1238043

Registered provider: Nurture Childcare Services Limited

Full inspection

Inspected under the social care common inspection framework

Information about this children's home

The home is registered to provide care and accommodation for up to five children. It is owned and operated by a private company. It is registered to care for children with emotional and/or behavioural difficulties.

Inspection dates: 22 June 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: Not applicable

Overall judgement at last inspection: Not applicable

Enforcement action since last inspection:

None

Key findings from this inspection

This children's home requires improvement to be good because:

- Young people who have lived at the home since it began operating have experienced variable outcomes. One young person's placement was terminated because the home could not meet her needs effectively.
- The quality of direct work carried out with young people is inconsistent. Direct work does not always address areas in accordance with young people's care plans.
- Risks to young people's safety and well-being have not always been clearly identified. Risk management guidance is not sufficiently clear to ensure that staff have the necessary understanding to keep young people safe.
- Practice in relation to safeguarding young people at risk of being missing from home or from exploitation is inconsistent. This means that young people have not always been protected from harm.
- There are inconsistencies in respect of behaviour management in the home and examples of staff failing to follow young people's individualised behaviour management plans. Arrangements to provide staff with training in recognised behaviour management techniques have not always been effective.
- Staff are not fully aware of some important policies such as those relating to smoking, internet use and mobile phone use. Without this guidance, staff will lack confidence in their practice and their approaches will be inconsistent.
- Shortfalls in record keeping mean that important information could be lost. In addition, the shortfalls impede the manager's ability to effectively monitor safety and quality.
- Quality assurance systems are not being used effectively to identify and address practice issues, patterns and trends. This means that opportunities to make improvements could be missed.
- The manager has not always ensured that relevant authorities, including Ofsted, are notified about significant events within the home.

The children's home's strengths:

- The young person who currently lives in the home has settled well and is making good progress in many areas.
- The current young person enjoys positive relationships with staff and is growing in confidence.
- The current young person's emotional well-being has demonstrably improved since he was admitted to the home.
- Managers and staff understand the importance of education and work closely with the young person's education provider to ensure that he continues to receive appropriate support.
- The turnover of staff, recently noted, has now settled. The manager has taken steps to ensure that only a small bank of agency staff is used. This means improved consistency for the young person.
- The current staff team members speak positively about the new manager and describe a good level of support.
- The manager of the home is able to demonstrate that she has identified areas for improvement and that she is taking steps to address them.

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
12: The protection of children standard 12.—(1) The protection of children standard is that children are protected from harm and enabled to keep themselves safe. (2) In particular, the standard in paragraph (1) requires the registered person to ensure— (a) that staff— (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; (vii) are familiar with, and act in accordance with, the home’s child protection policies; 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.	21/07/2017
13: The leadership and management standard 13.—(1) The leadership and management standard is that the registered person enables, inspires and leads a culture in relation to the children’s home that— (a) helps children aspire to fulfil their potential; and	21/07/2017

(b) promotes their welfare. (2) In particular, the standard in paragraph (1) requires the registered person to— (a) lead and manage the home in a way that is consistent with the approach and ethos, and delivers the outcomes, set out in the home's statement of purpose; (b) ensure that staff work as a team where appropriate; (c) ensure that staff have the experience, qualifications and skills to meet the needs of each child; (d) ensure that the home has sufficient staff to provide care for each child; (e) ensure that the home's workforce provides continuity of care to each child; (f) understand the impact that 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; (g) demonstrate that practice in the home is informed and improved by taking into account and acting on— (i) research and developments in relation to the ways in which the needs of children are best met; (ii) feedback on the experiences of children, including complaints received; and (h) use monitoring and review systems to make continuous improvements in the quality of care provided in the home.	
35: Behaviour management policies and records 35.—(1) The registered person must prepare and implement a policy ("the behaviour management policy") which sets out— (a) how appropriate behaviour is to be promoted in the children's home; and (b) the measures of control, discipline and restraint which may be used in relation to children in the home. (2) The registered person must keep the behaviour management policy under review and, where appropriate, revise it. (3) The registered person must ensure that— (a) within 24 hours of the use of a measure of control, discipline or restraint in relation to a child in the home, a record is made which includes—	21/07/2017

