Partnerships in Care 1 Limited

Newcombe Lodge

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service caring?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

Newcombe Lodge is a children's home that provides specialist treatment and care for people with mental ill health and self-harming behaviours to seven children and young people aged 13 to 21. The children's home is also registered with and inspected by OFSTED and at the time of the inspection the home provided accommodation for up to two children and young people under the age of 18 who are in care. The service can support up to eight children and young people in the home.

The published date on this report is the date that the report was republished due to changes that needed to be made. There are no changes to the narrative of the report which still reflects CQCs findings at the time of inspection.

Children and young people's experience of using this service and what we found.

Risk assessments had not been reviewed and guidelines to mitigate risks were not updated in response to young people's changing health needs. Care records lacked key information and had not been reviewed to ensure they contained current information about young people's health, education and social care needs.

Systems to assess, monitor and improve the service were in place but did not identify all the issues we found. Although some issues were picked up in the provider's audits these were not acted on over a significant amount of time. The provider's vision about the service was unclear and the service that was provided to young people did not align with the providers statement of purpose.

Young people were not always offered privacy in the home to ensure they received care and support in a dignified way.

Staff had received training to develop their skills and competencies, however, further face to face training was required to reflect the self harming behaviours of children and young people who lived in the home.

Young people understood how to make a complaint, however formal complaints were not recorded. Feedback questionnaires were not sent to young people, staff and professionals to provide feedback about how the service was run and the care they had received.

Staff understood how to recognise and report signs of abuse in line with the provider's safeguarding procedures and people and young people told us they felt safe.

Changes in young people's healthcare needs were identified and they had access to healthcare services. Young people were supported with their medicines as required and this was recorded in their care plans.

Young people told us that staff were supportive and their views were listened to. Young people told us they

were supported by caring staff and because of this they enjoyed living at Newcombe Lodge.

Staff spoke confidently about the management team and told us they were continually supported. Where incidents had occurred, actions were put in place to improve the delivery of the service and the actions taken to ensure lessons learnt.

Young people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

We inspected this service because this was a planned inspection based on the previous inspection findings.

We have found evidence that the provider needs to make improvements and children and young people were at risk of harm. Please see safe, effective, caring, responsive and well led domains sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Newcombe Lodge on our website at www.cqc.org.uk.

We have identified two breaches in relation to safe care and treatment and good governance. We have also made two recommendation in relation to the providers self -harm policy and complaints.

Follow up

We will request an action plan and meet with the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and Ofsted to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Inspected but not rated**
Is the service effective? The service was not always effective.	**Inspected but not rated**
Is the service caring? The service was not always caring.	**Inspected but not rated**
Is the service responsive? The service was not always response	**Inspected but not rated**
Is the service well-led? The service was not always well-led.	**Inspected but not rated**

Newcombe Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service under the Care Act 2014.

The inspection team consisted of a children's services inspector and a specialist professional advisor who carried out the inspection over two days.

The service is registered to provide accommodation and nursing or personal care as single package under one contractual agreement, and the treatment of disease, disorder and injury (TTDI). The Care Quality Commission (CQC) regulates TDDI which was looked at this during the inspection. Ofsted regulates the premises and the personal care provided in the service and we sought feedback from them before and after the inspection.

The service had a manager registered with the Care Quality Commission. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided. The inspection took place on 6 and 7 August 2019 and was unannounced.

We reviewed information we had received about the service since the last inspection. We sought feedback from Ofsted and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection. we spoke with five children and young people who used the service about their experience of the care provided. We also spoke with eight members of staff including the psychologist, two senior staff team leaders, three therapeutic workers, the deputy manager and the registered manager. Additionally, we spoke with a social worker and an independent reviewing officer who were visiting a young person on the first day of the inspection.

We checked six children and young people's care records and four young people's medicines records. We

reviewed four staff personnel files, training records, health and safety procedures, minutes of meetings, quality assurance records and policies and procedures related to the management of the service.

