1258769

Roc Northwest Ltd

Monitoring visit
Inspected under the social care common inspection framework

Information about this children's home

This home is one of several homes operated by a private provider. The home provides care and accommodation for up to 29 children who have disabilities and/or behavioural needs. Accommodation is provided across nine individual units on the site.

Inspection date: 21 and 22 August 2019

This monitoring visit

This children's home was judged as requires improvement to be good at the full inspection on 8 and 9 April 2019. Requirements were set in relation to safeguarding, risk management and leadership.

Concerns were identified by Ofsted following an increasing number of notifications of significant incidents that had occurred at the home since the full inspection. As some of the incidents indicated shortfalls in safeguarding practice, a monitoring inspection was carried out.

During the monitoring visit, managers were able to demonstrate that some young people have made good progress as a result of the care and support they receive. Parents and social workers largely reported the view that the service had made improvements in recent months. One young person spoke highly of the staff and said she loved living at the home. She said that staff helped her, especially when she was feeling upset or angry.

However, evidence was found of ongoing breaches of regulations relating to safeguarding, risk management and leadership.

Since the last inspection, there have been a number of adverse incidents at the home, some of which have resulted in physical and emotional harm to young people. Some of the incidents have occurred as a direct result of poor or unsafe practice, which in some cases has not been identified by managers or addressed in an effective manner.

There have been a large number of physical interventions at the home. Some of

these incidents have led to high-level restraints of young people, which are potentially harmful to young people's physical and emotional well-being. Significant shortfalls in the quality of recording of some restraints mean that managers are not able to evaluate or monitor incidents effectively.

Managers have made efforts to reduce the use of physical intervention. They have attempted to monitor trends, patterns and themes and reviewed some young people's behaviour support plans to help identify more proactive strategies. However, this positive work is being undermined by poor decision-making and poor practice on the part of some staff.

Safeguarding practice is inconsistent and not good enough to ensure that young people are protected from harm. In one case, an allegation of abuse to a young person was raised by a staff member but not referred to the appropriate agencies or investigated. This lack of action means that the young person, and others, continued to be at risk of further harm.

At the last inspection, shortfalls were identified in the management of risks to young people's safety and well-being. During this monitoring visit, it was identified that there has not been sufficient improvement in this area. There is ongoing failure to work in accordance with risk management plans. For example, a serious incident recently occurred when a young person was being supported by a single staff member, despite his risk management plan stating he should be supported by two staff members at all times. In addition, risk management plans are not always reviewed or updated following serious incidents. This means that staff may not have sufficient information to support young people in a safe and effective manner.

Managers have attempted to make improvements to quality assurance and monitoring systems. However, these have not had a discernible impact on the quality or safety of care. Furthermore, there is ongoing failure to eradicate poor practice and reduce incidents that compromise young people's safety and well-being.

Investigations of adverse incidents are not consistently robust. In some cases, key shortfalls are not identified. For example, an investigation relating to a serious incident failed to identify poor decision-making on the part of managers. In some examples, conclusions to investigations have been reached with no rationale. Failure to carry out robust investigations means that opportunities to learn and improve practice are lost.

As a result of the monitoring visit, three requirements have been raised, which are all subject to compliance action. Ofsted has received an action plan from the provider which details increased senior management presence in all areas of the home. In addition, the provider has sourced some external advisers to work with managers and staff in an attempt to increase safety and quality. Ofsted will continue to closely monitor the home and compliance with the requirements raised.

Recent inspection history

Inspection date	Inspection type	Inspection judgement
09/04/2019	Full	Requires improvement to be good
16/01/2019	Interim	Sustained effectiveness
17/10/2018	Full	Requires improvement to be good
30/01/2018	Full	Outstanding

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

Statutory requirements

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

Requirement	Due date
*12: The protection of children standard 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; are familiar with, and act in accordance with, the home's child protection policies. Regulation 12(1)(2)(a)(i)(iii)(vii)	20/09/2019
*13: The leadership and management standard The leadership and management standard is that the registered person enables, inspires and leads a culture in relation to the children's home that— 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; demonstrate that practice in the home is informed and improved by taking into account and acting on— feedback on the experiences of children, including complaints received; and use monitoring and review systems to make continuous improvements in the quality of care provided in the home. Regulation 13 (1)(b)(2)(c)(g)(ii)(h))	20/09/2019
*35: Behaviour management policies and records	20/09/2019

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— a description of the measure and its duration. (Regulation 35 (3)(a)(iv))	

*These requirements are subject to a compliance notice.

Information about this inspection

The purpose of this visit was to monitor the action taken and the progress made by the children's home since its last Ofsted inspection.

This inspection was carried out under the Care Standards Act 2000.

Children's home details

Unique reference number: 1258769

Provision sub-type: Children's home

Registered provider: Roc Northwest Ltd

Registered provider address: 5th Floor, Metropolitan House, 3 Darkes Lane, Potters Bar, Hertfordshire EN6 1AG

Responsible individual: Katie Stephens

Registered manager: Post vacant

Inspectors

Marie Cordingley, social care inspector

Sophie Thomson, social care inspector

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