(i) the name of the child; (ii) details of the child's behaviour leading to the use of the measure; (iii) the date, time and location of the use of the measure; (iv) a description of the measure and its duration; (v) details of any methods used or steps taken to avoid the need to use the measure; (vi) the name of the person who used the measure ("the user"), and of any other person present when the measure was used; (vii) the effectiveness and any consequences of the use of the measure; and (viii) a description of any injury to the child or any other person, and any medical treatment administered, as a result of the measure; (b) within 48 hours of the use of the measure, the registered person, or a person who is authorised by the registered person to do so ("the authorised person")— (i) has spoken to the user about the measure; (ii) has signed the record to confirm it is accurate; and (c) within 5 days of the use of the measure, the registered person or the authorised person adds to the record confirmation that they have spoken to the child about the measure.	
36: Children's case records 36.—(1) The registered person must maintain records ("case records") for each child which— (a) include the information and documents listed in Schedule 3 in relation to each child; (b) are kept up to date; and (c) are signed and dated by the author of each entry.	21/07/2017
40: Notification of a serious event 40.—(4) The registered person must notify HMCI and each other relevant person without delay 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;	21/07/2017

(d) a child protection enquiry involving a child— (i) is instigated; (ii) 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.	

Recommendations

- Please see Regulation 23. Care must be taken to ensure prescribed medicines are only administered to the individual for whom they are prescribed. Medicines must be administered in line with a medically approved protocol. Records must be kept of the administration of all medication, which includes occasions when prescribed medication is refused. Regulation 23 requires the registered person to ensure that they make suitable arrangements to manage, administer and dispose of any medication. These are fundamentally the same sorts of arrangements as a good parent would make but are subject to additional safeguards. Where the home has questions or concerns about a child's medication, they should approach an expert such as a General Medical Practitioner, community pharmacist or designated nurse for looked after children. ('Guide to the children's homes regulations including the quality standards', page 35, paragraph 7.5)

- The registered person should only accept placements for children where they are satisfied that the home can respond effectively to the child's assessed needs as recorded in the child's relevant plans and where they have fully considered the impact that the placement will have on the existing group of children. The statement of purpose is an important document in the process of care planning as it sets out the needs of children the home is set up and equipped to care for. ('Guide to the children's homes regulations including the quality standards', page 56, paragraph 11.4)

- In addition to the requirements of this standard, the registered person has specific responsibilities under Regulation 34 to prepare and implement policies setting out: arrangements for the safeguarding of children from abuse or neglect; clear procedures for referring child protection concerns to the placing authority or local authority where the home is situated if appropriate; and specific procedures to prevent children going missing and take action if they do. The policy on protection of children from abuse and neglect should include arrangements in relation to dealing with allegations involving staff in the home, e-safety and to counter risks of self-harm and suicide. All policies should be reviewed regularly and revised where appropriate. ('Guide to the children's homes regulations including the quality standards', page 44, paragraph 9.19)

- Where a child runs away persistently or engages in other risky behaviours, such

as frequently being absent from the home to meet with inappropriate adults, the registered person, in consultation with the child's placing authority, should convene a risk management meeting to develop a strategy for managing risks to the young person. The strategy should be agreed with the child's placing authority, the local authority where the home is located and the local police. ('Guide to the children's homes regulations including the quality standards', page 46, paragraph 9.32)

Inspection judgements

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

The outcomes for young people who have lived in the home since it began operating in January 2017 have been variable. One young person's placement ended abruptly after a number of serious incidents. The young person's care records demonstrate that her care, particularly in relation to areas of risk, was not consistently well managed. The young person presented with some complex needs that the staff team was not fully confident in meeting. This led to the young person's placement breaking down and an urgent move to another service, which did not support consistency or security for the young person.

The young person who currently lives in the home is making some very positive progress. Feedback from this young person's parent is extremely complimentary. The parent commented that to date, this has been the most successful placement that the young person has experienced and said, 'I think that this is because they have really taken time to understand him and what he needs.'

The young person reported having very positive relationships with staff and this was supported by observations throughout the inspection. Interaction between the young person and staff was natural, warm and mutually respectful. On the day of the inspection, the young person had organised a party, as several staff members had birthdays due. This was attended by the majority of the staff team. The young person hosted the party throughout, engaging with his guests in a confident and happy manner, performing magic tricks and singing.

Since the young person moved into the home, he has started to present as more socially confident. There has been a significant improvement in his ability to settle and sleep at night. Incidents of self-harm and anxieties in relation to perceived illnesses have dramatically decreased. This demonstrates a significant improvement in the young person's emotional well-being.

Young people's views are taken into account and the manager responds appropriately to any concerns that they raise. Records demonstrate that the manager acts swiftly to ensure that concerns raised by young people are taken seriously and acted upon.

The young person is engaging in education for the first time in several years. He has a

full-time placement and is currently being supported by staff from the home while attending school. In terms of formal planning, the arrangements around this are unclear and not formally agreed through his education, health and care plan. This should be addressed as a matter of priority, to help ensure that the young person continues to receive the necessary individualised support required to benefit from his education.

