Serendipity Family Assessment Centre

Serendipity (Devon) Ltd, 24 Victoria Road, Exmouth, Devon EX8 1DW

Inspected under the social care common inspection framework

Information about this residential family centre

This residential family centre provides parenting assessments for up to six families. The families are accommodated in two houses a very short distance apart. Parents must be at least 16 years old, and the service will accept children up to 10 years old.

Inspection dates: 22 to 23 August 2017

Overall experiences and progress of children and parents, taking into account	inadequate
How well children and parents are helped and protected	inadequate
The effectiveness of leaders and managers	inadequate

There are serious and widespread failures that mean that children and parents are not protected or their welfare is not promoted or safeguarded, and the care and experiences of children and parents are poor.

Date of previous inspection: 20 June 2017

Overall judgement at last inspection: inadequate

Enforcement action since last inspection:

A compliance notice was issued following the inspection of 20 June 2017. A monitoring visit took place on the 24 July 2017. The compliance notice was found not to be fully met, and was reissued.

Key findings from this inspection

This residential family centre is inadequate because:

- The compliance notice reissued at the monitoring visit on 24 July 2017 remains unmet, following this inspection. A 12-week notice of restriction of accommodation has been issued by Ofsted, because of serious safeguarding failures found at this inspection.
- Placement plans still fail to clearly document supervision requirements. This leads to confusion and lack of clarity about when parents should call staff to observe them and what level of staffing is required to ensure the safety of parents and their children. The first page of the plan, named 'What we are worried about', details parents' previous childcare failings and the reasons that they are undergoing assessment. Parenting shortfalls are described in negative and sometimes judgemental language. One parent described reading this plan as being 'penalised'.
- The staff fail to protect children and report to the relevant authorities when children are found to have unexplained injuries. A baby was found by the staff to have an unexplained injury. The parent of the baby has made a complaint that this injury occurred while the baby was in the care of staff. The injury was noted by the staff on duty, yet they failed to report it to the relevant child protection authorities, in line with child protection procedures, or to seek medical attention for the baby. This left the baby at risk of further possible harm. The manager failed to report the injury to the placing authority. When the placing authority became aware of the injury from a third party three days later, it notified the service. A staff member then attempted to investigate the incident themselves, rather than reporting it to the relevant safeguarding authorities.
- Leaders and managers continue to employ agency staff as the only worker awake during the night. This lone worker monitors up to three families all night through closed-circuit television (CCTV). The agency members of staff often lack the necessary experience to undertake this role. If the lone worker has to attend to a family during the night, there is no member of staff observing the other families as required. Over the past four weeks, agency staff have been the lone night-waking staff member on 39% of shifts. On four night shifts, both the waking and the sleeping-in member of staff were from an agency. This shortfall compromises the safety of children and families.
- Management oversight of the residential family centre continues to be poor. A development plan is not yet in place and there is little evidence to show how the managers intend to deal with the serious shortfalls in safeguarding practice.
- At the previous inspection, parents raised concerns about the quality of support provided by two agency workers. These concerns were passed to managers by the inspectors. Managers have failed to investigate these concerns or take them seriously. One of the agency members of staff whom the parent had concerns about is being interviewed for a full-time position at the family centre. The

parents' concern has not been taken into account during the recruitment process.

The residential family centre's strengths:

- Placement plans in pictorial form are available to parents who have a learning disability.
- A consultant has been recruited and is conducting a review of monitoring and recording systems and assisting the manager to improve the service. An improved format for parents' meetings has been put in place, and the aim is that the views of parents will feed into the development plan through this forum.
- Parents report that they are well supported by the core staff, whom they find helpful and supportive.

What does the residential family centre 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, Residential Family Centre Regulations 2002 and the national minimum standards. The registered person(s) must comply within the given timescales.

Requirement	Due date
Ensure that whenever practicable, the wishes and feelings of residents are taken in to account when making decisions about their health and welfare, or the manner in which they are treated. In particular, that residents' views are incorporated in to the quality monitoring processes. (Regulation 10(2))	22/09/2017
Ensure that proper provision is promoted and put in place regarding the health and welfare of residents. In particular, that any health care needs are clearly documented in plans, together with the actions staff need to take to address and meet these identified health needs (Regulation 10(1)(a))	22/09/2017
Ensure that the child protection policy and procedure is implemented through clear guidance and documentation in placement plans and safeguards children accommodated in the residential family centre from abuse and neglect. In particular, that staff follow this procedure when a child protection concern is discovered and report any unexplained injuries to the relevant authorities in a timely manner. (Regulation 12(1)(a))	22/09/2017
Ensure that before providing a family with accommodation in the residential family centre, or if that is not reasonably practicable, as soon as possible thereafter, draw up in consultation with the placing authority a written plan setting out in particular, an assessment of risks which a resident at the residential family centre may present to their own health, safety and welfare or that of other residents or staff at the centre. Ensure that an impact risk assessment is undertaken to ensure that it is safe for the family to move in with the centre's other residents. It must inform the level of supervision necessary for the parent and be kept under review. (Regulation 13(1)(b))	22/09/2017
Ensure that the aims, objectives, and intended outcomes of the placement are documented in the placement plan. In	22/09/2017