After the inspection we continued to seek clarification from the provider to validate the evidence we found.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that children and young people could be harmed.

Risks associated with children and young people's health and wellbeing lacked clear information about how risk should be managed to reduce the likelihood of harm. Key information in records to assess risks to young people were missing or incomplete. There was a lack of exploration about the risks to young people records in their care plans. In one case it was documented that historically the young person had been at the risk of suicide. However, this had not been discussed with the young person and there were no further explanations about how to support the young person with their emotional health and well-being needs. In a second child's record the risk assessment showed they were bullied in their previous placement and may be bullied by others in the home. However, there was a lack of guidance and control measures in the record about how staff should manage this risk to keep the young person safe from abuse. One young person was assessed as being at the risk of child sexual exploitation (CSE) and substance misuse. However, the actions taken to reduce to likelihood of the risks re-occurring were not recorded in their care plan to keep the young person safe in harmful situations.

Information contained in children's and young people records were repetitive and inconsistent. There was an element of copying and pasting information. For example, it was recorded that a young person had a history of absconding and sexualised behaviour. However, another young person's name was recorded and name of the person this information related to had been scratch out. This meant we could not be assured if the information was accurate and correctly attributed to the child.

We found no evidence that young people had been harmed, however the provider did not have appropriate risk assessments on young people which is necessary in order the service to carry out TDDI in a safe way. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard children and young people from the risk of abuse. Safeguards were in place to protect children and young people from abuse and the provider followed their procedures. The registered manager was the designated safeguarding lead for the home and had completed Level 4 training for safeguarding children and adults. Staff had received training in safeguarding children and adults as part of their training programme and demonstrated an understanding of how to recognise abuse, and what to do to protect young people if they suspected abuse was taking place. This was evident in the quality of the safeguarding referrals we reviewed. Information showed that when young people had made disclosures about alleged abuse, the provider had made referrals to the local authority and there was evidence of the action taken and follow up to protect children and young people from the risk of abuse.

The provider did not always notify the Care Quality Commission (CQC) when there were incidents of alleged

abuse of serious incident that took place, in accordance with the law. There was one incident that had not been notified to use in relation to sexual abuse. The registered sent the notification to the CQC after the inspection. Other notifications the CQC had received included staff conduct, children and young people missing from the home and hospital admissions due to self-harm. Referrals were made the relevant local authority and there was evidence of follow up and action by the registered manager.

Staff had completed incident forms when young people had self-harmed. In three cases we found that an investigation had taken place to show if physical or verbal de-escalation techniques had been used and if a safeguarding referral had been made. Serious incident debriefs were followed up with staff within the required timeframe of 72 hours to check if they required any further support. There was consideration of the alternative strategies staff could have used to manage young people's risky behaviours.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of children and young people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff completed an induction to help them support children and young people in the home. All new staff completed a children's workforce induction standards and were required to shadow a member of the permanent staff team until they had completed children and adults safeguarding, medicines and Management of Actual or Potential Aggression (MAPPA) training. Staff relied heavily on relational security and knowing the young person's potential triggers but would also benefit from adopting a dialectic behaviour therapy (DBT) strategy to reduce the risk of self-harm. The psychologist had some experience of DBT and we were told there were plans to roll this out for the staff team. Training records showed that staff had completed a training programme that comprised of basic life support including choking, the Mental Capacity Act, deprivation of liberty safeguards, fire safety, moving and handling, cyber security, data protection and confidentiality. The provider was 85 % compliant overall in these topics. Some of the training programmes comprised of e-learning courses such as medicines, safeguarding and mental health. However, as there were so many children and young people self-harming, e-learning would not be enough to ensure staff developed specialist skills reflective of their needs. Wound care management and ligature cutter training had not been done and was being sourced for staff. The provider was awaiting further information about the course, however at the time of the inspection this had not been booked. After the inspection we found that the provider had carried out this training in the home, however, it is too soon to say how effective this training has been, over a period of sustained improvement.

We assessed if children and young people's needs and choices were delivered line with standards, guidance and the law. The provider's 'working with children and young people who self-harm' policy reflected the national condition of the NICE guidelines (2004 and 2011). There was flow chart to provide guidance to staff about how to respond to incidents of self-harm and the information we checked showed this was being followed. Although staff stated this information was helpful the policy required updating to include new terminology, for example, non-suicidal self-injurious behaviour (NSIB) and indirect self-harm, substance misuse, bulimia and cutting. Information showed there were recorded incidents of young people head banging and staff had acted to reduce this risk, but the guidance did not include what staff should do and when these types of incidents occurred.

We recommend the provider update their self-harm policy to reflect current terminology and incidents that occur in the home.

Children and young people had access to a psychologist who worked with young people to identify their behavioural and emotional needs and prepare their positive behaviour support plans. Strength and difficulties questionnaire (SDQ's) were used to evaluate treatment outcomes and as part of a clinical

assessment to review young people's mental well-being. In one case record we saw there was clear information about the strategies staff should adopt to manage risky behaviours and this included a detailed recovery and prevention plan for staff to support the young person to reduce these risks.

Children and young people had sufficient food and drink to maintain a balanced diet. None of the children in the home required a specialist diet. The cook told us about children's and young people's dietary and nutritional needs and we saw information to show they catered for their individual food choices and preferences.

Young people had access to healthcare services to support them with healthcare needs and included health practitioners. There was a multi-disciplinary team comprised of staff with a range of skills and qualifications. As well as the support staff based at the home the team included a psychologist, occupational therapist and an occupational therapist. Health professionals reviewed young people's care and treatment needs monthly and discussed during multi disciplinary team (MDT) meetings. A GP with a specialist interest in mental health provided medical input in the home on a part time basis. They provided assessment and advice to the staff and contributed to the initial assessments of children and young people's care plans in liaison with the placing authorities, hospitals and health professionals. This was evident in the assessment we reviewed that was carried out with a Child and Adolescent Mental Health Services (CAMHS) nurse practitioner and the care co-ordinator in relation to the young person's emotional and physical health, self-harming behaviours and family circumstances. Following this a plan was formulated prior to the young person moving into the home. Where it had been assessed that children and young people required ongoing support with their mental health needs such as attendance at discharge and future care plan approach (CPA) meetings, the GP attended these meetings to ensure their care and treatment plans were continually reviewed and monitored by the staff team in the home.

Consent to care and treatment was sought from children and young people in line with law and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any decisions made on their behalf must be in their best interests and as least 'restrictive' as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA and other legislation. The registered managers were aware of the process they should adhere to ensure care and support was delivered in children's and young people's best interests. Two children were looked after under Corporate Parenting and decisions about their care and support were discussed with young people and the professionals involved with their care.

Records evidenced that young people were provided with clear explanations and understood the support and care they received, and their consent had been sought for specific aspects of their care. Service participation agreements for under 18's was signed by one young person to agree to attend medical appointments, comply with care plans and participate in their chosen activities. Capacity to consent to care was reviewed regularly with young people as part of the multidisciplinary care planning approach. However, in one care records we found that consent was not clearly assessed and there were inconsistences, as some records in relation to consent had not been signed by the young person. We pointed this out to the registered manager who told us they would ensure these records were reviewed with the young person and these records would be updated.

Inspected but not rated

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

Young people were not always treated with dignity and respect.

Children and young people's privacy was not always respected. The provider carried out hourly observations on children and young people in their rooms. The providers policy was used in the service and determined if they would be placed on enhanced observations at level 1,2, 3 or 4 depending on the severity of the risk; level four being the most severe risk. Records showed that observations were carried out when young people had self-harmed and these observations were done in young people's rooms to show when they were awake or asleep. This did not provide young people with privacy whilst living in the home. We spoke with the registered manager in relation to this and they told us they were following the providers observation policy to ensure that people were observed regularly when the self -harming behaviours had increased.

