1228522

Registered provider: Wood Grove (Childcare) Ltd

Full inspection

Inspected under the social care common inspection framework

Information about this children's home

This children's home is registered to offer accommodation for up to five young people. The home provides care for children with emotional and behavioural difficulties and children with learning disabilities.

Inspection dates: 10 to 11 October 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 widespread failures that mean children and young people are not protected or their welfare is not promoted or safeguarded.

Date of last inspection: 24 March 2017

Overall judgement at last inspection: declined in effectiveness

Enforcement action since last inspection:

None.

Key findings from this inspection

This children's home is inadequate because:

- Staff do not always follow safeguarding procedures when a child raises a concern. This fails to ensure the safety, health and well-being of young people.
- Poor management oversight has resulted in inadequate action being taken when there are concerns about a child's welfare.
- The response to complaints made by young people is poor. Effective arrangements are not in place to safeguard and promote young person's welfare when they make a complaint. Furthermore, because of this poor practice, young people do not benefit from sharing their thoughts and feelings, and staff are unable to demonstrate how they are learning from the views of young people.
- The staff and manager have failed to assess well enough the risk of harm to children in their care. Arrangements to reduce the risk of harm to children are inadequate, especially with regard to impact risk assessments and the needs of children living at the home and potential placements.
- The failure to follow procedures for the safe administration of medication means that staff cannot ensure the safety and well-being of young people.
- Staff recruitment is not sufficiently robust. Current practice does not ensure that only the safest and most suitable people are employed to work with young people.
- There has been no registered manager for 26 weeks. Inconsistencies in the leadership and management of the home have had an impact on the care of young people.

The children's home's strengths:

- Young people attend school or college regularly and make good progress.
- Young people take part in activities such as the gym and horse riding. This has helped them to improve their health and well-being.
- Young people have good relationships with some staff.

Recent inspection history

Inspection date	Inspection type	Inspection judgement
24/03/2017	Interim	Declined in effectiveness
04/08/2016	Full	Good

What does the children's home need to do to improve?

Statutory requirements

This section sets out the actions that the registered person(s) must take to meet the Care Standards Act 2000, Children's Homes (England) Regulations 2015 and the 'Guide to the children's homes regulations including the quality standards'. The registered person(s) must comply within the given timescales.

Requirement	Due date
10: The health and well-being standard Requires the registered person to ensure that staff help each child to achieve the health and well-being outcomes that are recorded in the child's relevant plans. Take part in any activities, and attend any appointments, for the purpose of meeting the child's health and well-being needs. (Regulation 10(2)(a)(i)(iii)) In particular regard to asthma reviews.	10/11/17
12: The protection of children standard The registered person must - 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; take effective action whenever there is a serious concern about a child's welfare ensure 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. (Regulation 12(2)(a)(i)(vi)(b)) In particular, crisis management plans must be implemented.	10/11/17
13: The leadership and management standard Ensure that there is a registered person to 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. (Regulation 13(2)(a))	10/11/17
13: The leadership and management standard The registered person must enable, inspire and lead a culture in relation to the children's home that: promotes children's welfare. In particular, records must not be altered. ensure that the home's workforce provides continuity of care to each child. (Regulation 13(1)(b)(2)(e))	10/11/17

34: Policies for the protection of children: The registered person must prepare and implement a policy, which sets out the procedure to be followed in the event of an allegation of abuse and neglect. In particular, this refers to the decision of whether to suspend staff. (Regulation 34(1)(b))	10/11/17
32 Fitness of workers The registered person must recruit staff using recruitment procedures that are designed to ensure children's safety; Full and satisfactory information is available in relation to the individual in respect of each of the matters in Schedule 2. (Regulation 32(1)(3)(d))	10/11/17

Recommendations

- The registered person must specify the procedures to be followed and the roles and responsibilities of staff when a child is missing from care or away from the home without permission and how staff should support the child on return to the home. ('Guide to the children's home regulations including the quality standards', page 45, paragraph 9.28)

Inspection judgements

Overall experiences and progress of children and young people: inadequate

The key judgement area of 'how well young people are helped and protected' is inadequate, due to the shortfalls found at this inspection. In line with Ofsted frameworks, once this area is judged as inadequate, the 'overall experience and progress of children and young people' is also judged as inadequate.

Outcomes for young people have been affected by poor matching procedures and poor impact risk assessments before young people are admitted to the home. Because of poor practice, the young people placed have undoubtedly had a negative influence on each other and have contributed to escalating each other's behaviours. For example, two young people were admitted from neighbouring areas, both had previously been sexually exploited and both continued to be at high risk of child sexual exploitation. Risk assessments were poor. They did not clearly identify the risks apparent to the young people. They also failed to say how the risk should be minimised. Following their admission to the home, both of the young people went missing together for several days. Their exact whereabouts were unknown and the young people would not disclose what they had been doing. As a result, there was considerable concern for their welfare.

These inadequate arrangements led to one young person's placement ending. Subsequently, a complaint was made to the home by the young person's placing authority regarding a disregard for care planning. In the complaint, the social worker

said, 'I would worry about a more vulnerable young person being placed and having her needs misunderstood'.

One young person made a complaint about a restrictive physical intervention and the conduct of staff during this intervention. Staff and managers in the home knew the issues in her complaint, but they had not investigated them. In addition, the home's complaint procedures were not followed. The young person said, 'I was scared to let my friends come round, it was awful'. After making a written complaint, the young person ran away from the home, as she did not feel that her views were being listened to.