particular, supervision and protection to be provided at the centre regarding how the child's welfare will be promoted. This plan must set out the level of supervision required and how this will change in time dependent on progress. (Regulation 13(1)(b))	
Ensure that an assessment or monitoring of parents' capacity to respond to children's needs and to safeguard their welfare is monitored or assessed by a suitably qualified person in accordance with the requirements of this regulation. (Regulation 13A(1))	22/09/2017
Ensure that all complaints made under the complaints procedure are fully investigated. (Regulation 20(2))	22/09/2017
The registered person shall not employ a person to work at the residential family centre unless that person is fit to work at a residential family centre. In particular, that the suitability of agency staff is checked and evidenced in the records of recruitment. (Regulation 16(1)(a)(3)(a)(b)(c)(d))	22/09/2017
Ensure that a system is established and maintained for reviewing at appropriate intervals and improving the quality of care provided at the residential family centre. (Regulation 23(1)(a)(b))	22/09/2017

Inspection judgements

Overall experiences and progress of children and parents: inadequate

Placement plans fail to clearly detail how progress will be evidenced. It is unclear what steps parents are expected to take to build on identified strengths, or how the identified parenting shortfalls will be addressed. The plans do not contain guidance for staff on how best to work with parents who have a learning disability. Pictures are used to help parents who have a learning disability to understand the plan, but previous expert assessments are not used to guide staff in what will be the most effective way to support a parent who have a learning disability. The first page of the plan is called 'What we are worried about'. The purpose of this is to give parents an understanding of why their parenting is being assessed. The language used in this section of the plan is very negative. For example, one plan details how the parents have failed in the past with their other children, who have been taken into care. It also prejudges parents' abilities, such as 'you have a learning disability and this makes it more difficult for you to care for your child', 'You have difficulties budgeting' and 'you didn't play with (your child who was removed) enough'. One parent reported that she felt 'penalised' by this part of the plan.

Plans lack sufficiently clear guidance for staff about the level of supervision that each family needs. Exit planning gives four different options rather than the outcome that parents will work towards if all goes well with the assessment, and then the contingency plan if there are concerns. There is a generalised statement in plans about how supervision will be reduced if assessments are positive. However, there is no clear guidance as to how supervision reduction will be planned to emulate a more realistic living situation outside of the family centre and to encourage progress. If supervision is not reduced, there is no clear statement on whether this approach has been considered and, if not, the reason why.

The staff continue to fail to document all the healthcare needs of families and children and how these will be met. One parent has recently been taken to hospital because of a medical condition. There is information available about the condition, but the plan does not document how staff should most effectively support her with her healthcare needs.

Concerns raised by parents at the previous inspection about two agency members of staff and the behaviour of another parent have not been acted upon by managers. One residents' meeting has taken place since the previous inspection. The outcomes of this meeting have not yet been incorporated into quality monitoring systems.

One parent has had their assessment extended by two weeks, as staff failed to complete the parent's report in time for the court date. The manager states that this was because of time spent by the staff in addressing the shortfalls identified by Ofsted at the previous inspection. Following discussion with staff, it is evident that the delay was due to a key member of staff being on leave. Because of this delay,

the parent has had to spend an additional two weeks away from her home town, remaining at the family centre even though her assessment is complete. The parent said that she hates being at the family centre, miles away from home. She also commented that she is fed up that the placement was extended because the report was not written on time.

A placing authority social worker commented that, in their view, reports are 'not hugely detailed', and could contain more analysis and less description. The quality of the attachment between the parent and child is now included in reports. For example, the report for one family now documents the quality of eye contact between parent and child, rather than focusing on practical parenting tasks, such as feeding and changing.

The staff have re-ordered placement plans and improved some areas. The staff are now obtaining parents' signed agreement to the plan. The child's legal status and social worker contact details are now easily found. Each plan has a 'chase' section, which evidences what action has been taken by staff to obtain the necessary information from the placing authority. It also details contact meetings with other involved professionals.

Parents commented positively on the permanent staff team. One parent said 'staff have been helpful'. Another said 'the staff are lovely and welcoming'.

