1248979

Registered provider: Little Belsteads Care Home Limited

Full inspection

Inspected under the social care common inspection framework

Information about this children's home

This privately owned home provides care for up to four children who have learning disabilities.

Inspection dates: 18 to 19 July 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.

Date of last inspection: 22 June 2017 (monitoring visit)

Overall judgement at last inspection: Not applicable

Enforcement action since last inspection:

A monitoring visit took place on 22 June 2017 following concerns received by Ofsted about the lack of induction for the staff, inadequate recording of incidents, poor administration and storage of medication, and significant gaps in recruitment files. A compliance notice relating to the leadership and management of the home was issued on 30 June 2017. A notice of restriction of accommodation was issued on 27 June 2017.

Key findings from this inspection

This children's home is inadequate because:

- Failures in the leadership and management of the home have compromised children's safety.
- The provider has failed to provide the care that is detailed in the home's statement of purpose.
- The staff employed to work directly with the children do not have the required experience or knowledge to provide care that meets the complex needs of the children.
- The induction for staff does not equip them sufficiently to meet the complex needs of the children.
- The training that the staff receive does not equip them with the skills that they require to meet competently the complex health, social and emotional needs of the children.
- Two of the previous children resident at the home arrived in an emergency, which meant that the staff had insufficient time to prepare for their arrival.
- Some of the staff who have been involved in physical intervention do not have relevant training.
- The written records for physical intervention do not provide sufficient detail of each incident.
- The registered manager failed to notify the local authority designated officer about verbally abusive conduct by a member of staff towards a child.

The children's home's strengths:

- Children's bedrooms are personalised and well furnished.
- The provider quickly makes additional equipment available for the children when needed.
- Family members are made to feel welcome when visiting the home. Feedback from one parent is very positive and praising of the staff's endeavours to meet her child's individual and complex needs.

Recent inspection history

Inspection date	Inspection type	Inspection judgement
22 June 2017	Monitoring	No judgement

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 must comply within the given timescales.

Requirement	Due date
The protection of children standard is that children are protected from harm and enabled to keep themselves safe. In particular, the standard in paragraph (1) requires the registered person to ensure that staff 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, and help each child to understand how to keep safe. (Regulation 12 (1)(2)(a)(i)(ii))	01/09/2017
*The leadership and management standard is that the registered person enables, inspires and leads a culture in relation to the children's home that helps children to aspire to their full potential and promotes their welfare. In particular, the standard in paragraph (1) requires the registered person to: lead and manage the home in a way that is consistent with the approach and ethos of the home, and delivers the outcomes set out in the home's statement of purpose; to understand the impact that the quality of care provided in the home is having on the progress and experiences of each child. (Regulation 13 (2)(a)(c))	*01/08/2017
The care planning standard is that children receive effectively planned care in or through the children's home and have a positive experience of arriving at the home. (Regulation 14 (1)(a)(b))	01/09/2017
The registered person must ensure that all employees undertake appropriate continuing professional development and receive practice-related supervision by a person with appropriate experience. (Regulation 33 (4)(a)(b))	01/09/2017
The registered person must implement the policy which sets out the procedure to be followed in the event of an allegation of abuse or neglect. (Regulation 34 (1)(b))	01/09/2017
The registered person must ensure that within 24 hours of the use of a measure of control, discipline or restraint in relation to a child in the home that an accurate record is made which includes a description of the measure and its duration, the name	01/09/2017

of the person who used the measure ('the user'), and of any person present when the measure was used, and a description of any medical treatment administered, as a result of the measure. (Regulation 35 (3)(a)(iv)(vi)(viii))	

* These requirements are subject of a compliance notice.

