Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Maple Tree House

Bridgend

Date Inspection Completed

27/09/2019

Description of the service

Maple Tree House is a children's home operated by Bridgend County Borough Council. The home provides care for up to six young people. It is a one-storey building; the main area comprises the assessment unit, which can accommodate four young people. The front of the building accommodates an emergency provision to accommodate two young people. The responsible individual is Laura Kinsey.

Summary of our findings

1. Overall assessment

Overall, young people who live, or have lived in Maple Tree House since it opened in December 2018 have not received care and support from a stable staff team or which is consistent with the service described in the statement of purpose. The service had changed its model and name from the former Newbridge House; the implementation of this had proved to be a challenge. There was a temporary manager in post at the time of inspection. Staff felt improvements were being made but highlighted the home had been through an unstable period where morale was low amongst the staff team. Improvements are required in relation to decision making around admissions of young people to the home. Staff members feel supported by the temporary manager but they have not received regular supervision or training to equip them with the skills to manage the complexities of young people's behaviours. Improvements are also required to the specific guidance for staff to enable them to manage the complex needs and behaviours of the young people the service seeks to care for, as well as the implementation of therapeutic approaches to working with the young people living in the home. The home environment is generally suited to the needs of young people but it shows signs of damage. Quality assurance systems are not robust and have failed to identify shortfalls within the service.

2. Improvements

This was the first inspection following the registration of the service as Maple Tree House.

3. Requirements and recommendations

Section five of this report sets out our recommendations to improve the service and the areas where the care home is not meeting legal requirements. These include the following:

- Provider assessments
- Personal plans and risk assessments
- Safeguarding

1. Well-being

Our findings

Young people's right and entitlements are generally upheld but improvement is required. Young people told us that on a day to day basis they were able to express and make their wishes and feelings known regarding the food they ate and activities they engaged in. We saw them making decisions during the inspection regarding their wishes. They had access to an advocate if required and were aware of the complaints procedure but no complaints had been made. Young people were consulted during their formal Children Looked After Reviews, and they were spoken to during quality assurance monitoring visits. Regular house meetings had not taken place for some time. One had been undertaken prior to the inspection, this involved seeking views of young people individually but not all young people's views were sought. Personal plans included young people's views. Key working sessions were not conducted as stipulated in the statement of purpose. We concluded that young people's view and wishes could be better captured but generally they have opportunities to voice their views, they are listened to and can access some control over their day to day lives.

Young people cannot be confident there are appropriate measures in place to safeguard them. There were concerns regarding the procedures in place to safeguard young people at the time of inspection. There were high assaults on staff, frequent police attendance at the service and young people were being criminalised as a result. Risk assessments and plans in place demonstrated limited guidance to staff to best manage young people's complex behaviours. Admissions to the service did not demonstrate robust decision making to ensure young people's safety. Systems in place do not always ensure young people are appropriately safeguarded at all times.

Young people are supported with their education and health needs but are not overall supported to be independent. Young people were supported to attend education where there was a provision in place. Feedback from social workers confirmed there had been improvement with some young people now attending college. Staff supported and transported young people to and from education. Young people did not have independence plans in place as outlined in the statement of purpose. We saw limited evidence of encouragement, recorded evidence of young people's progress. Some young people helped or cooked independently on occasions. Young people's were registered with local health provisions and appointments recorded, staff sought medical attention when required. Staff encouraged young people to engage in exercise. Young people's overall health needs are met and they are encouraged to take part, where they wish, in physical activities to keep fit but their development of independence skills requires improvement.

Young people's social well-being is promoted but they do not always receive timely care and support. Young people were supported to maintain contact with family and friends.

Staff supported with the transport arrangements and facilitated contact where required. Staff would routinely share any findings with the social workers. Young people's engagement with activities was inconsistent; some young people chose not to engage, whereas others were recently engaging well. Staff were motivated to take young people out. We did not see any activity planners in place as outlined within the statement of purpose. Additionally, we did not see any direct work undertaken with young people or a therapeutic programme to explore their risk taking behaviours in an attempt to reduce these. Young people did not respect or accept boundaries in place for them and there was minimal structure. Staff did not have the guidance, skills, support and training to meet the complex needs of the young people. Young people's departures from the service were mixed, some of which had been successful and positive, whereas others did not evidence appropriate assessment and a plan moving forward. They do not always receive timely, considered intervention in a therapeutic environment to ensure they achieve positive outcomes. Young people are encouraged to maintain contact with people who are important to them. Young people do not always receive the right care at the right time.

Young people live in suitable accommodation but improvement is required. The communal areas of the accommodation were clean. There was some damage evident including in young people's bedrooms. The accommodation would benefit from additional decorative items to present a more homely environment and photographs of young people to provide them with a sense of belonging. Health and safety measures were not consistently undertaken to ensure young people were aware of the procedures in place in the event of an emergency. Young people do not live in an environment which supports them to achieve their well-being.

