SC020558

Registered provider: Overley Hall School Limited

Full inspection

Inspected under the social care common inspection framework

Information about this children's home

This privately owned residential school is registered as a children's home to accommodate up to 22 young people who have severe learning disabilities and/or sensory impairment, challenging behaviours or autism spectrum disorders. Young adults may stay beyond the age of 18 to complete their education. A separate residential home for young adults, registered with the Care Quality Commission, also operates in the school grounds.

A new manager has been in day-to-day charge since November 2017. The new manager holds a level 4 diploma in management. She has submitted her application to be registered with Ofsted.

Inspection dates: 9 to 10 May 2018

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 failures that mean children and young people are not protected or their welfare is not promoted or safeguarded.

Date of last inspection: 3 October 2017

Overall judgement at last inspection: good

Enforcement action since last inspection: none

Recent inspection history

Inspection date	Inspection type	Inspection judgement
03/10/2017	Full	Good
27/02/2017	Interim	Sustained effectiveness
21/12/2016	Full	Good
29/03/2016	Interim	Sustained effectiveness

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
The registered person must ensure that staff ensure that each child is given appropriate advocacy support. (Regulation 7(2)(b)(iii))	06/06/2018
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; 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; take effective action whenever there is a serious concern about a child's welfare. In particular, the standard in paragraph (1) requires the registered person to ensure that the premises used for the purposes of the home are designed, furnished and maintained so as to protect each child from avoidable hazards to the child's health and that that the effectiveness of the home's child protection policies is monitored regularly. (Regulation 12(1), (2)(a)(i)(iii)(v)(vi)(d)(e))	06/06/2018
The registered person must use monitoring and review systems to make continuous improvements in the quality of care provided in the home. (Regulation 13(2)(h))	06/06/2018
The registered person must recruit staff using recruitment procedures that are designed to ensure children's safety. The registered person may only employ an individual to work at the children's home if full and satisfactory information is available in relation to the individual in respect of each of the matters in Schedule 2. (Regulation 32(1), (2)(a), (3)(d))	06/06/2018
The registered person must ensure that all employees receive practice-related supervision by a person with appropriate experience. (Regulation 33(4)(b))	06/06/2018
The registered person must maintain records ("case records") for each child. (Regulation 36(1)(a)(b)(c))	06/06/2018

Inspection judgements

Overall experiences and progress of children and young people: inadequate

Poor practice and ill-formed decisions have allowed incidents to escalate, with a detrimental impact on young people's welfare and safety. Staff are often confused about what is expected of them and fail to protect young people from harm.

Young people have experienced a high turnover of staff and this has caused some young people to experience instability.

The physical condition of the home is poor. Some young people's bedrooms lack appropriate furnishings and are in need of decoration. These shortfalls detract from young people having a homely environment to live in and to enjoy.

Staff do not always help young people to take the necessary actions to ensure that they receive services that they are entitled to. For example, one young person was denied access to an advocacy service. This meant that this vulnerable young person was not able to make his views and feelings fully known.

Visitors are not made aware of young people's food allergies. This means that young people are not safeguarded from people bringing into the home food that could have detrimental impact on their health.

Staff work closely with families to ensure that young people are able to stay in touch with people who are important to them. This includes staff providing the practical support to make this contact possible.

Staff work in partnership with teaching staff to minimise disruption to young people's learning. For example, individualised arrangements are in place to help young people to transfer to and from school each day. These arrangements enable each young person to attend school regularly and to engage in meaningful learning.

Young people enjoy a range of activities to help them to keep fit and healthy. Within the school grounds there is play equipment, including a trampoline, indoor play area and swings. Young people develop their social experiences through day trips, attending parties and going for walks with staff.

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

A number of serious incidents have occurred over the last four months, putting vulnerable young people at significant risk. There is a persistent absence of professional curiosity among staff, which means that incidents are allowed to escalate. Staff make poor decisions which result in compromising young people's basic rights. For example, on one occasion a decision was made to place a young person in distress in a padded room for one night, and then in the 'medi cinema' on a mattress for a further three

nights, with no access to a shower or bath.

Staff fail to understand the basic principles of safeguarding and the need for all members of staff to be vigilant in keeping young people safe. Staff do not have a clear understanding of their accountability to safeguard vulnerable young people, especially when they see poor care practice. Instead of immediately making a referral, staff have delayed telling managers. This delay has allowed poor practice to continue and has put young people at further risk of harm. When staff have finally told managers, swift action has been taken, including making the necessary referrals.

Staff fail to ensure that risk assessments for young people are followed. For example, on one occasion, the staff ratios do not correspond to young people's individual risk assessments. This leaves young people without the required supervision and support, which they need to stay safe.

Staff undertake regular health and safety checks and follow a range of safety procedures to protect young people from potential hazards. These include fire drills to ensure that young people know what to do in case of an emergency. There have been no instances when young people have gone missing from the home.

Since the last inspection, there have been improvements in the recording of physical incidents. On the occasions when restraint is necessary to prevent serious harm, there is now a careful debriefing and analysis of each incident. The records made by staff when a physical intervention has occurred receive management oversight, and young people have the opportunity to talk about the restraint. This is helping to ensure that the use of restraint is proportionate and that both staff and young people are receiving opportunities to reflect on incidents.

The effectiveness of leaders and managers: inadequate

Internal and external quality assurance processes have not been fully effective and have failed to identify shortfalls in the home. However, the manager and her team acknowledge the shortfalls identified by this inspection, and have a clear vision and development plans for future improvements to the home. These include developments in safeguarding practice and key working. The manager has also secured funding for redecorating the home.

The requirements made at the interim inspection have been met, with the exception of the effective review of young people's case files. Managers have not ensured that young people's records contain all of the required information. For example, many young people's files do not contain the up-to-date local authority care plans. This absence of key documents means that staff are less able to provide tailored care to help to improve the well-being of young people.

Staff do not receive good-quality supervision that focuses on the needs of young people. There has been a lack of management oversight to ensure that this has taken place. This means that there have been missed opportunities to help staff to reflect on their

practice.

The home has experienced a period of instability, with changes in management, practice and staff. Staff morale is currently variable. Some staff feel that the home has improved in recent months and other staff feel that changes take place without consultation.

Leaders do not conduct safe recruitment practice. For example, the manager has not verified the identification of two staff members. This shortfall weakens safeguarding practice.

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: SC020558

Provision sub-type: Residential special school

Registered provider: Overley Hall School Limited

Responsible individual: Anita Brown

Registered manager: Post vacant

Inspector

Lisa Walsh, social care inspector

Anna Gravelle, social care inspector

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