Epping Care Home Limited

Treetops Care Home

Inspection report

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06 October 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

At the previous inspection in June 2017 we rated the service as Requires Improvement and identified concerns around leadership, oversight, management of risks and safe staffing. This inspection was undertaken on the 15 and 16 August 2017, but due to ongoing concerns we returned again on 18 and 19 September 2017 and again on 6 October 2017. The visits were prompted by and continued because of ongoing concerns about staffing levels, competency and skills resulting in an inability to consistently and safety meet people's care and support needs. Concerns had also been raised about the financial viability of the service and the impact this had on the service to operate safely.

We have not reviewed all aspects of each Key Question but given the risks and ongoing concerns consider it appropriate to provide as much information as possible in this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

In this case we took immediate urgent action to restrict new admissions and impose conditions to force improvement at the service. Despite support from Essex County Council and other health care professionals over the last few months required improvements were not made. Essex County Council have since supported all those living at Treetops to move to alternative accommodation. The home has been empty since 13 October 2017.

Prior to and during this inspection we identified incidents where people may have been exposed to the risks of avoidable harm. The Commission is currently making further enquiries into the circumstances of these incidents to consider whether it should take further action under its criminal enforcement powers. We will report on the outcome of these enquiries once they are concluded.

During this inspection, we found that the registered provider was in breach of multiple regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We found that the quality of care at Treetops had significantly deteriorated and there were major concerns from people, families, commissioners of care and health care professionals about the ability of the registered provider to carry on the service without people being at potential risk of harm.

Treetops Care Home provides accommodation and personal care for up to 52 older people. There were 36 people living at the service in August 2017 and on our return in September 2017 there were 30. Those accommodated at Treetops are vulnerable due to their age and frailty, and in some cases have specific and complex needs, including dementia, mental health and physical disabilities.

A registered manager was in post at the time of this inspection. 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.

The provider was unable to demonstrate that a reduction of staff was appropriate to meet the needs of people using the service and keep them safe at all times. Additionally, the service had a shortfall of permanent staff and was reliant on external agencies to cover shifts. The availability of agency staff was restricted because the provider had not settled invoices and outstanding monies. This at times meant that some shifts were not covered as required and impacted on staff ability to meet people's needs.

At the time of this inspection, the provider's nominated individual (NI) was unable to demonstrate any contingency plans to mitigate any future risk of understaffing. They were also unable to provide a clear explanation as to how they intended to manage the current debts so as to ensure people at the service were not affected.

The Commission and other health and social care professionals observed and found a significant number of medication errors, omissions, accidents, incidents and poor practice. These incidents continued to be reported by the service, health and social care professionals, relatives and others throughout August and September 2017. As a result Essex County Council and health care professionals made regular visits and provided support to the senior leadership to try and mitigate the risks. However whilst this did have some impact it was not sustainable and the provider had no strategy to robustly address the root causes and improve the service. The quality of care remained poor, incidents continued to occur which placed people at risk of actual or potential risk of harm.

The provider was unable to demonstrate that they had the ability to ensure people in their care were safe. The infrastructure in place to support senior management and staff teams was significantly lacking. Resources were not easily available to ensure that improvements could be made and sustained. For example we found the main lift had broken down regularly over a two year period, the alternative platform lift was found to be unsuitable and unsafe for people to use. This was because it also stopped working and had entrapped people who had to wait for an engineer to be released.

People using the service and their relatives told us that they were not happy with the service. Concerns included poor care provision, not being provided with enough to drink and some staff not treating them with respect and dignity.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks were not managed appropriately to protect people from potential harm.

Staffing numbers, skills, competency and deployment were not adequate to keep people safe.

Is the service effective?

Inadequate

The service was not effective.

Staff skills and competencies were not good enough to ensure that people received the care they needed. This included monitoring food and drink, nutrition and mental capacity.

Is the service caring?

Inadequate

The service was not caring.

The provider did not ensure that systems were robust enough to demonstrate that they ran a caring service. This impacted significantly on staff's ability to provide compassionate care which respected people's privacy and promoted their wellbeing.

Is the service responsive?

Inadequate

The service was not responsive.

Poor communication, records and person centred care planning meant opportunities were missed to ensure people received the right care at the right time.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have the required resources in place to assess, monitor and mitigate risks to the health, safety and/or welfare of people who use the service.

