The Shaw Foundation Limited

Treetops

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

At our last comprehensive inspection of Treetops in January 2015 there had been multiple breaches of the regulations. At a further inspection in September 2015 we found that not all the breaches of regulation had been addressed. The provider was issued with two warning notices. We inspected the home again in February 2016 and found that action had been taken to comply with these notices.

We undertook an unannounced inspection of Treetops on 12 April 2016. Treetops is a care home with nursing for up to 24 people. The home mainly provides support for older people who are living with dementia. There were 20 people living at Treetops at the time of our inspection.

At the time of the inspection the home did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People said they felt safe living at Treetops. Risk assessments for people were in place but these did not always provide sufficient guidance for staff about how to manage the risks. Medicines were managed safely however, there were recording omissions.

Safe recruitment procedures were in place and new staff completed a full induction aligned with the Care Certificate. Staff received regular training to ensure they were skilled and effective in their roles.

Staffing was in accordance with the home's set levels. However, staffing was dependent on the use of agency staff. This meant that people did not have familiar people supporting them who knew them well.

Applications were made when appropriate in relation to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to treatment or care or need protecting from harm. However, we found that the conditions set out in people's DoLS authorisations were not always being met. Staff understood the principles of the Mental Capacity Act 2005 and applied these in their role. However, capacity assessments and best interest decisions, when needed, were not always made in accordance with the Mental Capacity Act 2005.

The feedback from people and relatives was mostly positive about staff at the home. We observed staff being kind and treating people with dignity and respect. However, we observed that care and support was not always person centred. People's visitors were welcomed at the home.

Care plans were not always fully completed. They were not always in an accessible format for people. They did not provide sufficient guidance for people to be supported in a person centred way.

Feedback was not sought from people or relatives through meetings or questionnaires. Staff had meetings where they were able to contribute ideas and feedback. Activities were provided in the home and community.

The home did not have a registered manager in post. There was a lack of stable management and this impacted on people and staff. Changes needed to improve the service had not been implemented. Notifications of important events had not always been sent to the Commission as required.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff had knowledge of safeguarding procedures. However incidents were not always reported to the local safeguarding team.

Safe staffing levels were maintained with the high use of agency staff. This meant that people were cared for by staff they were not familiar with.

Risks to people were identified but there was not always risk management guidance to ensure people were supported safely.

People's medicines were managed safely. However, there were some instances of recording omissions.

Recruitment procedures were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The home was not meeting the Deprivation of Liberty Safeguards as people's conditions as part of their authorisations were not always being met.

Capacity assessments and best interest decisions were not being made in accordance with the Mental Capacity Act (MCA) 2005.

Staff had effective induction and training.

Risks to people in relation to hydration and nutrition were managed effectively.

Is the service caring?

Requires Improvement

The service was not always caring.

People sometimes received care that was task led rather than person centred.

Staff treated people with kindness and respect.

People's visitors were welcomed at the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans lacked detail and people were not closely involved in planning their care.

Feedback was not sought from people, relatives or staff.

Activities were arranged for people.

The home had a complaints system in place.

Is the service well-led?

Requires Improvement

The service was not always well managed.

Statutory notifications and other significant information had not always been sent to the Commission as required.

Frequent changes in senior management and a lack of a registered manager meant changes to improve the service were not always implemented.

Staff did not feel valued in their role.

Quality assurance systems were in place and this had identified areas that required improvement.

Treetops

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed previous inspection reports and all other information we had about the service including statutory notifications. Notifications are information that the service is legally required to send us.

Some people at the home were living with dementia. This meant they were not always able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us

During the inspection we spoke with six people living at the home, four relatives, the acting manager and six staff members. We looked at eight people's care and support records and five staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Requires Improvement

Is the service safe?

