Partnerships in Care 1 Limited

Newcombe Lodge

Inspection report

City Gate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Tel: 01453882020
Website: www.priorygroup.com

Date of inspection visit:
16 June 2021
17 June 2021

Date of publication:
06 April 2023

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

About the service
Newcombe Lodge is a residential children's home for up to eight children who have mental ill-health or emotional wellbeing needs. The home is a described by the provider as a transitional recovery service. The home specialises in accommodating and treating children with emotionally unstable personality disorder (EUPD) and who have a history of self-harm.

Each child has their own room but shares some facilities with the other children living there. There were five children living there at the time of our visit.
Children live, and receive care and treatment, at Newcombe Lodge on a long-term basis. Children are either looked after by their local authority, and / or they have moved to the home under transitional arrangements from an inpatient facility.

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.

People's experience of using this service and what we found
Children were safe and protected from avoidable harm. The provider had systems in place to identify and respond to abuse or the risk of abuse. Children told us they felt safe and they were involved in the creation and review of their risk management plans. The registered manager had improved safe recruitment processes following specific safeguarding incidents. Medicines were appropriately stored and managed. There were effective arrangements for the prevention and control of infection and the provider had clear processes for managing the risk of COVID 19 transmission. Learning from incidents took place. We have made a recommendation about the way interventions are described in children's support plans. We have made a recommendation about the way controlled drugs are recorded.
Children had a treatment pathway that was planned through the provider's multi-disciplinary team and which made use of a range of therapeutic approaches according to national guidance. Staff, including newly recruited staff, had access to a range of role specific training and access to supervision. Staff had opportunities to develop their skill through an external qualification. Children told us they were involved in care planning and were able to express their wishes and feelings. We have made a recommendation about the way goals are recorded in children's treatment plans.
Children said they felt they were well-treated and that staff understood their needs. We observed staff speaking respectfully and kindly to children. Children were enabled to make decisions about their care and treatment and were involved in all aspects of planning. Children's independence was supported and they were treated with dignity and respect. We have made a recommendation about the routine wearing of masks by staff.
Children were supported to have maximum choice and control of their lives using the provider's MDT approach. Initial assessments were thorough and took account of information from other professionals and

the child. Plans reflected children's assessed needs. Children were supported to maintain contact with their families and could have pets at the home.
The registered manager promoted an inclusive culture and was well-liked by staff and the children we spoke to. A new statement of purpose was detailed and set out the strategic vision and the operating systems at the home. An open culture promoted the application of the duty of candour. Children's views were sought about how the service could be developed. The service worked appropriately with local partners.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The provider was in breach of regulations (report published in January 2020). At that time the provider did not;
-□assess and mitigate the risks to young people to take account of their changing needs and,
-□establish and operate systems to effectively assess, monitor and improve the quality and safety of the services provided.
Following that inspection, we required the provider to make improvements. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected
We conducted an unannounced, comprehensive inspection on 16 and 17 June 2021. This inspection was to follow up the breaches of regulation from our earlier inspection.
We also inspected following a concern that had been brought to our attention about the provider's ability to safeguard children from abuse. We found no evidence during this inspection that people were at risk of harm in relation to this concern. Please see the 'safe' and 'well-led' sections 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 will continue to monitor information we receive about the service until we return to visit according to 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?

Inspected but not rated

The service was safe.

Children were safe and protected from harm or abuse. Medicines were managed safely. Potential risks from COVID 19 were managed effectively.

Is the service effective?

Inspected but not rated

The service was effective.

Children's needs were effectively assessed and planned for. Consent was sought in line with national guidance.

Is the service caring?

Inspected but not rated

The service was caring.

Children's privacy and dignity was respected. Children were supported to express their views and these were acted upon.

Is the service responsive?

Inspected but not rated

The service was responsive.

Children's care was personalised and met their individual needs.

Is the service well-led?

Inspected but not rated

The service was well-led.

Managers and staff were clear about their roles. There was a clear vision. Children were engaged in their care.