Young people's routine healthcare needs are addressed and they are supported to access services such as dentists and opticians for regular check-ups. However, arrangements to support young people in areas such as smoking or substance misuse are not clear. In a number of examples, young people's care plans note that support in these areas will be provided through direct work, but records of direct work do not demonstrate that this is achieved on a consistent basis. Some staff were unclear about the home's policy on smoking and the action that they should take when young people attempt to obtain or smoke cigarettes. Guidance in this area should be improved and provided to all staff.

Young people's medication is appropriately stored and satisfactory administration records are completed. However, medication management is not sufficiently monitored within the home. This means that errors, such as failure to date medication with a limited shelf life on opening and unclear details about the duration of a topical treatment for one young person, had not been identified. Medication audit systems need to be improved to protect young people from unsafe practice.

The quality of direct work carried out with young people is variable. Some examples of good-quality key worker sessions are evident. However, some relevant areas are not covered on a consistent basis. In some examples, outcomes of sessions, action taken and next steps are not clear. This could lead to important opportunities to support young people in areas that matter to them being missed, and as such, a recommendation is made to review this area.

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

Arrangements to assess and manage risks to young people's safety and well-being require improvement. Individualised risk assessments are in place, which cover a variety of relevant issues. However, they are variable in quality and do not always provide clear information. In some examples, there is duplicated risk assessment information, which conflicts. For example, one young person had a risk assessment in place which stated that they had no known history of alcohol use. However, another risk assessment for the same young person directly contradicted this information.

Agreed measures to address known risks have not always been carefully considered. For example, known significant risks to a young person who previously lived in the home and was known to be at extremely high risk of exploitation, were not adequate. Risks were not mitigated because the actions in place to protect her were not sufficiently robust. This means that the young person was not adequately safeguarded while living at the home. A requirement has been made in relation to this matter.

There have been no incidents of the young person who currently lives in the home being missing. There is a clear protocol in place should this situation occur in the future. Records demonstrate that in the case of the previous young person, staff have not always acted in accordance with the home's policy. For example, the young person's individual risk assessment stated that she should be reported missing to police after a time period of 30 minutes, but the home's policy states that this report should be made immediately. In addition, records viewed demonstrate that on some occasions, staff missed opportunities to prevent the young person from going missing by failing to intervene quickly enough.

Some staff spoken with were unclear on the home's policy in relation to mobile phone and internet use. The manager was unable to confirm that up-to-date policies, which address these areas, are in place. Guidance for staff in these areas should be reviewed and provided at the earliest opportunity, so that staff have the guidance that they need to keep young people safe.

The manager and staff demonstrate awareness of safeguarding procedures and the action that they should take to report any safeguarding concerns to the relevant agencies. This helps to ensure that any allegations are promptly investigated, and as such, helps to protect young people from harm.

The support provided to young people in relation to their behaviours has not always been consistently well planned. There were a number of serious incidents involving the young person who previously lived in the home. Staff had felt it necessary to call the local police to the home on a number of occasions as they had felt unable to manage the situation safely. The manager acknowledged that staff had not felt sufficiently confident to manage the young person's complex behaviours. The young person's behaviour management plan lacked details about specific aspects of her behaviours and lacked clarity in terms of guidance for staff about how to manage them. There was also a lack of guidance for staff about making decisions to involve the police.

This lack of guidance means that staff did not have a clear understanding of strategies to be used, and as such, were not able to support the young person when in crisis, in a confident or consistent manner. It was found that the current young person's behaviour management plan also lacked detail and that at on at least one occasion, an ex-staff member had acted in direct conflict with instructions included in it.

Staff at the home receive training in a recognised behaviour management technique, which is designed to support safe and consistent practice. However, it was evidenced that on a number of previous occasions, some shifts had been staffed only by team members who were still to receive their training. As a result, there had been no staff on duty sufficiently trained to manage crisis situations. This meant that young people and staff were at risk of harm. The manager was able to confirm that this training has now been provided to all staff, so the situation will not occur again in the future.

Records relating to behaviour management are not always completed in a sufficiently

clear manner. Some reports of physical interventions with young people lacked clarity. It was also noted that consequences, used by staff as part of the behaviour management support provided to young people, were not always recorded. This means that the manager is not able to sufficiently monitor such matters and does not support consistent practice. A requirement has been raised in relation to behaviour management within the home.

