Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Maple Tree House

Bridgend

Date Inspection Completed

21/02/2020

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 manager is registered with Social Care Wales. The responsible individual is Laura Kinsey.

Summary of our findings

1. Overall assessment

This was a focussed inspection to test compliance on the outstanding non-compliance raised at the previous inspection in September 2019, and in particular those in relation to the well-being, care and support of young people and the leadership and management of the service. Whilst there have been some improvements made at the service with a more consistent staff team, better oversight of decision making regarding admissions, however, there remains areas of concern. The service has failed to achieve compliance in the specified timeframe and young people do not receive care and support in line with the service's statement of purpose. Improvements are required in the provision of specific and up to date guidance for staff to enable them to manage the complex needs and behaviours of the young people living at the home. Additionally, improvements are required in relation to the recording systems, staff training and support, safeguarding, incident management, the implementation of therapeutic support, admissions and discharge of young people and the responsible individuals' oversight of the service. Governance and quality assurance arrangements are in place but these require strengthening and action is required by the responsible individual to ensure that the service complies with legal requirements.

2. Improvements

- All about me documents were completed with young people to provide a better understanding of their wishes and feelings when placement searches commence.
- Time is set aside for staff to complete paperwork away from being on shift.
- A provider assessment has been developed.
- CIW have been notified in line with legislation.
- Reduction in agency staff being used.

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:

- Safeguarding
- Quality assurance

1. Well-being

Our findings

There are systems in place for young people to have their voice heard but improvement is required. Young people told us they were able to have a say about the food they ate and the activities they engaged in. We viewed the complaints records; these evidenced young people knew how to complain. The audit trail following a complaint required improvement to ensure this was easily accessible and young people signed to evidence they were happy with the outcome. Young people's views had been incorporated into their personal plans. Direct work plans had been drawn up and some sessions had been completed allowing time for young people to express what was important to them; however, this was being developed further. It was not always evident of sessions being completed with young people, in a timely manner, following incidents. In some cases, they were written retrospectively and it was unclear where the information had been obtained from. The staff had supported young people to maintain contact with their families. House meetings continued to be developed by speaking with the young people individually. All about me documents were created to capture young people's views for future placement searches. Attempts were made to seek views of young people during quality assurance visits. There was minimal evidence of young people personalising their environment. Practice and processes in the service allow young people to make decisions about their care but this requires strengthening.

Practice and processes in place to safeguard young people are in need of improvement. One young person we spoke with told us they felt safe living at the home but we saw reference to a previous young person stating they did not feel safe. Staff we spoke with felt confident about safeguarding processes and how to raise any practice concerns if necessary. Safeguarding meetings had been convened when required and CIW had been notified appropriately in line with legislation. The training matrix did not evidence all staff had safeguarding training. Risk assessments were in place, although they had improved, these still lacked detailed guidance to staff in how to manage young people's increasing risk taking behaviour and did not identify all known risks. There were frequently serious incidents occurring at the home, affecting staff and other young people's safety. Police involvement was still utilised, although reduced, to assist with managing young people's behaviours, thus resulting in young people being criminalised. Incident records were improved with better oversight, but these still lacked a complete picture of an incident and the safeguards implemented following a serious incident. Where safeguards were recognised, they were not routinely implemented, resulting in further incidents. Physical intervention levels were low and records we viewed, where used, they were proportionate, however, the records should indicate how long a young person were held for and by which staff. During the inspection process, we also had received notifications from the service indicating serious incidents at the home placing young people and staff at increased risk. There continues to be concerns regarding the safety and management of incidents at the

home by the actions taken by staff. Additionally, there was a lack of incident analysis and forward planning in managing incidents. The safeguarding arrangements at the service are in need of improvement to ensure young people's well-being is paramount.