Recommendations

- In some extreme cases where children have very complex care needs, a child may need to be restrained by chemical means. Any use of such restraint should follow a rigorous assessment process and, as with any restraint, be necessary and proportionate. Whenever such restraint is planned, it should be identified within a broad ranging, robust behaviour support plan which aims to bring about the circumstances where continued use of such restraint will no longer be required. ('Guide to the children's homes regulations including the quality standards', page 47, paragraph 9.45)
- The registered provider should have a workforce plan which can fulfil the workforce related requirements of regulation 16, schedule 1 (paragraphs 19 and 20). The plan should:
  Detail the necessary management and staffing structure (including any staff commissioned to provide health and education), the experience and qualifications of staff currently working within the staffing structure, and any further training required for each member of staff to enable delivery of the home's statement of purpose:
  - Detail the processes and agreed timescales for staff to receive induction, probation and any core training;
  - Detail the process for managing and improving poor performance;
  - Detail the process and timescales for supervision of practice and keep appropriate records for staff in the home.

  The plan should be updated to include any new training and qualifications completed by staff while working at the home, and used to record the ongoing training and continuing professional development needs of staff, including the home's manager. ('Guide to the children's homes regulations including the quality standards', page 53, paragraph 10.8)

Inspection judgements

Overall experiences and progress of children and young people: inadequate

The children's safety is compromised because of widespread failures in the leadership and management of this home. The home was registered in March 2017. The first, and only, three children were admitted in May 2017.

In June 2017, Ofsted was notified about concerns relating to the care of the children. The single placing authority removed the three children from the home because of these concerns. This resulted in significant disruption for each of those children. Ofsted undertook a monitoring visit on 22 June 2017 to review the quality of care. Following the monitoring visit, Ofsted issued a compliance notice in relation to the leadership and management of the home, and a notice of restriction of accommodation.

No children were accommodated at the time of this inspection.

The provider has taken some steps towards making the required changes at the home, and has met some of the steps that were identified in the compliance notice. However, not enough progress has been made. Consequently, the provider is likely to be subject to further enforcement action.

Three children were admitted to home within a three-week period. The staff who had been in post since the home had opened had been working well to move one child into the home carefully and in a planned way. They had been working closely with the child's parent and going to the child's home to observe daily routines. The staff had liaised with health colleagues about the complex and highly individualised health needs of the child, and about a medication strategy. However, before this child's actual admission date, two other children who also have significant and complex needs were admitted to the home in an emergency. The former registered manager, who was at the home at the time of the inspection, said, 'I believed that with the core staff we had that we could care for two children, but not for three.' The former registered manager stated that she felt under pressure to agree to accept the third child. She did not agree with the decision because she did not feel that the staff team were ready for a further admission.

The quality of the children's introductions to the home varied significantly. One of the children who was admitted in an emergency had been held in a police cell before being brought to the home by his parent and social worker. This did not give the core staff sufficient time to prepare to meet his needs. The staff did their best to welcome him and to try to understand him, but his unplanned arrival jeopardised the work planned for the other child. The three children arrived within a very short time of each other, and this did not allow sufficient time for each child to adjust to the new environment. It also meant that the inexperienced core staff members' attention was significantly diluted as they attempted to adapt to caring for the three children, each of whom has significant and complex needs, in a very short space of time.

Caring for the three children required an increase in the number of adults needed on

shift. The additional staff who were recruited did not have the required knowledge, skills or experience to meet the children's needs. This resulted in staff struggling to manage, and led to the children lashing out as each child arrived, seriously assaulting the staff. These incidents had a significant impact on the stability of the home, and staff members did not feel safe.

The care plans that have been written by the staff are poor in content and quality. The plans are incomplete in some sections. The manager has failed to provide effective oversight of the care plans. As a result of this shortfall in care planning, the adults who are caring for each child do not have access to full information about the child's needs.

The staff lack leadership and are thus unable to organise themselves effectively to meet the children's needs. Poor communication with the children has resulted in mistakes and staff being physically hurt. On one shift, a staff member told one of the children that he could not buy a particular toy. The staff member then took him out to a shop selling toys. The child hurt a member of staff during this trip.

The monitoring visit in June 2017 identified that one child had a particularly complex medication plan. This was due to be reviewed by external health professionals on 6 June 2017, and was therefore out of date at the time of the monitoring visit. At this inspection, Ofsted established that the relevant health professionals had in fact reviewed the plan within the required timescales. This means that while the guidance from the prescribing doctor was not out of date at the time of the monitoring visit, however, the current and correct information had not been made available to the inspector by the manager.