We recommend the provider may wish to consider an alternative means of observations in the service that is less invasive in the home.

We observed that the treatment room where young people received took their medicines or managed their wounds was located within the dining area of the home, which children and people used frequently. This meant that young people did not have any private areas in the home they where they could take their medicines and manage their wounds discreetly. The registered manager explained that the new refurbishments would include more private spaces to ensure young people could be receive treatment in a confidential and private space. After the inspection we found that improvements had been made and the treatment room had been located to a more private area of the building.

Children and young people told us they were supported by caring staff who listened to them and help was provided when this was needed. We observed young people were well treated and supported whilst respecting their equality and diversity. One young person told us that staff had changed their life because of the support and guidance they have received; and respected their wishes and choices and spoke well about their future and how they would potentially get there. Staff had supported the young person going through the transgender process and had supported the young person with their clinic appointments. With staff support the young person had secured a place at university and was moving into student accommodation.

Young people were supported by caring and committed staff. We observed there was an open-door policy and staff spoke respectfully to young people and listened to what they had to say. We observed that when young people asked for assistance or just wanted to talk, the staff took the time to speak with them candidly and discreetly. One young person had arrived back from visiting parents and they were greeted warmly by staff and spoke about the activities they had participated in during their visit.

Inspected but not rated

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were not always met.

Children and young people's needs were not thoroughly assessed prior moving into the home. In one case record for a looked after child we found that the pre-admission assessment was completed by the registered manager and the senior care co-ordinator to assess if the placement was suitable to meet their needs. The assessment included staff observations and discussions with the young person and their designated key worker. An admission impact risk assessment was carried out three days prior to the young person moving into the home. However, this lacked clear analysis of the identified the risks and key information about the young person's medicines was missing from the assessment prior to the young person moving into the home. Furthermore, the specialist set skills required by staff to meet the young person's needs was incomplete had been signed by the registered manager. There was no additional assessment carried out by jointly by the providers GP prior to the young person moving into Newcombe Lodge. This assessment was requested from the GP but at the time of writing this report we have not received this assessment to date.

For three young people we requested to see their initial assessments prior to moving into the service but this information could not be found. The registered manager told us these assessments were carried out prior to becoming the registered manager of the home and did not have access to this information. This meant we could not be assured that children had young people care and support needs had been appropriately assessed before moving into the home.

Care plans did not demonstrate that young people's developmental milestones and independent skills were being met. Each young person had four care plans and information was incorporated into recovery plans and risk assessments to show how the they wished to be supported. Keyworkers were allocated to provide one to one support to young people. However, records showed that one to one meetings were not held consistently to check progress in relation to young people's individual needs. In one record the young person had written they would like to be able to make their own GP and dentist appointments. However, there was no evidence to show that the young person had been supported to do this. The young person's care plan documented they had an Educational, Health and Care Plan (EHCP) in place. However, when we asked for a copy of the plan, this could not be located by the staff. This meant that we were not assured that the young person's education, health and care needs were being met.

Transition plans were not in place for four of the young people in the home. These plans are prepared to help plan transition when young people they leave or move between different services. Planning for transition should begin at fourteen years old and should ensure that young people are appropriately supported when they move from children to adult services. Two young people were due to move on from the service, however there were no written plans of how they would be supported with this and how this would be done.

Reviews of young people's health and care needs were not carried out consistently. In two case records where young people moved into the home, there was no information to show their needs had been regularly assessed and updated to reflect their changing needs.

Children and young people's care records did not contain and specific information relating to care and treatment to ensure their safety is not compromised and necessary in order to carry out TDDI in a safe way. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints policy and procedure in place at the home and young people told us they had no complaints and would speak with the registered manager and staff if they had any concerns. There were no records of formal complaints made by children and young people's in the home. However, the minutes of young people's house meeting showed that a young person had made a complaint about an agency member of staff sleeping whilst on duty. This was not logged this as an informal complaint and we could not see what action was taken in relation to this.

