1251947

Registered provider: Haven Care Group 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 four young people who have emotional and/or behavioural difficulties. A private company manages this home.

Inspection dates: 12 to 13 December 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 and the care and experiences of children and young people are poor and they are not making progress.

Date of last inspection: first inspection

Overall judgement at last inspection: not applicable

Enforcement action since last inspection: not applicable

Key findings from this inspection

This children's home is inadequate because:

- There has been a delay in staff reporting an allegation by a young person against a staff member.
- Staff do not understand their roles and responsibilities to help keep young people safe.
- Staff are not appropriately trained to meet the needs of the young people living at the home.
- Staff are slow to secure the right health services for young people.
- Staff fail to follow and action medical advice.
- Staff fail to ensure that young people's educational needs are prioritised at the point of admission. This has resulted in delays in young people attending school.
- Risk assessments are not accurate and do not always reflect the needs of young people.
- Placements are offered to young people without a full understanding of the risks presented.
- Staff turnover is high, which prevents young people from receiving consistent care or building positive, stable relationships with staff.
- Complaints from young people and placing authorities are not actioned in line with the organisation's policy.
- When young people return from a missing from care episode, they are not given the opportunity to speak to someone independent.
- Young people are not routinely offered the opportunity of a debrief following an incident of restraint. In addition, managers have not reviewed these incidents to maintain an understanding of staff practice.
- Staff do not use rewards and consequences consistently to support young people's behaviour management.
- The home is not providing care as set out in the statement of purpose.
- Staff do not receive an effective induction or regular supervision to help them improve their practice.
- Managers do not give sufficient attention to the safe recruitment of staff.

The children's home's strengths:

- Young people have access to a range of individual activities and are encouraged to join local groups.
- A new manager has recently come into post and recognises the areas for development. Positive changes are beginning to happen. However, these changes are still in their infancy and it is too early to assess the impact.

Recent inspection history

Inspection date	Inspection type	Inspection judgement
First inspection		

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
In meeting the quality standards, the registered person must, ensure that staff, seek to secure the input and services required to meet each child's needs. (Regulation 5 (b))	14/02/2018
The education standard is that children make measurable progress towards achieving their educational potential and are helped to do so. In particular, the standard in paragraph (1) requires the registered person to ensure that staff help each child to attend education or training in accordance with the expectations in the child's relevant plans. (Regulation 8 (1)(2)(x))	14/02/2018
The health and well-being standard is that the health and well-being needs of children are met, children receive advice, services and support in relation to their health and well-being and children are helped to lead healthy lifestyles. In particular, the standard in paragraph (1) 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 activities, and attend any appointments, for the purpose of meeting the child's health and well-being needs. (Regulation 10 (1)(2)(a)(i)(iii))	14/02/2018
The positive relationships standard is that children are helped to develop, and to benefit from, relationships based on mutual respect and trust, an understanding about acceptable behaviour and positive responses to other children and adults. In particular, the standard in paragraph (1) requires the registered person to ensure that staff encourage each child to take responsibility for the child's behaviour, in accordance with	28/02/2018

the child's age and understanding and communicate to each child expectations about the child's behaviour and ensure that the child understands those expectations in accordance with the child's age and understanding. (Regulation 11 (1)(2)(iii)(v))	
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, have the skills to identify and act upon signs that a child is at risk of harm, 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. (Regulation 12 (1)(2)(a)(i)(iii)(v)(vi))	31/01/2018
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 aspire to fulfil their potential; and promotes their welfare. In particular, the standard in paragraph (1) requires the registered person to ensure that staff have the experience, qualifications and skills to meet the needs of each child. (Regulation 13 (1)(2)(c))	28/02/2018
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 aspire to fulfil their potential; and promotes their welfare. In particular, the standard in paragraph (1) requires the registered person to ensure that the home has sufficient staff to provide care for each child and ensure that the home's workforce provides continuity of care to each child. (Regulation 13 (1)(2)(d)(e))	14/02/2018
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 aspire to fulfil their potential; and promotes their welfare.	28/02/2018

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, and delivers the outcomes, set out in the home's statement of purpose. (Regulation 13 (1)(2)(a))	
The registered person must make arrangements for the handling, recording, safekeeping, safe administration and disposal of medicines received into the children's home. (Regulation 23 (1))	31/01/2018
The registered person may only use devices for the monitoring or surveillance of children if the child's placing authority consents in writing to the monitoring or surveillance. (Regulation 24 (1)(a))	14/02/2018
If the Regulatory Reform (Fire Safety) Order 2005(a) applies to the home the registered person must ensure that the requirements of that Order and any regulations made under it, except for article 23 (duties of employees), are complied with in respect of the home. (Regulation 25 (2)(b))	31/01/2018
The registered person must recruit staff using recruitment procedures that are designed to ensure children's safety. Specifically, the registered person must ensure that 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))	28/02/2018
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, a record is made which includes; 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") has spoken to the user about the measure; and has signed the record to confirm it is accurate; and 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. (Regulation 35 (3)(a)(b)(c))	31/01/2018
The registered person must maintain in the home the records in Schedule 4. This includes a copy of the staff duty roster of	14/02/2018

persons working at the home, and a record of the actual rosters worked. (Regulation 37 (1) (a))	
The registered person must ensure that a record is made of any complaint, the action taken in response, and the outcome of any investigation (Regulation 39 (3))	14/02/2018

Recommendations

To improve the quality and standards of care further, the service should take account of the following recommendations:

- 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 to return to the home. ('Guide to the children's homes regulations including the quality standards', page 45, paragraph 9.28)
- Ensure that when a child returns to the home after being missing from care or away from the home without permission, the responsible local authority must provide an opportunity for the child to have an independent return home interview. Homes should take account of the information provided by such interviews when assessing risks and putting arrangements in place to protect each child. ('Guide to the children's homes regulations including the quality standards', page 45, paragraph 9.30)
- The registered person should actively seek independent scrutiny of the home and make best use of the information from independent and internal monitoring (including under regulations 44 & 45) to ensure continuous improvement. ('Guide to the children's homes regulations including the quality standards', page 55, paragraph 10.24)

Inspection judgements

Overall experiences and progress of children and young people: inadequate

Children's experience and progress are inadequate.

Young people's relationships with staff are adversely affected by multiple changes in the staff group. Since the home was first registered in April 2017, 20 staff have been appointed and 10 of these staff have left. In the same period, the home has had three managers. All of these staff changes prevent young people from being able to establish positive relationships with a stable staff group.

Managers show little awareness of risk when deciding to admit new young people. Consequently, on the first day of one young person's placement, a significant incident was able to happen which led to an allegation of sexual assault. A social worker told the inspector, 'The matching wasn't done correctly.'

Young people do not attend school. Staff do not consider how young people's educational needs will be met at the point of or prior to their admission. Staff do not understand the process for securing education for young people who come from outside the local authority area. This delay has a negative impact on young people and results in them being unable to attend school.

Staff do not promote young people's health needs. One young person was not registered with the local GP on admission. This was despite the fact that they had untreated needs being apparent. Staff also failed to follow up a health professional's recommendation for the young person to have a health assessment completed.

Staff have little understanding of young people's emotional needs. For example, suitable adjustments were not made for a young person who was known to be scared of the dark to enable him to use the bathroom at night. This shortfall is unacceptable and left a young person feeling vulnerable at night.

Staff support young people to visit family and friends, including family who live at a distance. However, these arrangements are not risk-assessed and this means that staff are not aware of potential concerns and so are unable to make plans to keep young people safe.

Young people's care plans are not progressed effectively as a result of placement records being incomplete. Necessary information has not been requested or pursued from placing authorities and so staff are not clear of placement objectives or the tasks delegated to them.

The physical interior of the home is well maintained. However, young people have not

had the opportunity to personalise their bedrooms until recently. This delay has left young people without the opportunity to influence decisions that directly affect them.

More positively, young people are encouraged to participate in a range of activities, for example going swimming, visiting the snowdome and attending army cadets. Staff support young people to join local groups. This encourages them to participate in activities that interest them alongside encouraging them to make social links local to their home.

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

Staff do not have a clear understanding of their roles and responsibilities in relation to protecting and safeguarding young people. They do not follow agreed procedures when safeguarding incidents occur and are not sufficiently alert to the importance of safeguarding and protection of young people. For example, staff have failed to report a young person's serious allegation that they were injured by a staff member during a physical restraint. This unacceptable poor practice means that risks to young people are not managed with sufficient timeliness or at a good enough standard.

Young people's individual risk assessments are ineffective and do not accurately portray an up-to-date assessment of risk. For example, one young person has been risk-assessed for shaving with a razor. However, he does not need to shave yet. Managers told the inspector that this risk assessment was 'copied' from an assessment relating to another young person. This means that staff cannot be clear what actual risks any individual young person may face and so the potential for risks to be unknown and unmanaged is high. Additionally, the clear management oversight and direction staff need to support the effective management of risk is absent.

Staff responses to young people who go missing from care are poor. Police and placing authorities have raised concerns about the ineffectiveness of staff responses when young people are located despite that staff follow young people when they go missing. Staff do not ensure that young people who return from missing from care episodes are offered the opportunity to speak with an independent person. This prevents the home from understanding the reasons why young people go missing and how they can best support them and minimise any risks.

Young people experience inconsistent and ineffective behaviour management strategies. Despite the manager telling the inspector that a young person 'responds really well to praise', there are no recorded rewards for this young person. This prevents the young person from recognising and celebrating their progress. Staff do not use sanctions appropriately. For example, a sanction was imposed on a young person following an incident of self-harm. This action fails to understand and respond to the young person's wider emotional needs and places them at risk of further self-harm.

Staff training in safeguarding young people is not prioritised and they are not all trained to understand the risks of child sexual exploitation or radicalisation. Because of this, not all staff understand the risks that young people can face. Although staff are trained in the use of physical intervention, their recording of such practice is poor. Records are often incomplete and show no evidence that a young person has been offered the opportunity to talk to someone after being physically held. Management oversight is of poor quality and managers often sign off records without any challenge to staff over missing information.

Staff use bedroom door alarms to monitor the movement of young people at night. These are used without the consent of the young person's social worker or any updated assessment of risk.

Staff oversight of young people's medication is poor. For example, during the inspection, the key to the medicine cabinet was found to be missing. It later emerged that a staff member had left the home with the keys in their possession. Also, there is a failure to ensure that medication records are safely stored. For example, a young person's medication record was removed from the young person's file and put onto a noticeboard. This prevented other staff from being able to find the record. When a young person was prescribed pain relief medication, staff failed to follow the prescribing doctor's instructions. This resulted in the young person not receiving pain relief medication. These shortfalls demonstrate poor management of the care of medicine.

Recruitment and vetting processes do not provide sufficient safeguards to reduce the likelihood of unsuitable individuals being employed to work with young people. For example, a member of staff was appointed without checks regarding a previous role with children.

Managers have failed to ensure that sufficient attention is given to fire safety. For example, actions from a fire risk assessment completed in March 2017 have still not been addressed. An empty fire extinguisher has not been replaced. This is of significant concern, because some young people have a history of fire setting.

The effectiveness of leaders and managers: inadequate

The home has been without a registered manager since July 2017. The current acting manager has been in post since the start of December 2017. She has yet to make an application to Ofsted to become the registered manager. She holds a level 5 qualification and has previously managed another service.

Managers do not prioritise individual supervision and staff induction. Staff supervision is not regular and does not ensure that staff continue to improve their practice and

skills. Three staff members who started work in September have only received two formal supervisions in this period. Staff receive little induction. One staff member told the inspector that they did not know what their induction objectives were and had not had chance to review these formally.

Despite the home's aims being to provide care to young people who may have behavioural difficulties, not all staff are trained in behaviour management. Other core staff training is not delivered comprehensively and shortfalls included first aid, medication management, and equality and diversity. Staff told the inspector that much of their training is completed and they feel that this does not always provide them with the level of knowledge and understanding that they need. Staff confirm that training to manage and deal with self-harm is provided. However, this does not cover ligature training, despite the home having cared for a young person with a known risk of this type of self harming behaviour. These significant gaps in staff training leave staff ill-prepared to meet the needs of young people.

Managers have not ensured that the home always operates with the staffing numbers required to meet the needs of young people. For example, managers agreed with police and social workers that they would increase staffing levels but failed to implement the agreement for 19 days. Managers explained that the delay was due to the responsible individual not securing the necessary financial agreement. The impact of this delay, as reported by staff members was that there was a significant deterioration in a young person's behaviour.

Staff rotas do not accurately reflect who has worked in the home. This means that there is no record that can be used effectively to support the investigation of concerns or allegations.

Managers have not ensured that the home operates in line with the statement of purpose. For example, the therapeutic services detailed are not operational. This prevents stakeholders having an accurate understanding of how the home operates.

Staff have not progressed complaints in line with organisational procedures. Despite the home's independent visitor noting a complaint from a social worker and three complaints from young people during one visit, these have not been recorded or actioned. The responsible individual could not find a record of these reported concerns during inspection. This demonstrates poor management oversight of managing and taking seriously the concerns raised by young people and other stakeholders.

The new manager, who has only been in post for two weeks, demonstrates an awareness of the issues identified in the inspection. There is some evidence that she has already started to have a positive impact in the home. She has contacted social workers to secure missing documents and to progress schooling for one young

person. Also, she has already met with the police to improve working relationships regarding their concerns about young people who go missing from care and has initiated plans to allow young people to personalise the home.

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: 1251947

Provision sub-type: Children's home

Registered provider: Haven Care Group Limited

Registered provider address: First Floor Unit 3, Barberry Court Parkway, Centrum One Hundred, Burton-on-Trent DE14 2UE

Responsible individual: Rachel Dyche

Registered manager: Post vacant

Inspector

Tracey Coglan Greig, social care inspector

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