Our findings

People told us they mostly felt safe living at Treetops. Several people when asked if they felt safe at the home replied positively with answers such as, "Yes," "Oh yes" and "Very." Relatives we spoke with said their family members were safe and well cared for. One relative said, "Yes, very safe and well looked after." Another relative said, "He is well looked after and safer than being at home." We observed people being supported to move safely around the home, using appropriate equipment and aides when required.

The provider had policies in place for safeguarding vulnerable adults and whistle blowing. These contained guidance on the action that would be taken in response to any concerns. Staff we spoke with were able to describe different types of abuse and ways these could be identified. One staff member said, "I would report any concerns to a manager." Staff received training in these subjects within their induction programme. There was ongoing refresher training in these subjects and the training records confirmed this. However, we found that when concerns had been identified these had not always been reported to the local authority safeguarding team. People could not be confident that the appropriate action would be taken to reduce the risk of harm in the future.

We viewed staffing rotas for the previous eight weeks. The home was currently recruiting for four positions. A manager told us that staffing at the home had improved. Staffing had been maintained at a level that the provider had determined to be safe. However, this was done through a high and regular use of agency staff both during the day, at night and at team leader level. On all shifts at least one third of the support staff were non permanent staff. Relatives and staff told us there was a high use of agency staff. One relative said, "It's a bit disappointing. They are using a lot of agency staff." A staff member said, "There is a high turnover of staff and a lot of agency staff used." Another staff member said, "Staffing levels are a bit low. Staff are coming and going all the time. Lots of agency staff are being used. Staff are not being retained." This meant it was more difficult for people to develop trusting and meaningful relationships. It also meant that some staff would have limited knowledge of individual preferences. One staff member said, "Lots of agency staff impacts on the residents, as they do not have familiar faces." Permanent staff took time to support agency staff to ensure care and support was given the way people wished. A manager confirmed there was no guidance or documentation aimed at agency staff to ensure they had the information they needed to support people safely and in their preferred way. One staff member said, "There are no details for agency staff."

We observed different parts of the home during lunchtime. Staff used appropriate food hygiene handling practices. However many people needed support to eat their meals and staffing levels made this difficult. A manager explained that a new system had been put in place to use other members of staff to support care staff during mealtimes. One member of staff said, "There is not enough staff to feed people safely." Another staff member said, "Mealtimes are an issue, there is not enough staff." One relative said, "As you can see there is no one here at all. It's lunchtime so the only two people available are helping feed everyone. It is impossible. There just isn't enough staff."

The home had systems in place to record accidents, near misses or incidents. Staff knew the procedure to

follow when an incident occurred and how they recorded this information. A monthly audit analysed accidents or incidents that happened to identify any trends or patterns. Actions taken to minimise future reoccurrences were recorded. For example, one person had their risk assessment updated due to a rise in falls. An alarm also alerted staff when they were going into the garden so they could be supported to reduce the risk of falling.

Individual risk assessments were completed. These included assessments relating to falls, personal care and night care. However, we found that where risks were identified there was not clear guidance for staff on how to manage the risk. For example, one person was identified as being at risk of poor personal hygiene. The risk assessment gave no direction to staff how to support the person to maintain good hygiene. We viewed two people's assessments that identified they were at risk due to their skin integrity. One person's assessment said they should be supported to be repositioned every two hours. However, records in the person's room showed they were being assisted between two and four hourly. The second person had been provided with an air mattress but there was no guidance in place to direct how care should be given. There was a risk that staff would not be using this support equipment correctly.

Medicines were mostly safely managed. However, we did find some shortcomings in relation to record keeping. A national pharmacy provided the majority of medicines in their original boxes. These were then stored within larger plastic boxes specifically allocated for each person, within medicine trollies. Nurses were responsible for the administration of medicines in the home. We observed a nurse on duty on part of a medication administration round and saw that they were well organised and safe practice was observed. Medicine administration records (MAR) were kept in a specific folder. This folder contained other relevant information relating to medicines alongside people's MAR sheets, such as photocopied prescriptions and diabetic monitoring charts. Some of this information was out of date. For example there was a 'Resident Medication Note' detailing one person's medicines that was dated 2013, which had been provided by another pharmacy previously used by the home.