Treetops Care Home

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 checked 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 prompted in part by notification of a reduction of staffing levels by the registered provider and insufficient staff available to meet people's care and support needs safely and to an appropriate standard. Furthermore, concerns were raised about the financial viability of the service and the impact this had on the service and the smooth operational running of the service. This inspection examined those risks.

This inspection took place on 15, 16 August 2017, 18, 19 September 2017 and 6 October 2017. It was unannounced.

The inspection team consisted of five inspectors involved over the five days of the inspection. On the first day of inspection an expert by experience attended. An expert by experience is a person who has personal experience of caring for older people and people living with dementia.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with fourteen people who used the service, eight people's relatives, twelve members of staff, the registered manager, the external consultant who was the provider's representative and the provider's Nominated Individual (this person is also a Director of Epping Care Home's Limited).

We looked at care, maintenance and staff records. This included staff rosters and records relating to the services call alarm facility. We also looked at safeguarding alerts and information relating to the financial viability of the service.

Inadequate

Is the service safe?

Our findings

Prior to this inspection concerns were raised that the provider's NI (Nominated Individual -also a Director of Epping Care Home's Limited) had reduced staffing levels at the service by one member of staff for each 24 hour period. The rationale was linked to the high level of reliance on agency staff and the financial burden this placed on them. The NI stated that in making the decision, they had sought advice from two local care providers and had acted accordingly from the guidance provided by them. They confirmed that although a dependency tool was in place to assess the needs of people using the service, they had not analysed and used this information to determine the number of staff required. After concerns were raised by the Registered Manager and Consultant, the NI gave permission to raise the staffing levels again. However, we were seriously concerned about the NI's lack of evidence based decision making when considering the safety and welfare of those vulnerable people in their care. Despite the increase in staff we continued to receive information that there continued to be risks associated with the numbers, skills and deployment of staff at Treetops. The provider had been unable to recruit enough permanent staff and was reliant on temporary agency staff to fill the gap. This resulted in over 80% of staff not being permanent.

We discussed these concerns with the NI but they were unable to demonstrate any short, medium or long term strategies to ensure the shortfalls in staffing were addressed. The NI did not have any contingency plans to mitigate being unable to maintain staffing levels and the impact this may have in meeting people's care and support needs. Without this information the senior management team were unable to demonstrate how they could get the service to a point where the deployment of staff, their roles and responsibilities were stable and consistent.

As a result of unpaid invoices the number of external agencies willing to provide staff was limited. This led to an inability to ensure all shifts were covered and effective management of staff related quality issues. There was a general lack of leadership on each shift to ensure consistency of care. The skill mix and deployment of staff remained inconsistent day to day and not all staff were able to demonstrate that they fully understood, knew about or had provided the right care.

One relative told us, "They always seem to be short staffed, staff turnover is quite high. You see carers tearing their hair out trying to get people to the toilet." Another relative told us, "There are lots of different staff coming and going, shame as residents need to know them. There is not enough consistency." One person told us, "The girls are very nice but staff suddenly disappears [sic]. Every day a different girl; every time I ring the bell I get upset as someone has to come and they [staff] have taken the wheelchair away. I know they [staff] are busy, but I need the wheelchair. I ring the bell and normally wait but when they [staff] don't come, I hang on to the furniture. There are fewer staff and you don't see anybody. The day before yesterday there was only one carer here on the top floor, they said they were by themselves." We discussed this with the registered manager and they confirmed that this had been the case.

Another person told us, "The service is poor, waiting is poor. When I am in my room they [staff] say they are going to come back but they don't. I wake up early, they come and wash me and sometimes I don't receive my cooked breakfast until 10.35. It's too late and I would like it earlier."

Staff told us they were distressed as they knew they could not provide the quality of care they wanted because they were too stretched. They gave us examples where people had to wait (some until midday) for support with personal care, medication and/or food and drink. They knew this was unacceptable but felt unable to effect any change. They felt this was the senior management's role and they had not addressed it adequately.

It was not clear how the provider had ensured that staff from external agencies had the right competency and experience to work in the service. A number were asked to leave after they were observed to have poor practice, this included moving and handling which put people at risk of injury because of unsafe techniques. This further compounded the services ability to ensure there were enough staff to keep people safe.

The NI had not recognised that the failures around staffing were significantly contributing to the number of safeguard concerns linked to poor practice, numbers and skills mix of staff. Both the registered manager and consultant openly stated that permanent senior staff needed more support to develop their competency and skills. They recognised more work needed to be done in this area but were reliant on the NI to provide the resources to do this. Emails demonstrated they had made the NI aware of these issues and ideas to resolve it from June 2017. We were seriously concerned that an appropriate strategy had not been agreed to improve the situation for people using the service.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The management of risk at Treetops was not effective and placed people at continued potential or actual risk of harm. This included needs around, nutrition, pressure area care, medication, moving and handling and management of specific health conditions such as diabetes and dementia.