How well children and parents are helped and protected: inadequate

The managers and staff fail to follow child protection policy and procedures and protect children effectively. This leaves children at risk of harm. One baby, known to be at high risk of rough handling from its parent, was found by the staff to have sustained an unexplained injury. The staff on duty noted the injury in the logs yet failed to take necessary action and refer it to the placing local authority and relevant child protection authorities or to seek medical attention for the baby. Senior staff at the family centre did not become aware of the injury until three days later. They also failed to report it. The injury was finally reported to the placing authority by the staff at the parent's new placement three days after it was discovered. The parent also made a complaint to the family centre on the day that they left, blaming the staff for the injury. An email from the placing authority following the discovery of the injury stated: 'I am concerned as yet again no incident log was received.' A senior member of staff attempted to investigate the incident themselves. They had to be told repeatedly by inspectors to stop, due to the risk of their contaminating the evidence. Managers and staff were unclear and confused about the progress of the safeguarding referral and informed inspectors that the incident had been reported when it had not.

Placement plans and risk assessments do not clearly document the levels of supervision that the families should receive, as agreed with the placing authority, to ensure the safety of babies and children. One plan states that at night a parent must inform staff if they are undertaking a parenting task such as feeding or changing

their child, as a staff member must be present. Another plan states that a parent does not need to alert a staff member. One parent commented that she called for a member of staff to observe her feeding her baby, but they did not come, so she fed the baby anyway. She commented that she is aware that staff should be supervising all tasks in person.

One placing authority reported that it was their understanding that the CCTV was being watched all of the time by the staff. At night, one member of staff is sleeping and one is monitoring the CCTV. Since the last inspection, this monitoring has regularly been by an agency member of staff. Some placing authorities understand that their family is being monitored at all times. However, if the lone member of staff attends to another family or takes a break, the other families are not being observed. The waking member of staff does rewind the CCTV, but if a child was being harmed it would be too late for the staff to intervene.

Managers have failed to obtain the recruitment records for agency staff who are employed at the family centre. Managers rely on the brief information that is supplied by the agency. Checks are not undertaken to ensure that these staff are suitably qualified and experienced to work with vulnerable children and families. This particular role carries a very high level of responsibility.

Managers fail to take concerns and complaints from parents seriously and do not investigate them thoroughly. At the last inspection, parents raised concerns to the inspectors about two agency staff members and another parent. These have not been discussed with the parents and no follow-up action has been taken. One of the agency staff who was the subject of a concern was recently interviewed for a full-time position at the centre. The concerns raised by the parents have not been used by managers to inform the decision on whether to employ this person.

Two families have been admitted to the family centre since the previous inspection. Impact risk assessments are not being undertaken by managers. Consequently, consideration has not been given to how any risks associated with a new family may impact on the existing families.

The manager has given consideration to repositioning the CCTV cameras and taken appropriate action. They no longer show parents' beds. This action promotes the privacy and dignity of parents. A new and improved policy is in place regarding the use of CCTV. Parents sign to state that they agree with the family centre's policy on the use of CCTV.

The effectiveness of leaders and managers: inadequate

The compliance notice reissued following the monitoring inspection was found at this inspection not to have been fully met. Due to concerns identified about the safety of children and families, a 12-week notice of restriction of accommodation has been issued by Ofsted. No families are to be admitted to the service until Ofsted is satisfied that serious shortfalls have been addressed.

A consultant has recently been appointed by the manager. This is to assist her and the registered individual in the improvement of recording and monitoring systems in the family centre. This work has just started and the priority has been to improve placement plans. A development plan that details identified shortfalls, and how and when these will be dealt with by leaders and managers, is still not in place for the service.

Managers continue to rely on a high level of use of agency staff. In the last month, 39% of overnight shifts were covered by agency staff. One parent said: 'it often happens that you make the call for staff to observe and they don't come in. This happens with agency staff.' Another parent reported that they have had to become used to many different staff faces, with about 30 to 40 different staff. This shortfall, together with a lack of detailed guidance for staff in placement plans about how best to support parents, is leading to a lack of consistency.

Reports for the court following a parenting assessment continue to be of mixed quality. Leaders and managers are looking at how to involve parents in quality assurance systems and how best to gather their views. One residents' meeting has taken place since the previous inspection. However, the views of parents have yet to be included in improving the quality of care in the family centre.

Feedback from staff is mixed. One member of staff reported that their views were not listened to by managers. They report that guidance for staff is inconsistent. The member of staff said that 'staff need their confidence built'. Other members of staff report that supervision is now taking place regularly.

Managers have written an action plan to address the shortfalls identified at the previous inspection. Six of the 15 requirements made at the previous inspection have been met.

Placing social workers report that communication from the family centre has improved and, since the previous inspection, regular weekly updates have been received. Reports from monthly monitoring visits by the registered individual are now being sent to Ofsted.

Information about this inspection

Inspectors have looked closely at the experiences and progress of children and parents. Inspectors considered the quality of work and the difference made to the lives of children and parents. They watched how professional staff work with children and parents and each other and discussed the effectiveness of help and care provided. Wherever possible, they talked to children and parents. In addition, the inspectors have tried to understand what the residential family centre knows about how well it is performing, how well it is doing and what difference it is making for the children and parents 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 Residential Family Centre Regulations 2002 and the national minimum standards.

Residential family centre details

Unique reference number: SC445624

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