the registered person must: 13(2)(c) ensure that staff have the experience, qualifications and skills to meet the needs of each child.	18/08/2017

This is a repeat requirement.	
13: The leadership and management standard In order to meet the leadership and management standard, the registered person must: 13(2)(f) understand the impact the quality of care provided in the home is having on the progress and experiences of each child and use this understanding to inform the development of the quality of care provided in the home.	18/08/2017
13: The leadership and management standard In order to meet the leadership and management standard, the registered person must: 13(2)(h) ensure the registered person uses monitoring and review systems to make continuous improvements in the quality of care in the home. This is a repeat requirement.	18/08/2017
Ensure that a copy of the statement of purpose is published on the home's website unless the registered person considers that such publication would prejudice the welfare of children in the home. (Regulation 16(4))	18/08/2017
Ensure that each employee completes an appropriate induction. (Regulation 33(1)(a))	18/08/2017
Ensure the quality of care review establishes and maintains a system for monitoring, reviewing and evaluating the feedback and opinions of children about the home, its facilities and the quality of care they receive in it; and any actions that the registered person considers necessary to improve or maintain the quality of care for children. The system referred to must provide for ascertaining and considering the opinions of children, their parents, placing authorities and staff. (Regulation 45(2)(b)(c)(5))	18/08/2017

Recommendations

- Ensure systems are in place so that all staff receive supervision of their practice from an appropriately qualified and experienced professional, which allows them to reflect on their practice and the needs of child assigned to their care. ('Guide to the children's homes regulations including the quality standards', page 61, paragraph 13.2)
- Ensure a record of supervision is kept for all staff. It is good practice for a note of the content and/or outcomes of supervision sessions to be kept and to ensure that both the person giving the supervision and staff member have a copy of the record. ('Guide to the children's homes regulations including the quality standards', page 61, paragraphs 13.3 and 13.4)
- Ensure that, after an episode of going missing, when a child is found, they are offered an independent return interview. This should be an in-depth interview and is normally best carried out by an independent person (i.e. someone not involved in caring for the child) who is trained to carry out these interviews and is able to follow-up any actions that emerge. ('Statutory guidance on children who run away or go missing from home or care, January 2014', page 14, paragraph 32)

Inspection judgements

Overall experiences and progress of children and young people: inadequate

There were no young people placed in the home on the date of inspection. Two young people have left the home since the last inspection.

The identified shortfalls in the home's safeguarding practice result in poor and unsafe care provision to young people. Managers and staff have failed to safeguard young people effectively when they have gone missing. Leaders and managers have failed to effectively deal with the concerns that have been raised about staff working at the home. Poor safeguarding practice has not promoted the safety and welfare of young people.

This significant ongoing failure to ensure that staff consistently apply the rules of the home places children at risk. The home has still regularly relied upon agency staff to provide care. Agency staff have solely staffed some recent night shifts. Inspectors' examination of records indicate that agency staff have not consistently upheld the boundaries expected. For example, night-time agency staff permitted young people to enter one another's bedrooms. The acting manager confirmed that this is not permitted, but informed inspectors that staff are not always able to uphold boundaries effectively.

Managers have failed to ensure that staff understand young people's needs and have a thorough working knowledge of their care plans. The new deputy manager was unaware of one young person's 'missing from care protocol'. This resulted in a delay in her being reported missing to the police. A lack of management and oversight of staff knowledge

and practice fails to make sure that staff have the induction, skills and understanding that they need to provide safe and effective care.

How well children and young people are helped and protected: inadequate

There are significant failings in the safeguarding practice of managers and staff. This disregard of good safeguarding practice fails to promote the safety and welfare of young people.

Staff have not safeguarded young people who are missing. There are delays in reporting young people missing to the police and practice is not always in line with young people's individual 'missing' profiles. For example, there were delays in reporting a young person who had been missing for a prolonged period. The deputy manager responsible informed inspectors that he was unaware of the missing person's protocol for this young person. In addition, he stated that problems with his mobile phone resulted in him having to return to the home from London before he was able to make the required 'missing' report to police. The manager had failed to monitor this 'missing' incident. There was no evidence of reflection or learning from the shortfalls identified.

The recording of 'missing' incidents is inaccurate and does not always present a clear picture of how, when and why young people went missing. The manager of the home had delegated the monitoring of 'missing' incidents to a senior member of staff, but had failed to ensure his competence and to oversee his practice. As a result, the manager was unaware of the significant shortfalls in practice identified by inspectors.

The home fails to actively pursue independent return home interviews for young people who go missing. This does not ensure a full exploration of young people's reasons for going missing and fails to support action to reduce the risk of future 'missing' incidents.