The monitoring visit identified that the arrangements for the storage of medication were not sufficient. Since the children have left, medication is no longer stored at the home. The responsible individual agreed that the system used when the children were living at the home was not adequate. A new system is yet to be fully implemented. Staff were receiving medication handling training during this inspection, and they spoke confidently about the new arrangements for the handling, recording and safekeeping of medication.

Before they left the home, the previous resident children attended school. Some children attended the on-site school and others were transported to schools in the local area. The staff shared information with education professionals and supported the children to engage with education, helping them to make progress and to achieve their education targets. There is a close relationship between the home and the deputy manager of the on-site school, who provides training as well as attending meetings at the home. This provides continuity for children at the home and the school.

Before the children left the home, the staff would take them out on trips to the park and to local attractions. These trips promote social inclusion, because the staff encourage the children to be part of the local community, and to take part in various activities which enable them to socialise and explore life outside the home.

Despite the differing and complex needs of the children, staff encouraged the previous

resident children to eat together. This practice helps children to engage and interact with each other. Building social skills is important and enables them to become more familiar with each other. A parent of one of the previous resident children said, 'I was so pleased to see that my son chose to go and sit at the table to have his meal with the other children.' Staff will encourage children who have the ability to use the kitchen and to cook. This helps to promote increased independence for those children.

The staff support children at the home to have family contact, and welcome parents into the home. The previous resident children's social workers were regular visitors, and they provided positive feedback about their children's experiences. One social worker said, 'I was always pleased with the work they did, they encouraged him a lot.'

Children's bedrooms are personalised, and the majority of the staff are keen to ensure that children's experiences are as comfortable as they can be. A parent of a previous resident child visited on a regular basis and decorated the child's room, and this demonstrates that the staff have an inclusive attitude to parents and carers and welcome their involvement. Some of the core staff, including the previous registered manager, worked hard under the circumstances to understand and build relationships with the previous resident children. One parent said, 'As soon as a need was identified, the manager acted quickly.' This means that communication was effective.

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

Serious incidents occurred for each of the children after their admission. The most significant being that when distressed, on two occasions one child tried to strangle staff. Placing social workers were made aware of these incidents, but the written review of the risk following the incidents was not good enough. Failure to update the risk assessments clearly does not help staff to understand the actions they need to take to reduce the risk of harm to the other children and/or staff from dangerous behaviour.

With some exceptions, risk assessments are disjointed, inconsistent and do not link to the previous resident children's plans. Most significantly, there are no impact assessments to demonstrate what consideration was given to placing three children who have very complex needs and behaviours together at the same home.

In the context of an inexperienced staff team who were poorly equipped to meet the children's complex needs, and the known risks of some of the children physically attacking others, the admission of these three children together unnecessarily placed them at risk of harm.

The staff use physical restraint to manage behaviour. Other professionals, social workers and parents are aware of this strategy. The staff write a brief log of the interventions. However, the written information is minimal and does not provide a sufficient account of the events. Specifically, when a child is held, the description of the measure and the names of the staff members who are involved in holding the child are not clear enough. As a result, managers and leaders do not have sufficiently detailed information to be able to review and fully understand what has happened, and to learn lessons from each

incident.

Staff records show that not all of the staff who have been involved in the physical restraint of a child are trained in the method. During an incident when one child was being restrained, an agency worker who had come to work at the home shortly before and had not had a sufficient induction became involved in helping colleagues to hold the child. This had minimal impact on this occasion because the child's parent was present. Lack of relevant training is unacceptable because it places children at risk of injury and staff at risk of complaint and allegation.

Children do not go missing from this home. On one occasion, one of the previous resident children left the building and walked towards the school adjacent to the home. Staff followed her around the grounds to ensure that she returned safely within minutes. Staff are aware of the missing from care policy, and the actions to take in the event of a child leaving the home. The number of adults working at the home reduces the likelihood of children leaving the building unnoticed.