A selection of MAR sheets was reviewed. People's photographs were attached to their MAR sheets to aid identification and any medicine allergies were recorded. Details of how people liked to take their medicines were also recorded. For example, '[Persons name] prefers in a pot followed by a glass of water. Ensure he takes as sometimes hides in mouth or spits out later.' Appropriate codes had been entered when medicines had not been administered and the reason for non-administration had been recorded on the reverse of the MAR sheet.

One person had been prescribed a transdermal patch. The area of the body the patch had been applied to was not always being recorded. This is seen as good practice as it lessens the risk of skin irritation. MAR sheets had been pre-printed by the pharmacy. There were some hand written additions found on MAR sheets. This was when staff had transcribed details of a prescription or alteration onto the MAR. We found that hand written additions had not always been signed by the person who did the transcribing and that a witness signature had not always been obtained.

The nurse said that when medicines were received in the home, they were counted or measured by two staff members. The amounts were then recorded onto the MAR sheet, which was then signed by both. We found several incidences where the amount of medicine received had not been recorded on the MAR sheet. This meant that clear records of medicine management in the home were not always being maintained.

The disposal of medicines was being recorded and witnessed by two people. There were appropriate disposal containers kept in the medicine storage room. The nursed stated that care assistants carried out the application of prescribed topical medicines and that they reported this back to the nurse for recording.

We spoke with a care assistant who confirmed this and saw a record that had been completed. Individual protocols for the use of 'when required' (PRN) medicines were available. This gave clear guidance to staff on how often and for how long the medicine can be used.

Medicines that required storage in accordance with legal requirements had been identified, stored and disposed of appropriately. Registers of these medicines matched the stock numbers held and were checked daily. People told us they received their medicines on time. One person said, "They bring my medication on time." Another person said, "Yes, they bring my tablets on time."

The temperature of the medicines fridge and the room where the medicines trolley was stored was checked and recorded daily in line with procedure. Records showed that there were two days in April and three in March where the fridge temperature had not been recorded. Also there were five days in April 2016 and 12 in March when the room temperature had not been recorded. This meant that it was not always known if medicines were stored at the appropriate temperature.

Records showed that regular checks were conducted on the facilities and equipment, to ensure they were safe for the intended use. This included fire safety systems, wheelchairs, call bells and electrical equipment. Gas, water and laundry appliances were also regularly serviced. We viewed records of weekly legionella testing. Risk assessments were in place for the premises, environment and use of equipment to ensure risks were kept to a minimum. For example, this included safe access to the smoking area for people and manual handling.

A manager monitored the premises and garden areas to ensure any safety issues were identified. These were now being done on a regular basis. However, we highlighted to a manager that it would be beneficial to be clearer on the follow up action taken.

People's Emergency Evacuation Plans (PEEP) were up to date. They were contained in care records and in the 'grab and go' emergency file at entrance to the home. The plans had guidance of people's mobility needs and level of staff support required to stay safe within an emergency evacuation. Records that showed practice fire drills had taken place. This recorded how people reacted and ensure staff knew the correct procedures to follow. At the last drill in April 2016 a discussion took place afterwards to identify areas for improvement. It showed that staff would benefit from further practical training in using the fire extinguishers. The home had a continuity plan in place. This document explained arrangements and procedures should an unforeseen event occur such as a gas supply disruption or a loss of accommodation.

The provider had safe recruitment processes in place before new staff started working at the home. Staff files showed photographic identification, a minimum of two references, full employment history and a Disclosure and Barring Service check (DBS). A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people. The recruitment process helped to ensure that staff only commenced working in the home when it was safe to do so.

The home was clean and well maintained. The home was free from odours apart from one bedroom. This had been identified and the flooring was currently being replaced. We observed staff wearing personal protective equipment, such as gloves and aprons when appropriate. One person said, "The home is kept clean." One relative said, "The environment is always clean." Another relative said, "The home is very clean."