Not all staff recognised, responded or escalated risks appropriately. Lessons were not always learned and opportunities were missed to avoid them reoccurring. For example we saw several people who were identified as being at risk from urinary tract infections (UTI), however their care was not being provided in a way which would limit reoccurrence. One person was left with a full catheter bag which was placed incorrectly and could not drain away. This placed them at risk of UTI from back flow. Even though we alerted staff to this it was several hours before the person received personal care and had the bag drained. We looked at other people whose records stated they were at risk or who had previously had a UTI or poor skin condition. Not having enough to drink can directly effect these conditions and make them worse. Where fluid charts were in place to record the volumes people drank these were not routinely totalled up to check they were drinking enough. There were instructions for staff to report if the total was under 1600mls in 24hrs but many did not add up to this and/or escalate this so appropriate actions could be put in place. Staff were unable to demonstrate if this was due to poor record keeping or if people had not been routinely encouraged to drink.

Other risk factors had not been considered, for example staff were very busy with little time to spend with people who needed support or help to drink. We saw water jugs and glasses placed too far away from people to be able to independently help themselves if able. Families also raised this as an issue and commented that their relative was often thirsty and they refilled the water jugs when they visited.

Staff told inspectors they had not read the care records including risk assessments for those they were caring for because they did not have time. This included Senior Team Leaders who are supposed to lead the shift and delegate tasks to others. Care plans in place were inconsistent and records of care poorly completed to demonstrate service user's needs are being met. Risk assessments are not accurate, complete

or in place for service users healthcare needs including, pressure care, nutrition including food and fluid records, catheter care and moving and handling. Regardless of this many staff did not consider the impact of their actions when providing care. Examples included the removal of walking frames so people were unable to get up and walk independently if they chose (placing them more at risk of falls) and trying to support a person without understanding or knowing that the person's personal preferences. This upset the person and put the staff member at risk of providing inappropriate care.

There had been a number of medication errors where people's medication had not been recorded as being given or had been omitted entirely because it was unavailable. Problems with reordering had impacted on some medication not being available for several days. This included one person's antipsychotic medication not being given for over 10 days. We also found examples of antibiotics being prescribed but delays in it being obtained given promptly. Others were at risk due to time critical medications which, due to staffing pressures, were given late or too close to the next dose to work effectively.

Medication records were poorly maintained and audited to ensure that practice was safe and staff were competent. We saw staff administering medication whose practice potentially placed people at risk due to poor infection control processes, security of medication and slow responses to providing PRN (as required) pain medication.

The environmental risks had not been effectively addressed to ensure risks were being mitigated and planned for. Although there was a fire risk assessment in place it was not robust enough. For example people who were unable to use the stairs did not have robust Personal Emergency Evacuation Plans (PEEP) in place which reflected what staff should do in the event of a fire. When we spoke with staff they could not tell us what they would do if the building needed to be evacuated for any reason. We were so concerned about this we alerted Essex Fire who visited the service the following day. They have highlighted action to be taken including obtaining evacuation equipment and a new risk assessment.

We saw that the main lift in the service was not working. Signs on the lift doors were dated 12 September 2017 and the Registered Manager confirmed the lift had not been working since then but also had a history of breakdowns. Records showed that the lift needed refurbishment and had been needing to be replaced for over a year. A lift engineer was on site who stated that as an interim a part could be ordered and the work would cost around £2.5k which would allow it to be used. However the part needed to be ordered from abroad and would take a minimum of a week to arrive. As an alternative staff had been using a platform lift which is much smaller than the main shaft lift. Records showed that the platform lift should not be used more than nine times an hour as it is then at risk of overheating, stopping and potentially trapping those inside. Records showed that engineer call outs between 3 January 2017 and 18 September 2017, 20 times for the platform lift. Seven were because of entrapments and 13 where the lift had stopped working, was not working as it should and/or needed to be reset. The engineer advised that it was not suitable for more than one person in a wheelchair to be accommodated in the lift. The consultant confirmed that no service user should be using the lift alone and given the information from the engineer the lift would no longer be used for moving service users between floors and the risk assessment updated to reflect this.