The staff are aware of the whistle-blowing policy. One member of staff followed the whistle-blowing procedure and reported to the manager that a colleague, after being hurt, had behaved inappropriately towards a child. The manager investigated this claim and dismissed the member of staff. Ofsted was notified after the event, but at the time the matter was not shared with the local authority designated officer. This means that the manager failed to fully implement the home's safeguarding policy, because it is the local authority designated officer's responsibility to coordinate the response when an adult is alleged to have behaved inappropriately towards a child.

The deputy manager of the on-site school undertakes an assessment of the potential risks that an individual child may pose to others and themselves. The assessment is based on the information from the referral documentation, and when possible, in conjunction with meeting the child before their admission. One of the children who was placed at the home in an emergency received a pre-admission visit at their family home from the behavioural support worker. The risk assessments use a traffic light colour code to draw the reader's attention to the significance of known behaviours. This provides clarity.

The effectiveness of leaders and managers: inadequate

The home does not have a registered manager. Ofsted accepted the former registered manager's voluntary cancellation of their registration following the monitoring visit.

This inspection has identified significant shortfalls in the former registered manager's oversight of documentation and recruitment of staff. The systems for monitoring the quality of care at the home, and any risks, are inadequate. An example of this is the lack of supervision for the staff, which means that they did not receive the support and guidance they required to provide safe care while the previous resident children were

living at the home.

As an interim measure, an acting manager who has experience of working with adults who have learning disabilities, and more recent experience of working for some months in a home with children who have emotional and/or behavioural difficulties, has been appointed. The acting manager has no intention to apply for registration with Ofsted.

There are no records of supervision for a number of staff including the former registered manager. Records of staff supervision began following the monitoring visit. This means that staff have not received the expected levels of supervision and guidance.

The monitoring visit in June 2017 identified that staff induction had not taken place for every member of staff. This inspection found that induction has been completed retrospectively for the current core staff. There is a newly introduced framework for the induction of agency and bank staff. This means that this step in the compliance notice is met.

The monitoring visit identified shortfalls with the recruitment and vetting process. Some of the recruitment files were incomplete and staff had not been adequately screened. This inspection identifies that the provider has taken some action to address the quality of the recruitment and vetting process. Yet, some recruitment files for the core staff are unclear. When employees have used more than one name, the record from their interview does not show whether additional discussions took place with the applicant. This means that full and satisfactory information is not consistently available at the point that some adults are recruited to work on shift with children. This increases the likelihood of unsuitable individuals having access to vulnerable children. As a result, this step of the compliance notice is not met.

At least three of the core staff who were recruited prior to the arrival of the previous resident children' arrival have left. Very few core staff hold the level 3 diploma in residential childcare. There is a lack of evidence to demonstrate individual staff members' qualifications. This means that the managers are not clear about the staff members' skills, experience and knowledge that are specific to this service. Most of the staff have previous experience of working with adults, some with adults who have learning disabilities. Some of the staff have experience of working with children in other settings. The training to enable the staff to understand the needs of children who have autistic spectrum disorders and learning disabilities is not sufficient. Some of the core staff attended two half-day courses that focused on the structured and practical framework for understanding the behaviour described in the home's statement of purpose. This does not equip all of the staff with the level of skill required to offer consistent, sustainable and high-quality care to children who have such complex needs. There are insufficient number of individuals who have the required level of skill and experience to work with children who have complex needs and learning disabilities. As a result, this step of the compliance notice is not met.

The managers have failed to apply the home's statement of purpose, which says, '[The home] does not primarily function as an emergency resource and every effort will be

made by the registered manager and the multi-disciplinary team to prevent such admissions.' The former registered manager told the inspectors that she had not felt confident that the team could manage having a third child in an emergency. The responsible individual says that it was the registered manager's decision to accept the third placement. This demonstrates that there was a lack effective and child-centred communication between the decision makers regarding admissions. The admission of two children in an emergency is not in line with the statement of purpose. These decisions placed children and staff at risk of 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. 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: 1248979

Provision sub-type: Children's home

Registered provider: Little Belsteads Care Home Limited

Registered provider address: Little Belsteads, Back Lane, Little Waltham, Chelmsford CM3 3PP

Responsible individual: Peter Adams

Registered manager: Post Vacant

Inspector(s)

Rosie Davie, social care inspector
Debbie Young, social care inspector

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