The arrangements in place to promote young people's physical, emotional and mental well-being requires strengthening. Young people's admission and discharge had improved but they were not consistently robust. Decision making to admit young people had improved with more ownership for the manager to make decisions about a suitable match and this was evident at inspection. Impact assessments, provider assessments and assessments to determine future placement needs were not consistently completed or effectively analysed young people's needs. This resulted in young people leaving and returning to the service on different occasions, affecting the number of placement moves. Efforts are made to improve this the service was advertising for a part time social work post to complete the assessments. The young people were able to take part in physical and non-physical activities, which they enjoyed, although their engagement was variable. Independence work had started to help young people develop their skills. Health needs were met; staff received necessary training to meet needs and medical attention sought when required. Input from specialist health support was available to young people when required, however, in some instances there was a lack of evidence of joined up working with guidance not incorporated into young people's documentation. Despite the service's statement of purpose indicating the placement was therapeutic, there was limited evidence of this. The RI recognised this and there were plans being implemented to achieve this with staff receiving the appropriate training. De-briefs for young people and staff were yet to be fully implemented, despite there being plans to. Records referred to young people having direct work undertaken with them following incidents and within their risk assessments and personal plans but there was limited evidence of sessions directly focussing on the known risks, or working with others to reduce and seek support for the behaviours. There was limited evidence of young people having made positive progress since residing at the service. Attempts are made to try to address some of young people's behaviours but there is limited evidence of sustained positive progress being achieved by young people living at the home.

2. Care and Support

Our findings

Improvements have been made regarding admissions but young people are not consistently supported to move on from the home successfully. We saw evidence of the manager being given ownership of the decision making regarding admissions and some placements had been declined due to inappropriate matching. Discussions with the social worker regarding compatibility and posed risks was also in place, which the manager explained was working well. Where young people were placed in the emergency unit with high complex needs, the service suspends further emergency admissions to ensure it is a solo placement. The service had developed a provider assessment which covered various pertinent issues, staff had received training on this but these were not consistently completed and filled in. The service had successfully supported some young people to move on with some outreach support in place. Impact assessments were not consistently completed and none were completed for the emergency placements in the emergency unit. Neither were assessments to determine future placement needs for young people in the emergency unit. Therefore, there was no record of decision-making and analysis regarding these placements. No further admissions to the assessment unit had taken place; therefore, we could not determine the robustness of this area during inspection. Some young people had been back and forth the service due to their assessed placement not being successful. Some young people were told they were leaving the service and later did not. The RI had amended the statement of purpose to provide scope for young people to stay past the designated timeframes in extenuating circumstances. Young people's needs are now prioritised before further admissions are made but the admission process still requires strengthening and their assessed needs and placement moves requires attention to give young people the best chance of success.

Young people are cared for by a consistent staff team with improved handover systems in place but documentation regarding young people's needs were not detailed to provide them with the necessary knowledge and guidance to meet their needs. Personal plans were in place and these now incorporated young people's views and they were offered a copy of their plan. However, they still lacked evidence of how young people were being supported to achieve positive outcomes. They lacked key information regarding young people's needs and how they would be supported day-to-day. Additionally, risk assessments lacked clear guidance regarding young people's risk taking behaviour and how they were to be supported to safely manage and reduce risk taking behaviour. Handovers were taking place prior to each shift which was recorded to evidence each update. Agency staff usage had significantly reduced and the staff team was more consistent to allow young people the means to develop relationships with familiar staff. Young people are cared for by a consistent staff team where there is a system in place to handover information but further attention needs to be paid to young people's documentation to ensure staff are clear and detailed guidance is available to achieve positive outcomes for young people.

3. Environment

Our findings

This was not an area of non-compliance at the previous inspection. However, there were areas of improvement required, therefore, we viewed the accommodation. There was less noticeable damage, albeit, there was still some including the carpet in the assessment unit needing replacing, the walls had been re-painted and repairs were completed in a timely manner. One young person told us it was not homely and reported to the manager that they did not want others to visit because it was not a 'home'.

The accommodation continues to appear unwelcoming and homely, the home lacked any personalisation or evidence that it was the young people's home. The emergency unit, which was for young people to stay for up to 28 days, often longer in extenuating circumstance, remained with only one place available at the dining table for a young person to sit, however, the manager informed us they intended to order a new table to accommodate more young people and staff to sit and eat together. The living room in the emergency unit was not particularly homely and did not have a television or particular signify it was a living room. We were informed young people had televisions in their bedrooms and the kitchen/dining area. The manager assured us a television would be ordered for the living room.

Documents viewed indicated that internal doors were being locked, thus linking to an increase in incidents. The manager assured us that doors were not locked routinely, only where there was an on-going incident, the kitchen would be locked.

4. Leadership and Management

Our findings

Young people are cared for in 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 as described in the document. The statement of purpose continues to outline the home as a therapeutic placement, we continued to see very little evidence to demonstrate the young people were cared for therapeutically. It also made reference to the service "*focussing on assessments and therapeutic interventions to stabilise the child's / young person's behaviour, work on improving any risk taking behaviours…and identify the most suitable long-term move on placements"* and being cared for by *"specialist qualified staff"*. However, the home's training matrix did not evidence that all staff had been provided with the training and support they required to deliver the therapeutic model. Staff training was not as described and there were shortfalls in admissions and discharge of young people, incident and behaviour management and overall quality assurance systems. Young people cannot be confident they will be cared for as described by the statement of purpose.

Young people are cared for by a consistent staff team who receive supervision but improvement is required in relation to staff training and guidance. The staff we spoke with enjoyed their jobs and felt supported by managers at the service; they felt things had improved since the last inspection. There were less agency staff being used to complete shifts and there was a focus on recruiting further staff to create a more stable staff team. Many of the staff team were new but there were staff who were appropriately qualified and experienced and had worked at the service for a considerable length of time. The training matrix did not evidence that all staff had been provided with the training and support they required to deliver the therapeutic model. Additionally, training had not been provided to all staff to meet the specific needs of young people living in the home nor had many staff undertaken the mandatory training identified by the service. 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.

Quality assurance systems are in place but these need to be strengthened. We saw monthly team meetings to allow opportunities for staff to raise matters. Monthly visits were undertaken by another manager within the service and the manager completed a monthly report to identify and address shortfalls. These evidenced some areas of improvement were being identified but primarily lacked detail regarding any analysis of information viewed.

Additionally, some months, some key information, i.e. incidents at the service were not being viewed, commented on or information analysed. The RI's three monthly visit had been undertaken in line with legislation. The last visit undertaken was by another senior manager in the absence of the RI, the visit, had not identified any areas of improvement nor had the visit been clear about what was viewed and there was no analysis. There was no evidence of them looking at or commenting on young people's documentation or how their outcomes are being achieved and there were no action points to follow up. However, they had attempted to engage and seek the views of a young person present at the time and sought the views of staff on shift. A quality of care review report was available and evidenced consultation with young people, staff and other professionals, albeit limited. It recognised areas of success and identified areas of improvement. Whilst some improvements had been made, there continues to be shortfalls at the service and these are not routinely identified and rectified in a timely manner as part of their quality assurance systems.

5. Improvements required and recommended following this inspection

5.1 Areas of non compliance from previous inspections

• **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.**	Achieved
• **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.**	Not achieved
• **Regulation 26: Safeguarding The service provider has not ensured that the service is always provided in a way which ensures that young people are protected from harm and abuse.**	Not achieved
• **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.**	Not achieved
• **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.**	Not achieved

5.2 Recommendations for improvement

- The computer systems for storing records including young people records requires improvement to ensure information is easily accessible and contained within the correct file.

- Frequency of chronologies to be completed.

- Ensure any agency staff sign to evidence they have read and understood key documents relating to the young people living at the home.

- Young people to sign to evidence they are happy with the outcome of any complaints made by them.

- Physical intervention records to clearly indicate which staff were involved in the hold and the length of the hold is recorded.

- Supervision records to evidence more clearly the discussions that took place.

6. How we undertook this inspection

This focused inspection was undertaken to determine whether the service had achieved compliance with legislation in the areas identified in the notices of non-compliance issued in September 2019. We therefore looked at the well-being of young people living in the home, their care and support and the leadership and management arrangements. One inspector made an unannounced visit to the home on 19 February 2020 between 9:30 a.m and 17:10 p.m and another announced visit on 21 February 2020 between 09:30am – 16:50pm.

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:
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7. About the service

Type of care provided	**Care Home Service**
Service Provider	**Bridgend County Borough Council Adults and Children's Services**
Responsible Individual	**Laura Kinsey**
Registered maximum number of places	**6**
Date of previous Care Inspectorate Wales inspection	**18/09/2019** **27/09/2019**
Dates of this Inspection visit(s)	**19/02/2020** **21/02/2020**
Operating Language of the service	**English**
Does this service provide the Welsh Language active offer?	**No**
Additional Information:	

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