This decision left 19 people (four were able to negotiate stairs with support) unable to move from the first and second floors. In addition the platform lift has a weight limit of 250kg and cannot therefore accommodate hot meal trolleys the kitchen use to transport meals. This is a further risk because of staff needing to use the stairs for this. We saw that meals transported in this way were getting cold and it impacted on staff time significantly.

The NI stated that in the interim they would increase staff at the service to address this. However the

consultant and Registered Manager again advised they were not confident in the skills and competency of permanent staff or that of agency staff. Given their lack of confidence in the current staff we were concerned that increasing the staff was not the only answer to minimising the potential risks for service users.

We were so concerned about all of the above information we took urgent action to impose conditions on the provider's registration to provide the necessary resources to ensure the immediate changes were made to mitigate the risks to people in respect of their care and welfare and quality of life. We also restricted any new admissions.

This demonstrated an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service effective?

Our findings

Our previous inspection in June 2017 found staff were not suitably skilled or competent in their roles, people's nutritional needs were not being met and the service was not always working in line with the Mental Capacity Act (MCA). This continued to be the case at this inspection with ongoing breaches of regulation.

People living in the service had various needs linked to frailty and old age. There was an unbalanced skill mix of staff, with some being intuitively caring but lacking skills or knowledge and others who had received training but were not putting it into practice. We observed staff who were unable to communicate effectively with people who had memory loss, dementia, hearing and sight loss. We saw that staff did not encourage people enough with meals, drinks and protecting them from the risks of isolation because they spend long hours alone in their rooms. A culture had developed where staff had to be reactive and prioritise tasks rather than being able to fully explore people's needs and how they could meet them more effectively. There was no overall strategy to encourage and promote better practice, investment in staff and as a consequence improve the quality of care.

Feedback from the Registered Manager and staff showed a high number of people living with dementia. Where staff had noticed a decline in people no formal action could be demonstrated that showed how their care had been reviewed and staff had the skills and knowledge to support them. Whilst some basic training had been completed there was no ongoing or specialist training for staff to help them develop and explore better ways of caring. Where people experienced high levels of anxiety, staff had no training in how to provide reassurance, distract them and/or take measures to avoid them harming themselves or others. We saw that people who had difficulty in communicating were frustrated, trying to make themselves understood and ended up giving up.

Poor staff practice had been tackled to some degree by the consultant and registered manager, which had led to some staff leaving, disciplinary procedures and more support being offered. However due to resources not being made available by the provider further improvements had not been made. Although there were profiles of each member of agency staff working at the service there was no system to monitor their competency ongoing. Though newer staff and agency staff had completed shadow shifts with existing permanent staff, at each of our visits we saw continued incidents of poor moving and handling and support to people using their walking frames (dragging or pulling the frame). Some agency staff had been working at Treetops for over a month without any intervention to improve their skills. The consultant had identified a training company to work alongside all staff which would provide immediate practical help, bespoke to staff and those in their care. However, despite the provider initially agreeing to this, payment was not made to secure it and it did not start. This lack of action left the consultant and registered manager unable to address the problems with staff skills in the short and longer term.

Staff and senior management acknowledged they had become task orientated because of the shortfall in staffing. Staff did not therefore always know the details about how each person needed to be cared for and how their health needs impacted on their wellbeing. This resulted in opportunities being missed to pick up

and manage any deterioration in their health. Professional health and social care professionals, who often visited and spent time in the service, reported they observed poor practice and that often staff did not know the details of those they cared for. For example they observed incorrect and out of date moving and handling techniques which could injure and harm people (for example underarm drag lifts).

We asked the consultant and registered manager who provided them as supervising managers with training, support and appraisals. They advised they had none in place apart from ongoing support for each other. In addition neither had a job description or a contract with the provider which demonstrated what the expectations of their roles would be. The provider had failed at every level to ensure a thorough, robust approach for staff training and support. This directly links to the failing culture within the home of poor practice and a lack of understanding and recognition about arrangements in place to ensure people received appropriate quality care.

This demonstrated an ongoing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked at whether the provider had considered the MCA and DoLS in relation to how important decisions were made on behalf of the people using the service. The consultant and registered manager had an understanding of the principles and practice of the Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS]. However we were concerned that this was not being put into practice by staff because we observed care which did not meet the requirements of the MCA and/or DoLS.