Requires Improvement

Is the service effective?

Our findings

Care and support was not always effective in meeting people's needs. At our last inspection of Treetops in January 2015 we found records relating to assessments of people's decisions about their care and treatment were insufficient. The steps the manager told us would be taken at our inspection in September 2015 had not been implemented and there were no improvements in this area.

There were not effective systems in place with regards to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to care or treatment or need protecting from harm. A manager told us that everyone living at the home had a DoLS application in progress. There was not a clear recording system to monitor and check the progress of people's DoLS applications. For example, information was not available about when applications had been made, authorised or expired. There was no system in place for reviewing if conditions had been met or authorisations had expired. We found one person's DoLS authorisation had expired in February 2016 and managers at the home were not aware of this.

There may be one or more conditions attached to a DoLS authorisation which there is a legal obligation to meet. Following a review of conditions attached to two people's DoLS authorisations we found that these were not always being met. Managers we spoke with were not aware of the conditions set out in people's authorisations. For example, one person's conditions described particular activities they were meant to be engaged with. However, a manager confirmed these activities were not currently being organised. Neither was there any guidance for staff about these activities within the care plan. For another person it described conditions relating to the person's culture and heritage. Whilst these were included in the person's care plan, there was no supporting evidence of what had been offered and how the person had responded.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act (MCA) 2005 provides the legal framework to protect people who may lack the mental capacity to make their own decisions about their care and treatment. We found there was not a clear process to establish and record if people lacked capacity to make a certain decision. In five of the eight care records we looked at, we found mental capacity assessments dated 2014, which related to people's capacity to agree to live at the home. As these were two years old they may no longer be relevant to the person or the person's condition may have changed. These did not record in sufficient detail what steps had been taken to engage the person in the process. In care records, sections that related to capacity had not always been completed. For example, in one person's file a section on the person's capacity which related to personal care had not been filled out.

Five people at the home were receiving their medicine covertly. The provider's policy relating to covert administration stated, 'Where a service user is considered to lack the mental capacity to consent and it is felt that any refusal to receive medication is not in their 'best interests' a formal assessment of capacity should be completed and a 'best interests' decision meeting convened to agree and document the action to be

taken. A DoLS referral will need to be undertaken before any agreed action can be taken. The issue should be fully discussed with other members of the care team, including the GP and pharmacy. Relatives of the service user should also be involved, where possible.'

We found that in three people's care records the policy for covert medication was not being followed. This was due to records not being completed consistently and agreements to covert medication were not being reviewed as directed. We saw no evidence that a capacity assessment relating to medicines had been completed. Neither did we see that a best interest meeting had been held in line with the home's policy.

From speaking with managers and a nurse they confirmed that some people who were having their medicines given covertly had, at times, had the ability to consent. They said that they would review current information regarding those people receiving their medicines covertly.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable in the principles of the MCA and could explain how they put the principles into practice. For example, by offering choice. One staff member said, "I offer choice when supporting people with personal care. I ask people to choose their clothes. Also at mealtimes I support people to choose what they would like to eat."

New staff completed an induction programme which was aligned with the Care Certificate. All staff we spoke with confirmed they had received an induction when they started work. We viewed records of the current induction which included an introduction to the home and systems of working. The indication was comprehensive and clear records were kept of areas covered. We viewed records that showed staff were observed in their practice and having reflective discussions with a manager as part of the Care Certificate.

Staff received training in a variety of subjects so they could care for people effectively. The training records showed staff had completed training in safeguarding, moving and handling and first aid. Staff told us they had also received training in dementia, DoLS and MCA. The provider also facilitated staff to pursue nationally recognised qualifications in care. Staff spoke positively about the training they received. One staff member described the training they received as, "Quite good."

Staff received supervision and an annual appraisal from a senior staff member. Staff told us that due to management changes supervision had not been occurring regularly but this was now being addressed. A manager confirmed this and said annual appraisals were now commencing. One member of staff described supervision as, "Useful" and another staff member said they, "Valued the feedback." We viewed supervision records and saw that training and personal development needs were identified. We also saw whistle blowing and safeguarding procedures were discussed to check on staff members' understanding.

Feedback we received about the food provided was generally positive. Dietary requirements were catered for and displayed on the menu. One person said, "The food is OK." Another person said, "Yes the food is OK. There are two choices on the board daily."

Systems were in place to support people who were identified as being at risk in regards to nutrition and hydration. People had their weights recorded monthly and the home used a nationally recognised assessment tool to establish a person's risk of malnutrition or obesity. Fluid charts were used to document hydration and these were being completed as directed.

Records were kept to help monitor and communicate information about people's health needs. Dates of appointments with health professionals such as the dentist, GP and optician were recorded. However, in one person's care record this information had not been recorded at all. A lack of accurate records could lead to health needs not fully being met. We viewed when people required access to further healthcare then referrals were made. For example, with the mental health team or speech and language therapist. Information was conveyed to staff in handovers and communication book, to ensure all staff were notified.

Requires Improvement

Is the service caring?

Our findings

We observed mostly positive relationships between people and staff. When we spoke with staff, they showed they knew people well and how people preferred their care and support delivered. One person said, "The staff are nice." One relative said, "Yes the staff are lovely. He's always kept clean and tidy, washed and shaved." Another relative said, "It is difficult sometimes, but the staff are excellent."

Some people were able to tell us about the care and support they received. One person said, "The staff are kind and they listen to me." Another person said, "They [staff] are kind and I get on with all of them. They do listen." Another person said, "I don't feel staff are particularly kind and they don't listen to me." One person said, "We are left to ourselves most of the time." Another person said, "They have no conversation. They are just here to work". One relative said, "Staff are very kind, but they don't always have time." Overall the comments we received about staff were positive. However, people and relatives told us about continual staff changes and staff being busy. People felt that they did not spend any 'quality time' with staff.

We observed staff on one occasion entering a room and not acknowledging or speaking to anyone in the room. One person asked several staff if they could have support to get dressed. As staff were engaged with other people they had to wait a considerable amount of time. Sometimes we observed that no staff were available to spend time with people in the communal areas where people were sat.

Some people were not able to tell us about the care and support they received. We made observations throughout the inspection and during mealtimes. We observed a member of staff who supported someone to eat their lunch. The person started singing. A member of staff joined in with them, which the person enjoyed. The staff member spent time with them ensuring they ate enough of their meal. They were patient and encouraged the person to engage in conversation. However, in another room during a mealtime we observed people ask different staff members what was for lunch. Staff did not know and were unable to answer. This meant that people kept repeating the question and were not reassured.

We observed one staff member be cheerful, happy and chatty with people. They were talking aloud about what they were doing. They asked people questions and if there were comfortable. People responded to the staff member and were smiling.

People felt their dignity was maintained. One person told us how staff maintained their dignity during personal care. One relative said, "Yes his dignity is preserved." Another relative said, "They definitely protect his dignity." We observed staff safely support a person back to their room to change their clothes as they had spilt a drink. However, we observed a member of staff put a clothes protector on a person without asking them first for their breakfast. The person then did not receive their breakfast for a further half an hour. We observed staff on several occasions during lunchtime not asking a person before they performed a task. Staff only said what they were doing whilst they were already engaged in the task for example, getting someone ready for their lunch or moving someone.

The home had received three compliments in the last 12 months. One thank you card read, "Thanking staff

for the care given to [relative's name]." Another one said, "Staff are all wonderful." It then went on to describe one particular member of staff who was, "Caring and lovely." Another comment read, impressed with the healthcare assistant. She must be an essential member of your team."

People's care records gave information on people's personal history and background. This enabled staff to have knowledge about the person so they could engage in conversation and topics that may interest people. We observed that staff knew people well. When people could not verbally communicate, staff knew how people communicated choices and responses.

Staff respected people's privacy by always knocking on people's doors and asking if they could come in. We saw one person using their own key to their room and locking the door whilst in there to maintain their privacy. People had memory boxes outside their rooms. These contained personal photos and mementoes. The boxes helped people to recognise where they were and to find their own rooms. We observed people moving around the home and going out into the garden when they wished.

Staff and relatives told us that family and friends could visit the home at any time. We observed and spoke with family members who visited on the day of our inspection. Some family members visited daily. People described the home as having a good atmosphere. One person said, "It is a good atmosphere here." Another person said, "The atmosphere is pretty good."

Requires Improvement

Is the service responsive?

Our findings

At the last comprehensive inspection of Treetops in January 2015 we found that people did not always receive care that was person centred and met their needs. Care records were sometimes incomplete and did not give sufficient guidance for staff on how people preferred their care and support to be provided.

Whilst at this inspection in April 2016 care records had been identified by the manager as an area that needed improvement, no significant improvements had been made.

Care records contained a pre assessment to ensure the home could meet people's needs. We saw that people had 'Life maps' which detailed people's personal histories. However, we found that care records were not always fully completed and had information missing. For example, in one care record the checklist at the front to ensure all sections had been completed was dated 2012. The personal profile, documentation of medical appointments and family contacts had not been completed. Another care record we looked at for a person who moved into the home in March 2016 showed that care plans relating to personal hygiene, skin integrity, night care, medicine support, meaningful activity, mental well-being and breathing had yet to be completed.

Care plans were in a format that meant they would not always be easy for people to follow and were not always accessible. People told us they had not been involved in producing their care plan. One person said, "No, I've not seen my care plan." Another person said, "Yes I've seen my care plan but I have not discussed it." Care records did not show how people preferred their care and support to be given. Information in care plans did not give enough detail about how to effectively support people. For example, in one record it said, 'Staff to ensure catheter care is in place'. However, it did not describe what this actually meant or what staff were to do. Whilst staff we spoke with knew people and could give examples of individuals' preferences, this information was not reflected in the care plans we viewed. This meant that new staff joining the home would not have the information or guidance on how to support people in a person centred or consistent way.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had an allocated key worker. This meant that the staff member who was in the role of key worker took responsibility to ensure needs identified in the person's care plan were met. However, this was difficult to implement effectively without the staff team in place to support it.

There were no systems in place to gain feedback from people or relatives. No meetings were held or surveys conducted. One person said, "There are no residents meetings." Another person said, "I've never been asked for feedback. I don't know of any meetings." One relative said, "There are no questionnaires." The home was not encouraging people to share their experiences and providing a means by which people could give their feedback. This meant that people's views were not being taken into account and being used to help identify where improvements may be needed.

An activities co-ordinator was deployed during the week. Their role was to facilitate, organise and engage people in meaningful and enjoyable activities. There was a noticeboard which displayed outside entertainment that was scheduled at the home such as, music, singing and a tea party. The co-ordinator told us there was no timetable currently in place so people could see what activities were arranged on a daily basis. The co-ordinator knew people well and what people liked to do. Activities were described that were designed for people living with dementia. For example using objects, photos and I pads. This was so people could locate places or things of interest and reminisce. A trip to a local place of interest was organised on the day of the inspection. We saw appropriate risk assessments were conducted to ensure the trip was safe and people received the support they needed. The co-ordinator knew people who needed to be asked in advance if they wished to participate and how to reassure people that may have any anxieties about participating in an activity. The co-ordinator also gave one to one time to people who remained in their rooms. Despite the activities on offer people felt they needed more to do. One person said, "Don't do much, just sit here." Another person said, "It's like a prison in here." Another person commented, "No activities, we just watch TV." A relative said, "There are no activities for [person's name]." One member of staff said, "There are not enough activities, people can't go out much."