Newcombe Lodge

Detailed findings

Background to this inspection

The inspection
We inspected the service 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 legal requirements and regulations associated with the Act. We looked at the overall quality of the service according to our duties under section 91 of the Care Act 2014.

Inspection team
One inspector conducted this inspection over the course of two days.

Service and service type
Newcombe Lodge is a residential children's home where children who have mental health and emotional difficulties live as part of as single package of care and treatment. The provider is Partnerships in Care 1 Limited, part of the Priory Group. The provider is registered with the CQC to carry out the regulated activity 'Treatment of disease, disorder or injury' at this location. OFSTED is the regulatory authority in respect of the care and accommodation whereas CQC is the regulatory authority in respect of the health aspects of the location.
The service has a manager registered with the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.
Inspection activity started on 14 June 2021 and ended on 18 June 2021. We visited the location on 16 and 17 June 2021.

What we did before the inspection
Prior to the inspection visit we reviewed information we had collected about the provider since the last inspection. This included incidents and events that the provider had told us about according to the terms of their registration. We also took account of reports about the service published by OFSTED.
We had not yet asked the provider to complete a provider information return (PIR) so we were not able to take this into account when making our judgements. A PIR is information we require providers to send us to

tell us about key aspects of the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with two of the children who were living in the home about their experience of the care provided – two of the children declined to speak with us and the fifth child was not present during both days of our visit. We spoke with the registered manager, the deputy manager and five other members of staff. These included a clinical psychologist, one of the children's case managers, two therapeutic care workers and an occupational therapy assistant.
We reviewed a range of records. This included three children's care and treatment records and multiple medication records. We looked at three staff files in relation to recruitment, training and supervision. We also looked at a variety of records relating to the management of the service, including policies and procedures and records of audits carried out.

After the inspection
We reviewed information that we had asked the provider to send us. This included the statement of purpose for the home and the location's service improvement plan for Newcombe Lodge.

Inspected but not rated

Is the service safe?

Our findings

Safe – for this key question we looked for evidence that the provider protected children from abuse and avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection we found risk assessments about children's health and wellbeing lacked clear information about how staff should manage these risks to reduce the likelihood of harm. Key information to support risk assessments for children had been missing or incomplete and there was a lack of exploration about risks in records. We also found information contained in children's records was repetitive and inconsistent with an element of copying and pasting information from one child's record to another. We considered these shortfalls amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection we did not see any recent evidence of copying and pasting in records to indicate if this was still an issue. We also found the provider had made improvements to the assessment and management of risks for individual children. This was evident from discussions with the registered manager and staff and in the risk management plans that were part of the records of children we reviewed.
Risks were considered for a range of presentations such as suicide, ligature use, self-harm, going missing and sexual exploitation and were graded as low, medium or high risk.
Monthly multi-disciplinary team (MDT) meetings used chronologies of incidents and events to update their assessment of risk. This meant that risk assessments were up-to-date and helped the MDT understand which interventions worked well. Children told us staff consulted them about how to support them for certain situations and this was evident in the way their behaviour was described in their records.
Risk management plans and positive behaviour support plans described staff interventions as 'primary prevention' (early steps to prevent escalation) and 'secondary prevention' (steps to de-escalate). Plans described least restrictive interventions (conversation and distraction) to most restrictive (restraint using specific techniques). These reflected the techniques described in a recognised programme for 'managing actual and potential aggression' (MAPA).
Staff understood the specific risks for each child and told us that the focus of support was on using non-physical intervention. Their explanations of how they supported children reflected the interventions described in children's plans.
Information in plans about how staff would support individual children for different presentations was mostly clear. However, a small number of interventions were described in a generic way. For example, one record described a 'primary preventative' action simply as 'support me in communicating' without setting out precisely how staff would deliver that support to that child.
We recommend the provider ensure all interventions in children's support plans are sufficiently specific and descriptive to enable staff to be clear about how to prevent escalation.
There was no longer a breach of this regulation in relation to records and risk management and this meant children were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

The provider had systems in place to identify and respond to abuse or the risk of abuse. Children told us they felt safe.
Staff had access to safeguarding policies and to safeguarding training and supervision (but see comments in 'effective' about the impact of COVID 19 on training). Staff demonstrated their knowledge of safeguarding procedures during our conversations and said they were frequently reminded about safeguarding responsibilities during meetings and supervision sessions.
We reviewed information about specific safeguarding incidents the provider had told us about as part of their responsibilities under their registration, and we discussed these with the registered manager and deputy manager. We were satisfied they had responded appropriately to concerns or allegations in respect of those incidents.

Staffing and recruitment
The registered manager had improved safe recruitment processes following specific safeguarding incidents and we saw evidence of this in staff files. These included a new interview structure for testing suitability of prospective staff, mandatory pre-employment checks for new staff and retrospective checks on files of existing staff to check for gaps in information.
At the time of our inspection there were sufficient staff on duty to ensure children were kept safe. The staff rota was adjusted according to the children's current needs for monitoring or support and whether children were staying at the home or away visiting relatives.

Using medicines safely
Medicines, were managed, stored and administered safely in a locked, air-conditioned clinic room with stable ambient temperature. There were separate, locked cabinets for controlled drugs.
Children living at Newcombe Lodge took a variety of medicines as prescribed by the provider's medical team following monthly review of their needs by the MDT. Some medicines were administered regularly during the day, and some were for use as and when required (PRN) for particular situations described in care plans. Children understood what their medicines were for and communicated with staff about when they needed to use PRN medicine.
Staff were trained by a senior colleague to support children to take their medicine. Staff could only carry out this work independently once they had been assessed as competent and signed off.
There were satisfactory arrangements for reconciling the numbers of medicines in storage at any one time. This was done twice daily by the staff member carrying out the medicine administration role for that day. Medicines that accompanied children whenever they went to stay with relatives were counted out and counted back in on their return.
A senior staff member formally audited all medicines every month and sometimes more frequently. Medicine errors were reported as incidents, investigated and findings used to inform future practice. For example, a counting error had been discovered during the daily checks, was reported as an incident and resulted in learning for staff. This showed the audit process was effective.
We checked the medicines in stock for three children and found that these were recorded accurately. Controlled Drugs stock and administration were recorded in a hard-bound register. However, once the register had been filled, additional sheets had been photocopied and inserted to keep a record of use. There is a risk that loose sheets could become detached or mislaid and this is not in line with the requirements for the recording of controlled drugs. We recommend that the provider ensures that a replacement book is used instead of photocopies.

Preventing and controlling infection
There were effective arrangements for the prevention and control of infection. Staff had access to the infection control and health and safety policies in a binder in the staff office. There was a health and safety policy statement in the entrance foyer visible to staff and visitors. The provider carried out a monthly health

and safety audit
Infection control and health and safety training were part of the provider's mandatory training programmes and all staff were up to date.
The environment had appropriate features to support the prevention and control of infection. For example, there were hand gel sanitising points throughout the premises and signage that reminded everyone about hand washing.
The provider had clear arrangements for managing the risk of COVID 19 transmission by children living there, by staff and by visitors. There were strict protocols for all visitors and staff entering the premises. These included a lateral flow test and temperature check on arrival, completion of a questionnaire relating to potential COVID 19 exposure and the mandatory wearing of masks supplied by the provider.
The use of masks throughout the location was mandatory for everyone except for the children living there. Staff had access to COVID 19 testing through the pandemic.
This meant that children and staff were protected from the risk of acquiring COVID 19 on the premises . We have commented on the appropriateness of this routine use of personal protective equipment (PPE) in 'caring' below.