One person said, "I need two carers to help me with a hoist – that's why I don't get up I can't get out of bed because of the sides, I can't get out". An assessment in their care plan for bedrails dated July 2017, did not provide adequate information around the assessment, it stated 'alternative methods have been considered' but did not say what these were. There was information that an assessment had been completed but it could not be found and staff could not tell us the contents of it. There was no indication that the person did not have capacity to make decisions about how they spent their day. There was no information about why they had bedrails up, for example risk of falls. Although there was a DoLS in place, this related to the person wanting to go home, and did not refer to the use of bedrails or other reasons for restrictive practices in place. They told us, "I like gardening, I used to grow marrows. I used to make bird boxes – that's what I would like to do. I do not leave my room; I do not go into the garden." Staff could not tell us the last time this person had been supported to go outside. We were seriously concerned that this person's choices were not being listened to and that could not establish any reasons for the lack of actions having been appropriately assessed and monitored.

Another person's records showed support with their personal care and dressing at 6am on 18 September 2017. At 7:15am we observed they walked with the aid of their frame to their bedroom door. A staff member blocked the exit to the door and told them to go and sit in their chair. The person told them, "I want breakfast" but the staff member refused to move and turned their frame around and guided them back to their chair saying, "Breakfast is not yet. I will get you a cup of tea." However, the staff member did not get a

cup of tea until 9am when the person was helped to go to a small lounge. They did not receive breakfast until 10.30am. The person was diabetic and therefore this practice not only deprived them of moving around the service freely, it also deprived them of receiving fluids for a significant period of time and the staff member had not explored how they were feeling or ensured they were listened to.

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

People did not always receive enough food and fluid to ensure their nutritional needs were being met. Records were contradictory and it was hard to clarify what the person's most up to date needs were. For example, one person's Malnutrition Universal Screening Tool (MUST) was last assessed on 1 December 2016 and stated the person 'eats well'. However other records identified a slow reduction in weight of between 7 and 8 kg January to July 2017 and no further weights were recorded. Despite the person being diabetic there was no clear care planning documentation around how this impacted on their eating and drinking or how this being monitored. We observed a full jug of water and empty glass out of their reach on a trolley table. They were unable to reach it without support from staff. Fluid charts in the care records showed low levels of fluids and output was not measured at all even though the person had a catheter which can be monitored more easily. The person was identified as being at risk from urinary infections (UTI) and catheter blockages. Fluid charts in the person's bedroom did not correlate with the fluid charts in the care records. At the top of the fluid charts it stated that night staff needed to add the total and record on daily reports. If any totalled less than 1600mls actions needed to be taken, documented and followed up. There was no effective oversight of this. We found four people who had fluid charts which regularly did not reach 1600mls but staff could not tell us what was being done about it. Families, health professionals and other visitors to the service also commented that they had to refill water jugs and move cups so they were in reach of people.

Because the lifts were out of use at the service, this impacted on the meal times. Staff were having to carry food and drinks between floors via the stairs. This meant that they were often going cold whilst being brought to people and serving each person took considerably longer. The registered manager and consultant realised they needed to make temporary kitchens on each floor so immediately purchased kettles, microwaves and toasters for each floor, this helped to reduce time spent for staff going up and down stairs and gave them equipment to reheat meals, make drinks etc..

Because most people could not use the stairs to access the main dining area on the ground floor, they ate in their bedrooms or in one of the small lounges on each floor. The number of people using the lounges meant that it was cramped with walking frames and tray tables adding to the challenge of the limited space. Staff did not recognise when people needed support with their meals. No thought had been given to providing equipment to help people eat independently, for example plate guards or specialist cutlery. One person was observed not to eat their meal because it was placed to their side, rather than in front of them. They were unable to turn easily to use their cutlery. Staff did not understand this and took the meal away mainly untouched. There was no offer of any alternative or questions about why they had not eaten the meal.

We asked for the weight records of those identified as at risk from malnutrition. A staff member told us they had them but had not transferred the information onto individual care records. They could not provide the list to us. We spoke with the registered manager who confirmed this had happened but they too could not provide the records at that time. There were no audit systems in place to monitor people's weights so the registered manager was unable to tell us what would trigger a review or a request to other professionals for support. Despite this we did find that some professionals had been involved including dietitians and speech and language therapists. However records were so poor that it could not be demonstrated that staff were following the advice given. In addition when speaking with staff they did not know who was at risk and their

understanding of the impact on people's health and wellbeing was limited.

This is a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service caring?