We recommend the provider records all informal complaints in accordance with their policy to demonstrate how they improve the quality of care and any lessons learnt.

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers. At the time of our inspection there was no one in the home who required information in an accessible format. Information we reviewed showed that four care records included the voice of the child, and care records had been signed to evidence that they understood the information presented to them.

Inspected but not rated

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

The management and leadership of the service was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Systems were not continually monitored by the registered manager and there was a lack of oversight about how the service was run. Quality assurance systems were not clear, and they did not identify all the concerns we found in relation to recruitment, risk assessments, missing documentation such as initial assessments and an EHCP. Transition planning for children and young people was not fully embedded and informal complaints were not always recorded. An improvement plan was in place; however, progress on this was slow to make change. For example, it was showed in Jan 2019 that updates were to be completed care plans and risk assessments, however this had not been done.

The provider had not notified the Care Quality Commission (CQC) of a safeguarding incident in relation to a disclosure made by a young person who alleged indecent images were sent to them by another young person. After the inspection we received the notification two weeks after the incident had took place.

The provider had an inconsistent view about the vision and how the service should be run. The website and the statement of purpose (SOP) were contradictory and this required a strategic discussion about the way best way forward with the service. There was no stable, overarching statement about who they are, what they provide and how they would provide it. The SOP did not align with our findings during the inspection.

Newcombe Lodge are part of the priory group, and have developed national protocols, such as the four care plans, online training and policy documents. The provider oscillates between being a specialised mental health unit to a therapeutic children's home. At the time of the inspection two of the young people were over 19 and two were under 16. The age range of children and young people present significant challenges and are and it is likely that children may learn to imitate risky behaviours from older children. The registered manager told us they planned to change age range of children and young people they would accept into the service from 16 to 24 years old. This results in complications and not being clear about where the service best fits in terms of a children or adult service. This would also have a significant impact on a child who had recently moved into the service and was reported by the young person and their social worker to have settled in well.

Children and young views were not sought about how the home was run and what the provider could do better. There was no evidence of annual surveys and feedback from children young people about what was working well in the home and what needs to be improved. The providers SOP noted that satisfaction questionnaires would be sent to primary care trusts, professionals, funding authorities, families and carers to obtain their views about the service delivery. However, there was no evidence to show that these questionnaires had been sent to obtain their views about how the service was run.

Young people's meetings were not regularly held to ensure their views were consistently heard. Records evidenced that meetings were held with young people to discuss, house issues, school holidays, food choice and maintenance issues. However, these meetings were not regularly done and there were large gaps in the dates when these meetings were held. The children and young people in the home, had a history of complex health and care needs. However, we did not see any information to show the provider worked with in partnership with organisations to invite them to young people's meetings to share information about how they would manage these risks, for example, with substance misuse and sexual health services to provide advice and key information about young people's health needs.

We found no evidence that people had been harmed. However, systems were not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of potential harm or abuse. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider had reviewed their statement of purpose to reflect the criteria and age band of children in the home and the service model for the future. However this will require sustained improvements over a period of time to see how these changes have been embedded in practice.

The registered manager told us that they always encouraged a culture of openness and transparency with their staff team and the care workers we spoke with confirmed this. The staff team were candid about their how they could make things better and what needed to change and were keen to get it right. Staff and the young people at Newcombe Lodge viewed the registered manager as a committed leader who adopted an open policy for everyone who lived and worked in the home. They stated there was a lot of camaraderie and were clear that children and young people were at the centre of the agenda.

The provider understood and acted on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong. Monthly monitoring checks were carried out by independent person reports carried out to check the service was being run. The reports showed the provider was working towards improvements, but further improvements were required to ensure that young people where effectively supported in the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not always provided in a safe way for service users as the registered person did assess the risks to the health and safety of service users and did not always do all that was reasonably practicable to mitigate risks. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Regulation17 (1)(2) (a)(b)(c)