Learning lessons when things go wrong
There were arrangements in place to enable learning from incidents.
Our review of information the provider had sent to notify us of certain types of incident under the terms of their registration showed that they reported these appropriately. This had been an issue at our previous inspection where not all notifiable incidents had been reported to us, but this was not the case at the time of this inspection.
We also reviewed the provider's incident log and noted that there were processes for reporting, recording and investigating all incidents. Many of these related to incidents of self-harm or to young people going missing from the home whilst a small number also related to the use of physical restraint.
Each of these incidents resulted in an investigation where the child and the relevant staff members were debriefed and a report to the provider's head office and the MDT was made. In each case an outcome was recorded showing that the incident was within expected parameters of behaviour according to the young person's care plan or that changes needed to be made to their care plan. This was borne out in our review of the incident chronologies within the young people's care plans .
Care plans were updated with any changes arising from incidents and these were communicated to staff through daily hand-over meetings and fortnightly team meetings.
A safeguarding audit tool was used by the registered manager whenever concerns arose. The purpose of this was to review the specific concern or incident and measure the effectiveness and currency of the use of the safeguarding procedures. In our discussions with the registered manager about specific incidents we noted that the audit tool was last used in June 2021 and indicated that the use of the safeguarding procedures had been effective.

Inspected but not rated

Is the service effective?

Our findings

Effective – for this key question we looked for evidence that children's care, treatment and support achieved good outcomes, promoting a good quality of life, based on available evidence.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
The provider followed the principles set out in the quality standards on self-harm (2013) issued by the National Institute for Health and Care Excellence (NICE) as well as the clinical guidance (2011) 'Self-harm in over 8s: long-term management'. (Note: this guidance is currently under review and due for re-issue in June 2022).
Children admitted to Newcombe Lodge had a treatment pathway that made use of a range of therapeutic approaches to support their recovery. These included Dialectic Behavioural Therapy (DBT), an approach suitable for children and young people with emotionally unstable personality disorder (EUPD) or who self-harm.
The deputy manager and one of the provider's consultant psychiatrists jointly assessed all children prior to admission over a number of face-to-face meetings. This psychosocial assessment was to determine the child's needs and whether the home could support them. In most cases this was whilst the child was still in their previous inpatient facility, and involved consultation with the facility's clinical team, the child's social worker, and the child themselves.
Children also undertook a short-term familiarisation stay at the home so that they became accustomed to their prospective living arrangements.
Care and treatment at the home was planned through the provider's MDT. The MDT comprised the psychiatry, clinical psychology, therapeutic staff, children's case managers, the child and their social worker. Care and treatment plans were reviewed at each of these MDT meetings and changes made according to the progress, or not, that the child had made. The MDT made use of incident chronologies to ensure they considered up-to-date information in their planning.
In the records we looked at we saw that all assessments, care and treatment plans and positive behaviour support plans demonstrated collaboration with other professionals and the children.
Plans showed what children's objectives were for the next period. However, in each of the three children's files we looked at, regular planning was reactive to events within a brief time period from meeting to meeting. It was difficult to draw a direct link to the child's initial principal recovery goal or to determine how their short-term achievements showed progress towards it. We recommend that treatment plans demonstrate clearly how short-term achievements contribute to the overarching recovery goal so that care remains focussed and can be tracked during reviews.

Staff support: induction, training, skills and experience
At our last inspection in August 2019 some staff had been insufficiently trained and supported. At this inspection this has now improved due to improvements in the extent of training, opportunities for development with a role specific-qualification and the extent of supervision and staff support. This meant that children were cared for by staff that were appropriately trained and supported.
Staff training comprised programmes the provider regarded as mandatory as well as other role-specific training. Online training included health and safety, infection control and information governance.