Our findings

Staff practice did not always ensure people were treated in a respectful manner or that their privacy and dignity was fully considered or promoted. Some staff were very caring and we saw them try their best in difficult circumstances linked to shortfalls of knowledgeable staff and a lack of leadership on each shift. Permanent staff were under pressure to ensure temporary agency staff knew what they needed to do. However, when we observed handovers between shifts there was little information which explained what people needed or how to support them. Some staff we saw did little to communicate or treat people with consideration. For example people told us they felt they were not always listened to, they were rushed or they didn't like to ask for anything because they knew staff were busy.

Staff had not ensured that people, who were not able to move independently, had access to a call bell. We heard staff speaking in a cold manner, for example just saying "Sit" and "You go there". A person using the service disclosed to us that a member of staff had spoken to them in a critical, derogatory and disrespectful manner. The Care Team Leader [CTL] failed to pass this information to the registered manager or external consultant or to record this incident. We shared this information with the management team and a safeguarding alert was duly completed and investigated.

Staff failed to act with compassion or understanding around people's wellbeing. A person cared for in their bedroom told us they were in pain and their back hurt. They told us that they were unhappy. The inspector called staff on their behalf but they did not give the person time to tell them what was wrong. The inspector had to intervene and inform staff of the problem. Staff did not explore pain relief or why the person was unhappy. There was no care plan, notes, or daily entries to indicate if this was unusual for the person, if they suffered from low mood or were normally content. Staff did not take the opportunity to engage in a positive way, explore the concerns or take action which could improve the person's quality of life and help them to manage their pain.

During a mealtime in a lounge staff supported people to the toilet. As the toilet door opened straight onto the lounge those sitting there could see right in when staff went to assist someone with their personal care. The registered manager and consultant told us these toilets should not have been in use for this reason. However staff continued to use them without recognising that it compromised people's privacy and dignity.

Whilst some relatives were positive about the relationships staff had with people at the service, others were not. This was mainly linked to the inconsistency in staffing impacting on their ability to get to know people. Systems were not good enough to ensure that staff who had not worked in the service for long were encouraged, introduced and took time to get to know people. There was little interaction and we saw that often staff would just be present in a communal area watching people. Staff said they were making sure people were safe but did not take the opportunity to meaningfully talk with people and/or undertake activities with them, other than routine interventions that were completely task led. Our observations showed that people's lives revolved around mealtimes and visitors with little else to occupy their time, promote their independence and autonomy.

All of the above is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service responsive?

Our findings

At the last inspection in June 2017 we found that information about people's care was inconsistent and not always accurate. At this inspection we found that this continued to be the case.

There was a system in place for recording care provided. This was a combination of shift handover records, (day and night) care records, care plans and risk assessments. Staff told us they did not read the care plans but did write up the daily notes for people. When comparing the two they did not match and therefore it was not possible to tell if staff were not following the care plan or if people's needs and preferences had changed. For example daily records reflected one person was declining but their care plan did not reflect any information about how a person was being supported both physically and mentally. In another case care plans stated the person could walk, but in the daily records staff were using a hoist to move them because they could not stand. We saw care that was not being carried out in line with risk assessments. For example we observed staff removing people's walking frames when in the lounges (on all floors), restricting their movement. Conflicting information was given by staff; one of whom said they should be next to the person and another stating that they were to be removed, and only left with those who are deemed safe to independently use them. In another example a staff member removed all the frames and used one to help anyone who wanted to move. They had not considered the impact on mobility when using a frame they have not been assessed for.

Because care staff had not always read care plans, shift handovers were not detailed and there was a lack of leadership on each floor, people were at risk of receiving inappropriate or unsafe care. In one case we heard a person shouting at a staff member. The staff member was trying to help them with personal care. However they did not know that the person's care plan identified they did not need or want this and were very private. The staff member put themselves and the person in a vulnerable position without understanding the needs, wishes or preferences of the person concerned. This also did not respect their right to privacy.

Opportunities were missed to ensure people were receiving the right care. Records did not demonstrate that those with diabetes, at risk of UTIs, pressure areas, weight loss and/or limited mobility were being adequately monitored and prompt action taken to address changing needs. There was a lack of ongoing review and updating of people's records to ensure that these accurately reflected what was happening for each person. Because of this staff were not always able to respond effectively and address people's deteriorating conditions. Examples included risks around dehydration due to lack of fluids, medication not being obtained or administered promptly for example antibiotics, analysis of falls to identify any themes or trends to inform care practice or staffing levels, and risks associated with being isolated. Care records lacked information about how staff supported people to have meaningful lives. