Inspection Report on

Maple Tree House

Bridgend

Final unpublished report

Date Inspection Completed

10/08/2020

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About Maple Tree House

Type of care provided	Care Home Service Children's Home
Registered Provider	Bridgend County Borough Council Adults and Children's Services
Registered places	6
Language of the service	English
Previous Care Inspectorate Wales inspection	19 & 21 February 2020
Type of Inspection	Focused
Does this service provide the Welsh Language active offer?	No

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Summary

We carried out a focussed inspection in line with our improvement and enforcement process. This was to test the outstanding non-compliance raised at the previous two inspections in September 2019 and February 2020, relating to well-being, care and support and leadership and management of the service. The service has recently been deemed a service of concern. There have been some improvements made at the home including:

- Good analysis of incidents and behaviours which has seen a recent reduction in risk taking behaviour for some young people.
- There are improved systems to support staff and some young people are engaging better in activities.
- Complaints have been responded to appropriately and an increase in direct and independence work with young people.
- The behaviour clinic has completed some staff training.

Despite this, the service has failed to achieve compliance. There continues to be concerns about the service and keeping young people safe. Documentation at the home provides the staff team with limited understanding about the overall needs of the young people to ensure they receive a high standard of care and achieve positive outcomes. Young people's diet is poor and their overall care and support requires improvement. Medication management is poor with continued errors occurring. Training to meet the needs of young people continues to be inadequate and although quality assurance systems have been strengthened, these continue to fail to identify and rectify shortfalls at the home.

Well-being

Young people have a voice and are able to express their views and opinions day to day but their involvement in their overall care requires improvement. Young people told us they engaged in activities of choice, have a say about the foods they eat and can talk to staff about any problems they have. We saw complaints were responded to appropriately. House meetings take place but some young people chose not to engage but they have other opportunities to include their views. Their involvement in the development and review of their personal plans was limited. De-briefs for young people following incidents were not in place.

The arrangements in place to promote young people's physical, emotional and mental well-being is in need of improvement. Routines, consistency and structure was minimal at the home. Although, Young people have newly developed activity planners outlining their plans and routines for the week in an attempt to implement good, consistent routines and structure. These have been successful for some young people who have engaged well with better structure to their days. We acknowledge that Covid-19 has had a negative impact on young people's access to activities. However, engagement for some was limited and there was a lack of encouragement by staff. Sleeping patterns were poor for some young people; they were awake throughout the night and asleep during the daytime. The food consumed by young people was not healthy, balanced or nutritious. Efforts are made by the staff team to offer healthier options but further work regarding this is necessary.

There are safeguarding measures in place but are not always effective. The majority of the care staff have completed safeguarding training. Training to meet the more specific areas of young people's risk taking behaviour was limited. Staff told us they felt confident in the procedures and how to raise concerns. Young people told us they felt safe living at the home, but there was information to highlight that one young person told staff they did not feel safe. Efforts are being made to improve the systems in place to ensure young people are safe but serious incidents continue to occur. CIW have been notified of the majority of incidents, which have occurred at the home. Physical interventions used at the service are low. Medication is not managed in a safe way and there have been errors, which have not been dealt with appropriately.

The accommodation is suitable for short-term placements in line with the services model but is not particularly homely. Improvements have been made to the environment including new flooring. Areas of concern identified during our inspection including the maintenance and personalisation of young people's space remained.

Care and Support

Personal plans are in place, but they do not provide a detailed overview of how the service will meet young people's needs to ensure they achieve positive outcomes. Plans were lacking in detail regarding important and key aspects of a young person's life. These were not always updated in line with changes. They did not consistently evidence how staff were to support young people to reduce risk taking behaviour and make progress in other aspects of their life. These include areas relating to how the service intended to meet the young person's day-to-day needs, including establishing good routines and maintaining good overall health and well-being were not evident. Young people's involvement was limited and their views were not established for reviews of the plan.

Young people are not appropriately safeguarded at the home. Prior to the inspection, we received a high volume of notifications, some of which were of concern. This led to CIW seeking further assurances that young people were safe. They indicated poor decision-making and actions to appropriately safeguard young people in seeking the right care. Incident reports do not always fully reflect and outline what occurred during an incident at the home. Learning from the incident is not always effective to establish what could have been done differently. New protocols have been developed to provide a more consistent approach by staff during incidents although these have not been built into the risk assessments but are readily available to staff. Risk assessments and personal plans do not provide full details of the risk taking behaviours for each young person and clear guidance in how staff are to respond. Despite the efforts to reduce risk taking behaviour, there continues to be serious incidents occurring at the service. Young people have been criminalised by their actions at the home and although reduced, police continue to be called to assist with behaviour management. The recording systems at the home are not providing an overview of the young people's daily actions in order to provide full details of young people's daily activities, their whereabouts and the staff monitoring systems. The service operates with sleep in staff, this is despite the young people's night time behaviours/routines and is not suitable to appropriately manage and safeguard young people.

Young people cannot be confident there are safe systems in place to manage medication. There have been occasions where medication has run out, the recording of medication is not clear and the agreed facilities to administer medication were not in place during the inspection. There had been three errors in a short space of time. Where it has been required, medical attention has not always been sought in a timely manner. The systems and oversight in place are not robust, they do not effectively identify errors and appropriate action is not always taken following a medication error. The medication cabinet had been repaired and had been moved to a more suitable space within the home to prevent further unauthorised access.

Environment

This was not an area of non-compliance during the previous inspection. However, we viewed the environment and found that whilst improvements had been made some areas are still in need of improvement.

A new small table had been purchased to ensure there was sufficient space for young people to eat their meals. Flooring had been replaced throughout. The outdoor area and some internal areas required maintenance but there had been a delay due to COVID-19; However, there was planned maintenance to resolve the issues.

We viewed a young person's bedroom; this was not in a suitable, acceptable condition. The responsible individual was informed of this. Items of concern were identified which were removed during the inspection.

The accommodation is appropriate for short-term placements but it does not particularly provide a homely, therapeutic, warm environment. There are plans for the service to relocate to a new provision in the future.

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Leadership and Management

The responsible individual is committed to supporting staff, making the necessary improvements to meet regulations and to provide a service in line with their statement of purpose. The service has taken action to establish better systems and oversight of the service. A new group manager is overseeing the service. The service is currently in the process of recruiting a new manager. In the interim, a temporary manager oversees the service full-time and is based physically at the home twice a week. Additionally, they have a workforce development officer at the service on a part time basis, providing staff support and undertaking some quality assurance audits. A detailed provider assessment had been completed for a new admission to the service and the intention is to upskill staff to enable them to undertake assessments moving forward. The behaviour clinic, an assessment and therapy clinic have been commissioned to be based at the service three days a week to provide assessments, therapeutic input, behaviour analysis and training for staff to provide a more consistent and engaged approach with young people. There has been evidence of some real trends in what has been effective and what has not been. As a result, there has been a risk reduction in some instances and good investment and engagement from some young people.

The behaviour clinic have completed some training with staff regarding supporting young people, managing their behaviours and the implementation of their protocols. The RI informed us that it has been difficult to obtain further training and assistance from other professionals to embed plans during the pandemic. The majority of staff have not received training to meet the specific individual needs of the young people or the mandatory training. Staff receive regular supervision and de-briefs have been introduced to provide staff with time to reflect following an incident. Staff told us they felt supported and felt the service was improving but recognised further progress is required.

Quality assurance systems are in place but their effectiveness to identify shortfalls still require strengthening. Monthly team meetings for staff have not taken place during the pandemic. Handovers between shifts take place to share information and any updates between shifts. Monthly quality assurance visits were undertaken by other managers within the service, action points have been identified but there was no method to follow these up to determine that action had taken place. Due to the pandemic, the RI undertook their three monthly visit by means of a telephone discussion with the manager. The report had not identified any areas of improvement but highlighted an overview of the current circumstances. Documentation was not viewed to provide an overview of young people's experiences of their care at the service. There was no analysis to determine how young people's outcomes are being achieved and there were no action points to follow up. Whilst some improvements had been made throughout the service and there is a commitment to continue making progress. There continues to be shortfalls at the service and these are not routinely identified and rectified in a timely manner as part of their own quality assurance systems.

Areas for improvement and action at the previous inspection Manually add 'Description' and 'Regulation Code' from cassi data and the wording "Achieved" of improvement and action completed since the previous inspection		
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 15(1)	**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.	Regulation 26	**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.	Regulation 36(2)	**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.	Regulation 80(1)	**Not Achieved**

Where providers fail to improve and take action we may escalate the matter by issuing a priority action (non-compliance) notice.

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Areas where immediate action is required	
None	

Areas where improvement is required	
None	

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