Safeguarding training had been delivered online during the COVID 19 pandemic although the registered manager's plan was to revert to face-to-face training once restrictions had eased. Other face-to-face training included medicines administration, first aid and MAPA.
Newly recruited staff undertook an induction programme comprising this training. They also completed a competency checklist for each particular task. This required observation and sign off by a supervisor before they could carry out tasks independently.
Staff had access to the provider's academy portal for a range of online training programmes. All face-to-face training was also logged on this system and this allowed the registered manager to have oversight of the skills and competency of staff at any given time.
One staff member told us they accessed the training portal frequently and knew when they were due to refresh certain programmes. Another staff member told us the registered manager reminded them when they were approaching a date for refreshing a training.
Staff were also given the opportunity to undertake a level 4 (according to the Regulated Qualifications Framework) qualification as a 'practitioner in children's residential care' run by a local college. Staff were expected to do this in their own time, although the provider funded it and we spoke to one staff member who said they had already embarked on this.
Staff received monthly one-to-one management supervision from the registered manager and deputy manager and monthly group clinical supervision from a clinical psychologist. Staff said they were well supported through supervision and through fortnightly team meetings.
This means that children were cared for by a staff team that was trained and supported to carry out their role.

Staff working with other agencies to provide consistent, effective, timely care
Staff worked with other agencies to help coordinate different parts of children's care. For example, children were supported to attend school and college as part of their package of care.
The staff had also developed working relationships with the local acute hospital and with the local police and shared appropriate information about the children to enable those services to provide support when they self-harmed or went missing. We saw examples of this in the case records and incident logs.

Supporting people to live healthier lives, access healthcare services and support
Children living at Newcombe Lodge were supported to attend the dentist, their GP and hospital appointments when appropriate as part of their care plan.

Ensuring consent to care and treatment in line with law and guidance
Children living at Newcombe Lodge, or those who had responsibility for them were enabled to provide consent for their care and treatment and for the range of interventions they experienced.
Staff knew and understood the principles of Gillick competency for children under 16. This is a legal standard that ensures children are given enough information to enable them to make their own decisions about their care and treatment as long as they are competent to do so.
At the time of our inspection there were no children between 16 and 17 who were subject of Court of Protection orders about being deprived of their liberty. There were also no children of that age who lacked or had limited capacity to consent to certain aspects of their care.
Some children were looked after by their local authority whereas others had less formal arrangements, with parents also having shared responsibility for decision making. Our review of records showed when social workers or parents had been consulted about their children's care as well as the children themselves.
Part of the stated philosophy of care at Newcombe Lodge was to build trusting and supportive relationships with the children so that they could be fully involved in decision making about their care. Staff told us that they always provided clear and simple explanations to the children so they could agree to each different intervention.

Children told us they were involved in care planning and were able to express their wishes and feelings. Our review of positive behaviour support plans showed how children had been involved in agreeing certain interventions when they were struggling or their behaviour was escalating.

Inspected but not rated

Is the service caring?

Our findings

Caring – for this key question we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.
The provider had refurbished a room into a brand-new clinic room that enabled children and young people to receive medicines in private.

Ensuring people are well treated and supported; respecting equality and diversity
The provider's statement of purpose for Newcombe Lodge emphasised the importance of providing care in a warm, safe and nurturing environment where children could feel secure, wanted and valued. The stated aim was to empower children and young people through developing positive, respectful and trusting relationships.
One staff member told us they felt they and their colleagues at the home were all well trained and highly skilled and were genuinely interested in the welfare of the children. We spoke with staff about individual children and it was clear that staff knew them very well.
Children said they felt they were well-treated and that staff understood their needs. One young person said they felt that it was really great at the home and that staff supported them with anything they needed. Another child told us they were happy there and that they felt valued.
During our two days of visiting the home we observed and listened to staff and the registered manager interacting with children. All encounters were low key, with no raised voices. Staff spoke respectfully and kindly to children.
The service respected diversity. For example, one child's care plan had specific goals for them to develop an understanding of the cultural backgrounds of both of their parents.

Supporting people to express their views and be involved in making decisions about their care
Children were regarded as partners in their care.
Staff said that children were enabled to make decisions about their care and treatment and were involved in all aspects of planning. This was evident in care plans which were child-focused, with some being written in the first person, as if the child had written the plans about themselves.
Children told us that they were given opportunity to express how they felt and that they took part in their MDT discussions. They welcomed the opportunity to do this as it gave them some control over their care pathway.