2. Care and Support

Our findings

Young people's health needs are generally met. We saw young people were registered with local health services and were supported to attended medical appointments. A health record of all appointments was recorded on young people's files. Looked After Children health assessments were available on young people's files. Young people's diet was recorded, often with young people refusing breakfast. The food sample we saw young people eating was varied in terms of nutrition. Young people were encouraged to engage in physical activities and we saw they had been out walking with staff. Some young people were more reluctant than others to engage. There was suitable storage for medication but not for controlled drugs (although no young people were currently being prescribed controlled drugs). Some staff had received training in medication but this required improvement to ensure the safe storage and administration of medication. Specialist health services were sought when required to support young people. Young people are supported to achieve and maintain good physical and mental health.

Practice and processes in place need to improve regarding safeguarding and to prevent young people being criminalised. Some staff had undertaken safeguarding training and they said they felt confident about their knowledge of the procedures they should follow should they have concerns for a young person's welfare. Records demonstrated a high number of incidents at the home, involving physical and verbal aggression and threats to staff. The young people showed disregard for the boundaries in place for them. Incident records were not sufficiently detailed and lacked oversight for a considerable period. Individual incidents evidenced staff did not act to appropriately safeguard young people. There were high levels of assaults on staff, some of which were serious with frequent damages to property and high levels of police intervention with young people being criminalised as a result. Risk assessments were not sufficiently detailed to assist staff to manage young people's behaviours. The systems in place for recording and handing over important information to staff was inconsistent and not clear. Young people we spoke with told us they felt safe. Nevertheless, an atmosphere such as this was not consistent with a calm, secure, therapeutic environment where young people can feel safe and thrive. Young people have not consistently experienced a safe, nurturing environment.

Young people are not cared for by a consistent staff team who understand their needs. Young people told us they had some staff members they could confide in if required. The acting manager and staff spoke positively about young people and we saw warm kind, respectful interactions between them. Some staff had been longstanding team members and were very committed to, and enjoyed their roles; however, there had been a high volume of agency staff utilised at the service for a considerable length of time, thus not providing consistent staff. Although attempts were made by the service to use the same

agency staff where possible. Young people's care and support plans were on their files. Young people had personal plans in place which we were informed had only recently been completed; on the first day of inspection, they were incomplete. They contained some information regarding young people's needs but it was not evident that plans were based on a provider assessment, outcome focussed or reviewed as required. Personal plans and related documents did not contain sufficient guidance to enable staff to achieve positive outcomes for young people. Young people did not have a copy of their personal plan and there was limited evidence staff had read and understood key documents. De-briefs records were not available following incidents to determine whether young people were listened to, to allow them an opportunity to reflect and raise any worries. Young people are not cared by a familiar team who know and understand them.

Young people's admission and departure to and from the home is not robustly considered. Impact assessments prior to admission were evident, in some, though not all young people's files. Therefore, we could not see that consideration had been given to the compatibility of all young people with others already living in the home, or to staff skills and experience to ensure that the needs of each individual could be safely and effectively met. Some completed impact assessments evidenced why a young person would not be a suitable match alongside the existing young people already living at the home. Regardless of this, the decision was made to admit the young person contrary to the assessment, thus negatively impacting on the service. Some young people moving on from the service had experienced a successful transition with positive outcomes, some had returned to family and some to foster placements. Others not so, an assessment was supposed to be completed during the placement to determine young people's placement needs moving on, these were not consistently completed and of the assessments we did see, they lacked appropriate detail, analysis, partnership working and forward planning. In some instances, young people had returned to the service on more than one occasion and had had significant placement moves in a short period of becoming looked after. Young people's admission and departure to and from the service does not evidence carefully considered decision making to ensure comprehensive plans are in place to give young people the best success.

3. Environment

Our findings

Young people live in appropriate living accommodation, although it is not particularly welcoming and homely. It is a one storey building which can accommodate six young people. Attempts had been made to make the environment more welcoming, the hallway walls were painted in various colours to uplift the long corridor. However, areas of the home required re-painting. The main area comprises the assessment unit which can accommodate four young people. The front of the building accommodates an emergency provision to accommodate two young people, a shared bathroom and a shared lounge kitchen area; a desk in the corner of this room allowed for one young person to eat food, we were told this was the dining table. This did not accommodate enough space for staff and young people to eat and enjoy a meal together; this area has its own access. The accommodation lacked decorative items or photographs of the young people to provide a sense of belonging. We were informed they had been damaged. We saw young people's bedrooms, these were basic and built in wardrobes were damaged. Some young people had limited belongings and some young people's bedrooms required staff to monitor more frequently to prevent the presence of certain items remaining in their room. There was other noticeable damage within the accommodation to the walls, items and furniture. Whilst action had been taken to address some of the damage we were concerned for the safety of other young people living in the home, and for the safety of staff, given the frequency of incidents. Staff, were clearly struggling to effectively manage the behaviours of some of the young people and we could not see that they had been provided with appropriate guidance and support from senior management, to ensure that strategies to reduce risk levels had been developed and implemented. Young people do not experience a homely or safe living environment. Their individual needs are not met, and ongoing regular damage to the property impacts on their well-being and sense of security and belonging.

Young people cannot be confident health and safety measures are always followed. External doors were alarmed and there was a key fob entry system. There was an up to date fire risk assessment in place which was amended accordingly. Records evidenced weekly fire alarm tests were conducted. There was daily checks conducted on emergency lighting. Monthly fire drills and fire instruction were not conducted as stipulated and the last was undertaken in July 2019. We would expect this to be more frequent because of the turnover of young people being admitted to the home via the emergency accommodation. Health and safety systems in place are not adhered to and a system is not in place for young people to be confident to know what to do in the event of an emergency.

4. Leadership and Management

Our findings

Young people are cared for within a home which does not consistently meet legal requirements, the service provider has not ensured that the home operates in accordance with its statement of purpose. We saw that the home's statement of purpose outlined the ethos, aim and objectives of the service, and provided information regarding service delivery. However, the operation of the service was not seen to be as described in the document. Our examination of records identified significant shortfalls in the day-to-day running of the home, these shortfalls included the home's matching and admissions processes, the day-to-day management of the home, arrangements in respect of staff training and supervision, the therapeutic model and the governance and oversight of the service. Young people's care and support needs are not properly met as the service does not consistently operate as set out in its statement of purpose and comply with legal requirements.

Young people are not cared for by staff who receive the supervision, training and support they require to provide appropriate care. We saw within records viewed that young people's needs were extremely complex. The home's statement of purpose outlined some of the difficulties which might be experienced by young people living in the home. It also made reference to being cared for "through a therapeutic programme" and "specialist qualified staff", trained to deliver a therapeutic placement. However, the home's training matrix (of training undertaken) by staff prior to our inspection, did not evidence that all staff had been provided with the training and support they required to deliver the therapeutic model. Nor had training been provided to all staff to meet the specific needs of young people living in the home. Incident records referenced risk-taking and challenging behaviours by young people, together with a high number of assaults on staff. However, we saw limited evidence of support and guidance provided to staff to ensure that incidents were effectively managed and the safety of young people and staff maintained. Given the complexities, we would expect staff to be supervised at the frequency stated in the home's statement of purpose. However, this was not evidenced at inspection. There was a system in place where a senior member of staff visited the service to offer de-brief sessions with staff. However, staff de-briefs were not consistently undertaken subsequent to individual incidents to allow them an opportunity to reflect. Staff members do not receive the direction, training and support they require to deliver a therapeutic service and effectively meet young people's needs.

Young people's emotional well-being is considered but they are not provided with the therapeutic support as described in the statement of purpose, and staff are not provided with the specialist advice and guidance they need to meet young people's complex needs effectively. There was a general lack of recording to evidence that this was a 'therapeutic children's home' as described in the home's statement of purpose. Given the high number

of incidents, we would have expected evidence of a timely, co-ordinated response to ensure staff and young people well-being was paramount. There was a high volume of agency staff being utilised at the home to ensure sufficient staff numbers, however this had reduced slightly with attempts made to recruit and retain some casual staff members. Records of agency staff qualifications, training and experience were not available during the inspection because they were not kept at the home and the manager was unaware of the agency staff profiles. Therefore, we could not be confident agency staff had the appropriate training and skills to meet the complex needs of the young people. Overall young people cannot be reassured that they will receive the therapeutic support they need to achieve good outcomes.

Although measures are in place to monitor and review service quality, they are not sufficiently robust. Service shortfalls including areas where the home does not meet legal requirements, are not consistently identified and are not addressed in a timely way. We saw evidence of senior management oversight of the home, with monitoring visits undertaken by the responsible individual and another senior manager visiting monthly, although monthly reports were not available during the first day of inspection, thus leaving the home without adequate quality assurance and monitoring. It was evident that some service shortfalls had been identified, and recommendations made e.g. regarding staff recruitment, supervision and training. Senior management meetings had also resulted in action being taken to address service shortfalls by an experienced manager being requested to oversee the home in the absence of the manager. However, monitoring did not clearly focus on outcomes for young people and despite the frequency and intensity of incidents taking place, action was not taken to meet young people's needs by promptly addressing service shortfalls. CIW were not notified of a significant number of events required by legislation and significantly, this was not identified through internal quality assurance processes for a considerable length of time. A quality of care report was yet to be completed by the responsible individual but the current manager had prepared their input for this report which was available to us. Young people cannot be confident that the home is carried on with sufficient care, competence and skill. The organisation's quality assurance mechanisms and governance arrangements are not robust enough to ensure that service shortfalls, including non-compliance with legislation, are identified and addressed in a timely way.

5. Improvements required and recommended following this inspection

5.1 Areas of non compliance from previous inspections

This is the first inspection since the service was registered under The Regulation and Inspection of Social Care (Wales) Act 2016.

5.2 Areas of non compliance at this inspection

During this inspection, we identified areas where the registered manager is not meeting the legal requirements and this is resulting in potential risk and poor outcomes for people using the service. We have issued non-compliance notices in relation to the following:

- **Regulation 14(1) – Suitability of the service:** The service provider must not provide care and support for individuals unless the service provider has determined that the service is suitable to meet the individual's care and support needs and to support the individual to achieve their personal outcomes.

- **Regulation 15 – Personal Plan:** Personal plans were not prepared in line with statutory guidance - outcomes were not specific and measurable. They also did not include the detailed guidance to staff about how personal outcomes would be met. Risk assessments did not include specific and detailed guidance to staff to minimise risk or evidence the success or otherwise of strategies staff were to follow.

- **Regulation 26 – Safeguarding:** The service provider has not provided the service in a way which individuals are safe and protected from abuse.

- **Regulation 36 – Supporting and developing staff:** The service provider needs to ensure that staff are supported, receive regular supervision, core training appropriate to the work to be carried out and more specialist training as appropriate.

- **Regulation 80 – Quality of care review:** The service provider has not ensured suitable arrangements were in place to establish and maintain a system for monitoring, reviewing and improving the quality of care and support provided by the service.

Details of the actions required are set out in the non-compliance notices attached.

- **Regulation 17 -** The service provider has not given a copy of the personal plan to the young people living in the home.

- **Regulation 18 – Provider assessment:** The service provider has not carried out, within 7 days of the commencement of service, an assessment of how young people's individual needs can be met in line with requirements.

- **Regulation 22 – Continuity of care:** The service provider must put arrangements in place to ensure individuals receive continuity of care as is reasonable to meet their needs for care and support.

- **Regulation 35 – Fitness of staff:** The responsible individual has not ensured that agency staff are subject to the same checks as permanently employed staff and have evidence to demonstrate the checks have been undertaken.

- **Regulation 60 – Notifications:** The service provider has not notified CIW of all the events specified in Schedule 3 of the regulations and has not ensured notifications were made without delay.

- **Regulation 78 – Duty to ensure there are systems in place for keeping records:** The responsible individual has not ensured that there are effective systems in place in relation to the keeping of records.

Notices have not been issued on this occasion, as there was no immediate or significant impact for the young people using the service.

We expect the registered persons to take action to rectify the above which will be followed up at a future inspection.

5.3 Recommendations for improvement

- The frequency of fire evacuations drills is amended so that one is carried out whenever a young person is admitted to the home or a new member of staff appointed.

- Activity planners are developed together with young people to ensure they are engaged in meaningful activities.

- House meetings take place more frequently to provide opportunities for young people to have their voice heard formally.

- Independence plans are developed.

- A system to ensure any damage is repaired in timely manner.

- Key worker sessions to take place more frequently.

- More structure, routine and space to be established within the home to allow opportunities for young people and staff to congregate together, for example, eating meals.

- The accommodation to have more decorative items and photographs to provide a more welcoming environment where young people feel a sense of belonging.

6. How we undertook this inspection

This was a full inspection as part of our annual inspection programme. One inspector made an unannounced visit to the home on 18 September 2019 between 09:55 – 17:25 and another announced visit on 27 September 2019 between 09:45 – 16:45.

The following methodology was used:

- We reviewed information about the service held by CIW.
- We spoke with the responsible individual, temporary manager and staff on duty.
- We spoke with one young person.
- We considered case records and information held by the service.
- We reviewed a sample of staff supervision records.
- We looked at a range of documentation including the Statement of Purpose, Service Users Guide and a sample of policies and procedures.
- We considered the quality monitoring records.

Further information about what we do can be found on our website:
www.careinspectorate.wales

About the service

Type of care provided	**Care Home Service**
Service Provider	**Bridgend County Borough Council**
Manager	**Sian Morgan-Jones**
Registered maximum number of places	**6**
Date of previous Care Inspectorate Wales inspection	**02/08/2017**
Dates of this Inspection visit(s)	**18/09/2019** **27/09/2019**
Operating Language of the service	**English**
Does this service provide the Welsh Language active offer?	**No**
Additional Information:	