Strategies to manage young people's behaviour, such as self-harm, are not sufficiently risk assessed. For example, staff are instructed to undertake checks on young people every 15 minutes throughout the night, but there is no lone-working risk assessment in place to keep the staff or young person safe when this is carried out. Records incorrectly state that one young person is receiving counselling when this has not yet been arranged, therefore she is not receiving the support that she needs. Consequently, records do not give an accurate reflection of the care being provided to young people.

There have been 17 room searches since January due to concerns of young people smoking cannabis. Despite the fact that cannabis has been found during these room searches, not all staff have received the training that they require to enable them to understand or meet the needs of young people in their care regarding substance misuse.

Arrangements in place to promote the health needs of young people are inadequate. All the young people who are prescribed medication for their long-term health needs refuse to take their medication, and this impacts on their health. Work by the care staff to try to address this is inconsistent and ineffective. For example, one young person continues to have infections as staff do not support her to take the prescribed antibiotics. Unused medication is not returned to the pharmacy and the storage of medication is poor. The recording of medication is inconsistent and has not been accurately completed. One young person's annual health assessment recommends that she have an asthma review, yet three months later this has not been undertaken or actioned by care staff.

There are three young people currently living at the home, even though the home is able to accommodate five young people. The current managers have given assurances that they will carefully consider any future referrals and the impact that these could have on the young people.

All the young people are engaged with school or college. One young person regularly attends the gym and goes horse riding, and this has helped to improve her health. She said that she has lost several stone in weight since living at the home, and is happy about this. Staff support the young person in these activities. They take her to the gym and she says 'they give me a good workout', and they help her to buy the food that she likes.

The young people report that they have good relationships with some of the staff. One young person said 'staff are willing to listen to any problems, no matter how big or small'. The relationships and interaction observed between staff and young people by the inspectors were positive, and one young person told inspectors that things are getting better.

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

There are serious shortfalls in safeguarding practices that impact on the welfare of young people.

The day-to-day care arrangements for young people do not promote their safety or welfare. Risk assessments are not clear. They do not fully identify the risks apparent to young people. They fail to detail how to minimise these risks. For example, one young person's risk assessment does not indicate the known risk to her from gang activity when she is missing from home.

Records of physical restraint are poor. In addition, procedures for the review of restraint do not allow for independent review. For example, a debriefing of a restraint incident was conducted by the same member of staff as was involved in the restraint of the young person. The failure to investigate properly the young person's concerns about the conduct of staff during this restraint does not promote the safety and welfare of young people.

Safeguarding concerns at the home have not been routinely referred to the designated officer for the local authority and placing authority social workers. A young person's complaint was not promptly referred or acted on in accordance with the home's safeguarding procedure and, as a result, the staff failed to safeguard her.

Following the investigation of an allegation of abuse against a member of staff, the actions identified by the designated officer were not followed. The member of staff was subject to their probationary period of employment, yet these concerns were not discussed as part of their probationary reviews. This means that staff do not reflect and learn from incidents to improve practice. This lack of robust action does not protect young people.

Recruitment and vetting procedures are not sufficiently robust to safeguard young people. For example, references from previous employers when staff have previously worked with children have not been sought. Safeguarding procedures are not always followed when there are concerns about the conduct of staff. This poor practice does not ensure that only the safest and most suitable people are employed to work with young people.

The effectiveness of leaders and managers: inadequate

The home has been without a registered manager for more than 26 weeks. The management arrangements at the home have been ineffective since the departure of the former manager on 31 March 2017. An application to register the manager of the

home was received by Ofsted on 29 June 2017, but was subsequently withdrawn. A third manager has been appointed. However, Ofsted has yet to receive an application and until then the application cannot be processed, references sought or the applicant interviewed. These management arrangements have resulted in inconsistencies and poor leadership that have had a negative impact on the care and protection of young people.

Shortfalls identified as a result of external monitoring procedures by an independent visitor are not fully investigated or actioned by managers. Moreover, internal monitoring procedures have failed to identify the shortfalls in practice and procedures that have been identified as part of this inspection. Medication audits have failed to identify the issues around recording and the refusal of young people to take medication. This means that managers have not taken action to remedy shortfalls and improve practice. Procedures to monitor standards of care at the home are therefore ineffective.

Staff receive regular training to enhance their competence and skills. Despite this training, shortfalls in safeguarding practice and substance misuse were identified at this inspection. Although staff receive regular supervision, the quality of supervision does not adequately monitor standards in care practice for vulnerable young people. Not all staff have received the necessary training to meet the current needs of young people. One member of staff reported, 'I've asked for a training course that is relevant to the job role for over a year and have never had an answer to whether I can have it or not'.

Although there has been some good feedback from professionals about regular communication, there has also been a formal complaint from one social worker about the appropriateness of communication received from the home. Despite regular multi-agency risk management meetings held for one young person, some significant information about potential grooming of young people accommodated at the home has not been fully shared with all relevant professionals.

Managers do not recognise the strengths and weaknesses of the home. They have not been proactive in prioritising and making improvements to address previous requirements and current shortfalls. Requirements and recommendations made at the last inspection have not been addressed. These requirements have therefore been repeated. This demonstrates poor management oversight that has had a detrimental impact on outcomes for young people living at this home.

The young people and staff speak highly of the recently appointed manager.

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: 1228522

Provision sub-type: Children's home

Registered provider: Wood Grove (childcare) Ltd

Registered provider address: Suites 3 and 4, Stockley Park Business Centre, The Arena, Stockley Park, Uxbridge, Middlesex UB11 1AA

Responsible individual: Paul Brosnan

Registered manager: Post vacant

Inspector(s)

Jessica Forshaw, social care inspector

Elaine Clare, social care inspector

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Piccadilly Gate
Store Street
Manchester
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