Respecting and promoting people's privacy, dignity and independence
Children's dignity, privacy and independence was respected and promoted at Newcombe Lodge.
Staff said they felt this was the children's home and thought it was important that they were enabled to move around the home freely and socialise in private with each other. Staff said they routinely knocked on children's doors and waited to be invited in before entering to ensure their privacy and dignity was maintained.
Since the last inspection the provider had refurbished one of the ground floor rooms and had turned it into a specially equipped clinic room. This enabled staff to distribute medicines to children behind closed doors in private.

Children told us they could make choices about the décor in their own rooms.
Children were supported to access the community. Staff took children on occasional outings and to school or college. One child's care plan described a new goal to attend college and undertake a vocational course and showed measurable objectives about how this would be achieved.
One child said they had been able to tell the MDT they wanted to increase their unsupervised time in the local community. This had resulted in their involvement in re-writing their care plan with the measures that would be taken to help them to achieve this goal.
Care plans showed children were also supported and encouraged to occasionally stay over with family members, especially at weekends.
This meant children were supported and treated with dignity and respect; and involved as partners in their care.
However, the requirement for staff to routinely wear masks as part of the COVID 19 arrangements went beyond those set out in the Government's guidance on 'The use of personal protective equipment (PPE) in education, childcare and children's social care settings, including for aerosol generating procedures (AGPs)'. This guidance requires providers to assess whether there is a specific need for staff to wear PPE for different situations and to take account of individual children's behaviours. The routine wearing of masks by staff detracted from the sense of 'home'. We recommend that the provider reviews its policy on the use of PPE to ensure that masks are not worn unnecessarily .

Inspected but not rated

Is the service responsive?

Our findings

Responsive – for this key question we looked for evidence that the service met people's needs.
At the last inspection initial assessments were not carried out effectively and had a lack of clear analysis of risks. Care plans did not demonstrate that young people's developmental milestones and independent skills were being met and there was a lack of appropriate transition planning .
At this inspection improvements had been made in the way assessments were carried out and the way that care was monitored and reviewed through the MDT process. Assessments and plans were child focused and reflected children and young people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
Assessment and planning of care and treatment was child focused.
Initial assessments carried out by the deputy manager and a consultant psychiatrist prior to the child moving into the home were thorough and took account of information from other professionals as well as the views of the child.
Following admission, care plans were devised for four key areas; keeping safe, keeping well, keeping connected and keeping healthy. This psychosocial approach meant care planning was holistic and took account of risks to safety, mental health, social interaction and physical health.
Care plans and risk management plans were initially devised, and then reviewed monthly, using the provider's MDT approach. This was responsive to changing needs as identified in up-to-date chronologies.
Each child had a case manager responsible for meeting regularly with the children to check their progress.
Each child also had a designated, or 'key' therapeutic care worker with whom they would have most of their daily interaction. Both the case manager and the key worker were part of the MDT process, as was the child. This ensured the child's voice was prominent in ongoing planning and this was evident in records we looked at.
The provider's occupational therapy team planned to deliver an independent living skills pathway in the week following our visit. This was to help measure short-term goals in relation to independent living such as cooking, going to school or college, looking after oneself and shopping for food. This had not yet been implemented so we could not test its effectiveness.

Meeting people's communication needs
From 2016 onwards all organisations that provide NHS care or publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS) 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 living in the home who met these criteria or who required information in an accessible format.
One child had special educational needs for which an education, health and care plan (EHCP) was in place. Records of all children we reviewed showed evidence of the voice of the child and had been signed by children to demonstrate they understood the information presented.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them
Children living at Newcombe Lodge were supported to maintain contact with their families. This was either by facilitating overnight, or longer, contact at families' homes, often at weekends, and by encouraging visitors to the home. Since the children had been placed at the home by local authorities that were geographically some distance away this was proving to be a challenge through the pandemic but communication with families was also supported through virtual means and over the telephone.
Children were supported to have pets at the home. One of the children had a hamster that had helped them to maintain focus by providing a sense of responsibility.