People and relatives said they would complain if they felt a need to. One person said, "I have never had a complaint." A relative said, "Yes we have been given a copy of the complaints procedure." Another relative said, "I know how to raise a concern, but I haven't had to." The home had received two formal complaints in the last 12 months. Both complaints concerned how staffing, in particular the use of agency staff impacted on their relative's care. Records showed that complaints had been investigated, action taken in response and the outcome fed back to the complainant to ensure they were satisfied.

People told us that the television in one area of the home had not been working for some time. One relative said, "The television in here hasn't worked for months." We viewed the maintenance records and saw this had initially been reported in December 2015 with some faults and then again in March 2016 with further faults. Whilst there was another television available for people in the activities room, it meant one area of the home had been without a television for some time. A manager said this would be addressed without delay.

We observed call bells ringing for prolonged periods of time during the inspection. At one point we had to go and ask a manager to attend as a person's call bell was ringing for some time and no one had responded.

Requires Improvement

Is the service well-led?

Our findings

People could not be confident that Treetops was well managed and led. At the time of our inspection there was no registered manager in post.

A notification is information about important events that affect people or the home, which the home is required to send to the Commission. We found that an incident reported to the local safeguarding authority in May 2015 had not been reported to the Commission as it should have been. We also found an incident in July 2015 that had occurred between two people who lived at the home. This incident had resulted in an injury to one person. The incident had been recorded in people's care records. However, this incident should have been reported to the local authority safeguarding team and the Commission and it was not. In addition to this when people had an authorised DoLS in place, notifications had not been sent to the Commission as required since 2014.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff told us there had been numerous changes in management over previous years. One staff member said, "The managers are constantly changing. It means we are not well supported." Another staff member said, "We have had a lack of stability in management for a long time." People knew who the managers were. One person said, "Yes, I can talk to the manager." Another person said, "The management could be more approachable. I give feedback all the time but they don't listen." One relative said, "The management are approachable, but often very busy." Another relative said, "The managers keep changing." A lack of stable management meant that the changes needed to improve the home were not always implemented or sustained.

Information was communicated effectively to staff. Messages and important information were written down in the staff communication book. Staff also used a diary to keep appointments and arrangements for people. However we found that people and relatives felt communication was less effective. One person said, "There is little communication." A relative said, "They do communicate when less busy." However, another relative said, "When [person's name] was poorly, they contacted me straight away."

Team meetings had not been occurring regularly. This meant that staff were not always fully informed or had the opportunity to give feedback and suggestions about the care and support they provided for people. The last staff meeting in February 2016 had been an open forum for staff to discuss the changes that had occurred and to give their opinions. The current managers were trying to engage staff so they felt involved in the running of the home and to contribute ideas for improvement. One staff member said, "We can put forward ideas at the staff meeting."

Staff did not feel valued in their roles. One staff member said, "I don't feel valued." Another staff member commented, "Staff do not feel valued." A relative commented, "They [the provider] do not appreciate their staff. They have a high volume of turnover." Staff we spoke with confirmed they had not received a staff survey.

Since our last inspection, a manager had introduced a new audit system to monitor areas such as medication, the environment and care plans. These audits then linked to a document to show what had been changed on actioned. The audits identified areas which required improvement. The provider conducted audits of the home on a regular basis. These audits had identified information missing in care plans for example, no photographs of people and personal information not fully completed.

The home was recruiting for new staff members and the provider had identified in their business plan that there was a need to reduce the use of agency staff. However, the provider had not reflected and addressed how it could improve its staff retention rate. A high turnover of staff meant that the home was not able to develop ideas and improve the way it worked as there was not the staff team in place to implement changes.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications about significant events had not been sent to the Commission as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not fully protected because the requirements of the Mental Capacity Act 2005 were not being followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not being lawfully deprived of their liberty in accordance with the Deprivation of Liberty Safeguards.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

People were not protected from the risk of unsafe or inappropriate care and treatment due to the lack of accurate and complete records.