Managers fail to effectively deal with allegations made against staff by young people. This leaves young people at risk. One recent allegation made by a young person against an agency member of staff was reported to the LADO three days after the allegation was made. The manager informed inspectors of the reason for the delay in safeguarding reporting and said, 'Due to the high level of challenging behaviour in the home, reporting to the LADO was not a priority.' The manager disregarded a further allegation made by one member of staff against another as she did not believe the allegation. This allegation remains unreported by the home. The manager failed to follow the home's safeguarding procedure to report all allegations to the LADO. She does not demonstrate an adherence to good safeguarding practice.

The home has failed to maintain full, written records of the investigation of allegations. For example, the manager was unable to provide inspectors with records of her discussion with young people in the investigation of one allegation and was unsure if she had made a written record of that discussion.

The LADO stated concerns about the home's delay in providing requested safeguarding documentation in respect of allegations. The LADO was also concerned that the home

had failed to report an allegation against an agency member of staff. This was brought to the LADO's attention by the inspector.

The home's child protection policy does not provide clear guidance to staff and fails to provide clear timescales for reporting concerns.

The effectiveness of leaders and managers: inadequate

There is no registered manager. The organisation's operations manager is currently managing the home.

A number of staff have left the home following disciplinary procedures. The provider is in the process of recruiting a new staff team. A recently appointed deputy manager provides the sole staffing for the home at the current time.

The manager has failed to provide new staff with an effective induction to equip them to undertake their role proficiently. The induction of the new deputy manager was neither individualised nor undertaken within the stated timescale. The manager had failed to effectively evaluate and monitor the deputy manager's induction learning to ensure that he had the knowledge and skills that he needed to provide safe and effective care to young people. In addition, there was no record of supervision or written supervision records on the deputy manager's personnel file. As a result, the deputy manager failed to demonstrate a thorough understanding of the processes and procedures at the home. Inspectors asked how the home records sanctions, and the deputy manager was unaware of the sanctions log. During discussions with inspectors about young people who go missing, the deputy manager stated that he was unaware of young people's individual missing protocols.

The home fails to respond to complaints effectively. The system for recording complaints and their investigation lacks clarity, and does not provide a transparent chronology of the process of investigation and decision making. Inspectors found it difficult to follow up the investigation and outcome of one recent complaint, as the manager was unable to supply inspectors with records of interviews undertaken to investigate the complaint.

Health and safety monitoring at the home is superficial. It lacks detail and does not identify all potential hazards. For example, the deputy manager, responsible for completing health and safety assessments in the home, was unable to tell inspectors why some upper windows had restrictions on their opening while others did not. He had failed to identify and assess this risk. Furthermore, health and safety assessments have no clear action plan or timescale to rectify the safety and maintenance issues identified.

The manager has failed to monitor the functioning of the home effectively. This ineffective monitoring means that poor standards of care remain unaddressed and unrectified. She informed inspectors that she had delegated the monitoring of the recording and the reporting of missing young people to a senior member of staff. However, she failed to monitor his competence in undertaking these tasks. The manager failed to oversee staff practice in response to missing young people, and missed

opportunities to address poor practice by staff, and to improve and to rectify the home's poor response to missing young people.

The manager consistently failed to respond to recommendations made by the home's independent visitor. For example, the report of the independent visit on 17 April 2017 highlights the fact that a sanction that had been imposed on one of the young people was not monitored and evaluated for effectiveness. Inspectors' check of the home's sanction log indicated that this had still not been reviewed by the date of inspection. Managers had failed to complete the 'manager's response' sections of the independent visit reports. This does not demonstrate a proactive engagement with the recommendations of the home's independent visitor.

The manager's quality of care monitoring is insufficient and does not meet regulatory requirements. The serious shortfalls identified in monitoring are an ongoing concern regarding the home. The lack of committed and effective monitoring means that leaders and managers lack the information that they need to raise standards at the home, and this means that poor practice persists.

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 whom 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: 1234163

Provision sub-type: Children's home

Registered provider: Jamores Limited

Registered provider address: 2 Thames Innovation Centre, Studio 52, Veridion Way, Erith DA18 4AL

Responsible individual: James Adebayo

Registered manager: Post vacant

Inspectors

Lucy Chapman, social care inspector

Sophie Wood, regulatory inspection manager

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for looked after children, safeguarding and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.

This publication is available at http://www.gov.uk/government/organisations/ofsted.

Interested in our work? You can subscribe to our monthly newsletter for more information and updates: http://eepurl.com/iTrDn.

Piccadilly Gate
Store Street
Manchester
M1 2WD

T: 0300 123 1231
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: http://www.gov.uk/ofsted