The manager has systems in place to help provide a safe environment for young people. The recruitment of new staff is carried out in a careful manner and all prospective staff are required to undergo a selection of background checks before being offered a post at the home. This reduces the risk of young people being exposed to adults of unsuitable character.

Young people are provided with safe and secure accommodation. Staff carry out regular health and safety checks and external contractors visit regularly to monitor areas such as fire safety. Any repairs are carried out quickly, thereby protecting young people from avoidable hazards. This helps to promotes young people's safety.

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

The home has experienced some disruption following the resignation of the previous registered manager. A suitably qualified manager has been appointed and is going through the process of registration with Ofsted.

The manager reported a good level of support and confirmed that she was provided with the necessary resources to effectively manage the home. She gave an example of being quickly provided with access to specialised training for the staff team when she made this request.

External professionals have reported improved communication with the home since the appointment of the new manager. During the inspection, examples were seen of effective partnership working with external agencies such as education providers and specialist mental health teams. Records of meetings with external professionals demonstrate that the manger is able to challenge outside services where appropriate, to help ensure that young people receive the care and support that they need.

It was found during this inspection that some decisions in relation to the admission of new young people had been made without full consideration of the relevant information. For example, the current young person was admitted to the home before the manager was fully aware of some previous concerns around his behaviours. However, this young person has settled well and is experiencing good outcomes. The manager advised that she had learned from previous shortfalls in the admission process and will ensure that these are not repeated in the future.

Placement planning for young people has been variable. While the current young person's plan is well detailed and reflective of his current circumstances, aspects of the previous young person's care were unclear and not always well detailed in their

placement plan. Gaps in care planning can lead to young people not receiving the care and support that they need.

There has been some turnover in staff since the home began operating, which previously led to a high use of agency staff. This turnover has now settled and the manager has been able to recruit a full team. In addition, the manager has ensured that only consistent agency staff are used in the home. This means that the young person currently living in the home receives his care from a stable and consistent team that he is familiar with.

There is a core training programme in place which all staff are expected to complete as part of their mandatory training. The programme includes a number of areas designed to enhance the staff team's skills such as safeguarding, training around child sexual exploitation and positive behaviour management. Staff are trained in a recognised behaviour management programme, which is designed to support consistent and safe practice. Training records and staff rotas evidence that prior to this training being provided to all staff, there were occasions where none of the staff on duty had completed this training. This means that the manager had failed to ensure that young people were consistently supported by staff with the appropriate skills and knowledge to support them safely. A requirement has been raised in relation to this matter.

Staff speak positively about the progress made by the home in recent months and report a constantly improving picture. Staff demonstrate very good understanding of the current young person's needs and communicate pride in the service that they provide. Staff confirmed that they had access to regular supervision and described the manager as approachable and supportive.

In discussion, it was noted that some staff members were not fully aware or clear on certain polices within the home. For example, the home's policy on young people smoking and mobile phone and internet use. The manager advised that she had recognised some gaps in the guidance provided to staff about their day-to-day work, and as a result, was in the process of developing improved guidance for staff. It is recommended that this process be completed as a matter of priority, so that staff have the information that they need to practice in a safe and consistent manner.

It was identified during this inspection that a number of aspects of record keeping in the home need to be improved. In some instances, information was found to be missing. For example, the details of a complaint raised by an external professional. In other examples, information was difficult to access as it had been archived and sent to the organisation's head office. Some records, such as risk assessments and behaviour management plans, lacked clarity. A requirement has been raised in relation to this matter.

Improvements are required to systems used by the manager to monitor safety and quality across the service. For example, incidents logs, designed to provide an overall picture of incidents are not always completed in an accurate manner. This means that the manager is not able to carry out effective trend analysis to help identify themes for

improvement.

Following this inspection, a number of requirements and recommendations have been made and it has been judged that the home requires improvement to be good. This demonstrates that internal quality assurance processes should be improved to enable the manager to identify areas for improvement in a prompt and effective manner.

During this inspection, it was noted that a number of incidents had occurred which HMCI should have been notified about, but were not. Shortfalls were also identified in relation to reporting to external agencies. For example, a RIDDOR reportable accident had occurred within the home which had not been reported through RIDDOR processes. A requirement has been raised in relation to this matter.

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 differences 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: 1238043

Provision sub-type: Children’s home

Registered provider: Nurture Childcare Services Limited

Registered provider address: 71 Edge End Lane, Great Harwood, Blackburn BB6 7QD

Responsible individual: Lee Wignall

Registered manager: Post vacant
Joanne Catlow

Inspectors

Marie Cordingley: social care inspector
Lisa Gregoire-Parker: social care inspector

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