Improving care quality in response to complaints or concerns
There was a system in place for recording and acting upon complaints. However, there had been no recent complaints made by children and young people or their families so we could not assess if the system in place was effective.
As we have reported above, in 'safe', the provider had acted appropriately in relation to safeguarding concerns and this had led to the implementation of a new recruitment process.

Inspected but not rated

Is the service well-led?

Our findings

Well-led – for this key question 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.
At the last inspection there were a number of shortfalls as follows:
● Systems were not continually monitored, there was a lack of oversight about how the service was run and quality assurance processes were unclear and were ineffective at identifying shortfalls;
● the provider had not notified CQC of safeguarding incidents;
● there was no clear vision about how the service would be run;
● the statement of purpose (SOP) was ambiguous;
● there was no mechanism in place for seeking views of children and young people about how the service would be better run.
We considered that these shortfalls amounted to a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection these shortfalls had been addressed as set out below.
There was no longer a breach of this regulation in relation to quality monitoring, strategy and vision and the contribution of children and young people to the running of the home.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
The registered manager promoted an inclusive culture and was well-liked by staff we spoke with and by the children. Staff said the registered manager was visible, 'hands-on' and supportive. The registered manager's open-door policy meant any member of staff or child could approach them and discuss any concerns.
In response to our previous inspection the registered manager had produced a new SOP specifically for this location. This SOP was detailed and set out the strategic vision and the operating systems at the home. The strategic vision was set out in the philosophy of care based upon empowering children to make decisions and on engaging in activity to develop self-worth. Our discussions with staff showed that they shared this vision too.
Children told us of their aspirations to achieve good outcomes as part of the goals that they had been involved in setting, such as living independently and attending college.
The operating systems were clearly described in the SOP and this reflected our view of the service that we had reviewed during our two days visiting the home.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
An open culture promoted the application of the registered manager's duty of candour. For example, a medicines error from April 2021 where a young person missed a dose of their medicine resulted in the error being disclosed to the child and their family along with an apology.
This also resulted in some additional training for a staff member that we could see reflected in training records.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
The registered manager was clear about their role and responsibilities for their registration with CQC as demonstrated by the notifications submitted under their registration responsibilities.
Staff members' role descriptions were set out clearly in the SOP. Staff we spoke with were aware of their role in the pathway of support for children and in the MDT. Staff were appropriately supported by regular individual and group supervision processes.
The registered manager and deputy manager used a variety of monitoring processes to assure the quality of performance. These included a premises walk-around, a medicines audit, a documentation audit, a safeguarding audit and a review of incidents.
The registered manager had produced a service improvement log which contained actions to be carried out to remedy shortfalls identified in health and safety audits, internal compliance reports and regulatory inspections. For example, we noted an action that called for a plan to be produced to set out a new recruitment process that we reported on in 'safe' above. This action was shown as complete with the new process already being in use.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
Children's views were sought about how the service could be developed. This included the weekly children's meeting called 'Ketchup Catchup' where they engaged with the registered manager and deputy manager about household issues and any concerns. For example, children had observed that the lack of adequate air conditioning in the building, other than in the clinic room, had resulted in the first floor being unpleasantly hot. This led to a business case being submitted to the provider for this to be installed and a formal entry on the service improvement plan.

Continuous learning and improving care
The service learned when things went wrong as we set out in 'safe' above. The service also learned from the contribution of children and young people, staff and regulatory inspections.
This learning approach was evident in individual children's cases in the way risk and needs were identified through the use of chronologies. This meant staff learned about the children they were caring for by understanding what worked, and what did not work well for different situations.

Working in partnership with others
The service worked appropriately with local partners. This included open sharing of information with the local safeguarding children partnership and positive relationships with the police and hospitals. This helped local services to support children on those occasions when they self-harmed or were missing from the home.