# 1253711

Registered provider: Beacon Child Care Limited

Full inspection

Inspected under the social care common inspection framework

## Information about this children's home

The home is registered to provide care for three young people up to the age of 18. The home offers care for young people who have behavioural and/or emotional needs. The home is privately owned.

**Inspection dates:** 12 to 13 March 2018

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| **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 | inadequate |

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:

- Staff do not follow the organisation's policy for the storage and administration of medication.
- Managers do not ensure that risk assessments are kept up to date, and do not identify all known risks.
- Managers do not ensure that staff are clear about their responsibilities in regard to reducing risk for young people.
- Staffing levels are not sufficient to provide adequate support for young people.
- The registered manager does not provide sufficient challenge to the local authority to bring about change for young people.
- Some members of staff are not safely recruited.
- Staff do not have access to training to raise their awareness of first aid, online safety and the 'Prevent' duty.
- Staff have limited experience and lack the professional curiosity to notice the potential indicators of risk to young people.
- Managers have not ensured that staff rotas reflect the actual times that staff are on duty.
- Areas of the home require improvement to maintain an environment that is clean, safe and homely.
- Managers fail to ensure that staff maintain accurate records of physical restraints.
- The manager and staff do not receive regular supervision.
- The manager has not received an annual appraisal of his performance.
- Staff do not always receive an appropriate induction when they commence work at the home.
- The workforce plan does not detail the ongoing training and professional development needs of the staff.
- The manager does not take the views of young people, parents and professionals into account in his review of the quality of care.

The children's home's strengths:

- Staff support young people to stay in contact with people who are important to them.

- Young people benefit from accessing specialist services.
- All young people have appropriate school placements.
- Young people have well-planned admissions that enable them to quickly settle into their new home.
- Staff help young people to develop their independence skills in keeping with their age.

## Recent inspection history

| Inspection date | Inspection type | Inspection judgement |
|---|---|---|
| This is the first inspection since registration. | | |

# 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, if the registered person considers, or staff consider, a placing authority's or a relevant person's performance or response to be inadequate in relation to their role, challenge the placing authority or the relevant person to seek to ensure that each child's needs are met in accordance with the child's relevant plans. (Regulation 5(c)) | 25/06/2018 |
| 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. (Regulation 12(1)(2)(a)(i)) | 25/06/2018 |
| The protection of children standard is that the registered person must ensure that staff understand their roles and responsibilities in relation to protecting children that are assigned to them by the registered person. (Regulation 12(2)(a)(v)) | 25/06/2018 |
| The protection of children standard is that the registered person must ensure that the premises used for the purpose of the home are designed, furnished and maintained so as to protect each child from avoidable hazards to the child's health. (Regulation 12(2)(d)) | 25/06/2018 |
| The leadership and management standard requires the registered person to ensure that staff have the experience, qualifications and skills to meet the needs of each child and to ensure that the home has sufficient staff to provide care for each child. (Regulation 13(2)(c)(d)) | 25/06/2018 |
| The registered person must make arrangements for the handling, recording, safekeeping, safe administration and disposal of medicines into the home. (Regulation 23(1)) | 25/06/2018 |
| The registered person must recruit staff using recruitment procedures that are designed to ensure children's safety. (Regulation 32(1)(3)) | 02/07/2018 |
| The registered person must ensure that each employee completes an appropriate induction (Regulation 33(1)) | 25/06/2018 |
| The registered person must ensure that all employees undertake | 02/07/2018 |

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| appropriate continuing professional development (Regulation 33(4)(a)). This is in relation to training to raise awareness of the 'Prevent' duty, online safety and first aid. | |
| 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 the name of the child, details of the child's behaviour leading to the use of the measure, the date, time and location of the use of the measure, a description of the measure and its duration, details of any methods used or steps taken to avoid the need to use the measure, the name of the person who used the measure ('the user'), and of any other person present when the measure was used, the effectiveness and any consequences of the use of the measure and a description of any injury to the child or any other person, and any medical treatment administered, as a result of the measure. (Regulation 35(3)(a)(i)(ii)(iii)(iv)(v)(vii)(vii)) | 01/06/2018 |
| The registered person must ensure that, within 48 hours of the use of the measure, the registered person, or a person authorised by the registered person to do so, has spoken to the child about the measure, has signed the record to confirm it is accurate and within 5 days of the use of the measure adds to the record confirmation that they have spoken to the child about the measure. (Regulation 35(3)(b)(i)(ii)(iii)) | 01/06/2018 |
| The registered person must maintain records ('case records') for each child that include the information and documents listed in Schedule 3 (Regulation 36(a)). This is with particular reference to obtaining copies of young people's statutory health assessments. | 01/06/2018 |
| The registered person must maintain in the home the records in schedule 4 (Regulation 37(2)(a)). This includes a copy of the staff duty roster of persons working at the home, and a record of the actual rosters worked. | 01/06/2018 |
| The registered person must complete a quality of care review by establishing and maintaining a system for monitoring, reviewing and evaluating the feedback and opinions of children about the children's home, its facilities and the quality of care they receive in it. In particular, the system referred to in paragraph (2) must provide for ascertaining and considering the opinions of children, their parents, placing authorities and staff. (Regulation 45(2)(b)(5)) | 02/07/2018 |

## Recommendations

- Ensure that there is a workforce plan in place which can fulfil the requirements of Regulation 16, Schedule 1. ('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: requires improvement to be good**

This home was registered in July 2017. Since registration, three young people have moved into the home. A planned introduction to the home has helped young people to feel at ease and settle in quickly. One young person told the inspector, 'I got to visit the home before I moved in so I could meet everyone. It helped me feel comfortable.'

Relationships between staff and young people are developing. One young person told the inspector, 'The staff are nice. We are still getting to know each other. I get on with a lot of the staff very well.'

Staff maintain good communication with young people's teachers. All young people have suitable education placements and staff work hard to ensure that young people attend school on a regular basis. For example, staff transport one young person a considerable distance to school on a daily basis. A teacher told the inspector, 'The team genuinely care for the young people and want the best for them. They are prepared to go the extra mile. They bring him in and have never griped about it. There's really good communication. We couldn't ask for anything more supportive.'

Young people have good physical health and attend routine appointments with the dentist and the optician. When young people need support from more specialist services, such as child and adolescent mental health services or substance misuse services, the manager ensures that referrals are promptly made.

Young people have the opportunity to choose their activities. As a result, young people have accessed a variety of experiences. For example, young people get the chance to go trampolining, attend boxing, go swimming and attend the gym. This helps young people to keep active and supports a healthy lifestyle.

Staff help young people to develop their independence skills in keeping with their age. One young person shared with the inspector, 'I'm doing my own washing and I generally shop and cook for myself. On weekends, I join in with the meal plans for the home. We sit together and eat, which is good.' This helps to equip young people with the skills they need for adult life.

Young people are supported to have contact with family and friends, in keeping with their care plans. When contact does not work out as planned, staff are sensitive to the impact that this can have on young people. A young person told the inspector, 'I am supported to have contact, but I've been let down by [family name] at least three or four times. Staff try to make me feel better about it and my social worker has been dealing with it.'

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

Young people say they feel safe. Weekly young people's meetings provide young people with the opportunity to share their thoughts and opinions, and to choose meals and activities. Information on display around the home ensures that young people know how to complain and how to access an advocate should they need to. There have been two complaints from a young person and one from a parent. Each complaint has been resolved in a timely way and to the satisfaction of the complainant. Young people are comfortable in each other's company and there have been no incidents of bullying.

Staff are able to talk about the action they would take should they have a safeguarding or whistle-blowing concern.

Staff use individualised incentive schemes, rewards and consequences to encourage young people to display positive and responsible behaviour. Staff have training in behaviour management techniques, and are patient and skilful in their approach to managing challenging behaviour. For one young person, this has resulted in a decrease in aggressive and violent behaviour.

There have been four allegations made by young people about the conduct of staff. The registered manager has taken appropriate action and notified the relevant agencies, including the designated officer for the local authority, social workers and Ofsted. This means that the safety of young people is increased through external oversight of the conduct of the home.

Staff receive online training in relation to the receipt, administration and storage of medication. However, there is no written guidance for staff on the administration of medication when a young person returns home late or appears under the influence of an illegal substance and/or alcohol. Furthermore, the arrangements for the administration of prescribed medication and the arrangements for the storage of controlled medication are not in line with the organisation's medication policy. The absence of guidance to inform staff practice and the lack of adherence to organisational policies increase the likelihood of medication errors and risks to young people's health and well-being.

Young people's plans and risk assessments are individualised. However, risk assessments do not identify all of the known risks posed to young people. For example, one young person's risk assessment does not reference that he has previously stolen a car. Risk assessments lack key information. For example, one young person is at risk of self-harm, but there is no detail about how the young person self-harms. In addition, one young person has been assessed as being at risk of child sexual exploitation by a specialist agency. However, the home's risk assessment does not show how it takes into account the recommendations of the specialist assessment to help increase the young person's safety. Furthermore, there have been a number of incidents when young people have been missing from the home. Missing-from-care risk assessments guide staff practice

and staff are able to talk in detail about the action needed when a young person goes missing from the home or free time. However, for one young person it is not clear what action staff should take when she goes missing from college. In addition, an administrative shortfall has meant that the risk assessment includes conflicting information about the time for reporting the young person missing to the police. A lack of attention to detail in the development of young people's risk assessments makes it difficult for staff to understand the full range of risks for each young person, and to take the required action.

Routine servicing of electrical and firefighting equipment ensures that the premises is kept well maintained and in working order.

## The effectiveness of leaders and managers: inadequate

The registered manager has been in post since the home was registered in July 2017. He is working towards a level 5 diploma in leadership and management, and is anticipated to complete the award within the timescales required by regulation.

Since the home opened, there have been significant changes to staffing, with seven staff leaving the home and six new staff joining. The manager has tried to manage this change thoughtfully, by covering gaps in the rota with regular agency staff and by using staff from within the organisation. However, the turnover of staff has been high and the manager recognises the effect this change has had on the consistency of the care and support given to young people. A young person told the inspector, 'The constant changeover of staff is a bit annoying, as you might not always know the people and they don't know you. It's awkward.'

In addition to the manager, the home has two team leaders, three residential care workers and two night staff. All staff are still in their probation periods. As a result, none of the new members of staff have commenced the level 3 qualification in residential childcare. Staff are motivated and enthusiastic about their work. However, overall, staff lack the experience and skills necessary to meet young people's complex needs. Five staff have no previous experience of working with young people in residential care and three have no prior experience of working with young people with complex emotional and behavioural needs. As a result, staff lack the professional curiosity to notice the potential indicators that a young person may be at risk of exploitation. The manager recognises that the lack of experience in the staff team is a shortfall, and understands that the development of staff is central to ensuring that young people achieve good outcomes.

Staff speak highly of the manager. A member of staff shared with the inspector, 'He is firm but fair. He is supportive. If I'm unsure I can ask and he will give guidance.' However, support for staff and workforce planning are significant weaknesses. Not all staff have received inductions into the home or into their role before they have started working with young people. In addition, there is no specific induction for team leaders to help them understand their specific roles and responsibilities within the team. The

manager has a workforce development plan. However, this does not detail the training completed or the ongoing training and professional development needs of staff. Consequently, there are no plans for staff to receive training in key areas such as first aid, the 'Prevent' duty or online safety. Staff do not receive regular supervision. The significant lack of attention to the induction, support and development of the workforce means that staff do not have sufficient opportunities to understand their responsibilities regarding the care and protection of young people, or to plan how they will develop their own practice.

The registered manager receives practice-related supervision from the responsible individual. However, the frequency of supervision is not in line with the company's policy. In addition, the registered manager has not had an annual appraisal of his performance, despite the fact that he has worked for the organisation for 15 months. Consequently, opportunities for the registered manager to review his practice and plan for his continued development are limited.

Managers have failed to ensure that they appropriately vet staff prior to them commencing their work with young people. One member of staff started their employment without the required references. Gaps in the employment histories of two staff were not checked. One agency member of staff with a history of convictions began work without an assessment of their suitability for the role. A lack of diligence in vetting means that there is the potential for young people to be exposed to care from unsuitable adults.

Staff say they enjoy working at the home and that the team is becoming more stable. However, shortcomings in rota planning mean that there are not always enough staff on duty to meet the needs of the young people. A member of staff shared with the inspector, 'We could do with another person. There are times when [name of young person] doesn't get a look in. We wouldn't manage if they were all here and they all had activities planned.' Insufficient staffing limits the opportunities for staff to engage with young people to help reduce risk and enhance young people's experiences.

Management oversight of records is lacking. Staffing rotas are not clear about the actual times that staff are on duty. This means that it would be difficult to identify who had been in contact with young people should this information be needed in the future. In addition, two young people's records do not contain copies of their annual health assessments. This means that staff do not have access to all of the available information needed to inform young people's care.

Poor oversight by managers means that records of physical intervention do not meet regulatory requirements. During the inspection, the inspector became aware of three incidents of physical intervention that had no corresponding records. When records are completed, managers fail to ensure that this is done appropriately. For example, one record did not specify the duration or the location of the restraint. For all three incidents, there were no records to show that the members of staff or the young people were spoken to following the physical restraints. This means that safeguarding issues go unidentified and opportunities to understand the reasons for young people's behaviour

are lost.

The registered manager and the staff maintain good relationships with other professionals, including social workers and health professionals. A social worker told the inspector, 'The communication and working with professionals is good. Considering what they are up against, they are doing a good job.'

However, when the registered manager has identified concerns in relation to the availability of services to meet young people's needs, he has not escalated his concerns. For example, the manager has not escalated his concerns about the fact that return home interviews do not always happen when young people return back home after being missing. In addition, a concern about a significant delay in the local authority assessing a young person's access to school transport has not been raised with senior managers in the local authority. Failing to hold partners to account means that young people do not have access to the services they need to promote their welfare in a timely way.

The registered manager and staff do not give sufficient attention to the upkeep of the physical environment. Aspects of the physical environment require attention. For example: the kitchen's hot tap is leaking from the stem when it is turned on; walls in the dining area are dirty; a window to patio doors in the dining room is marked; and the carpet is coming away at the entrance to a young person's bedroom. There are holes in tiles on the kitchen floor and there is no lightbulb in the ceiling light above the fridge. Kitchen cupboards, skirting boards and doors are grubby. Some young people's bedrooms are extremely unkempt. In one young person's bedroom, a blind is missing from a window; there is a burn mark on a window restrictor; and there is a hole in the inside of the bedroom door. Young people's belongs are scattered across their bedroom floors. This lack of attention to the home environment detracts away from young people living in a homely and comfortable environment.

Regular visits by an independent visitor and the registered manager's review of the quality of care help him to have some understanding of the strengths and development areas for the home. However, the manager has not established a system for gaining and considering the views of young people, partner agencies and parents as part of his review of the care. This compromises the home's development plan, as the manager has not taken into consideration the opinions of others about when the home is doing well and when it needs to improve.

## 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:** 1253711

**Provision sub-type:** Children's home

**Registered provider:** Beacon Child Care Limited

**Registered provider address:** Hazlewoods, Windsor House, Bayshill Road, Cheltenham GL50 3AT

**Responsible individual:** Hilary Grimshaw

**Registered manager:** James Henderson

## Inspector

Alison Cooper: social care inspector

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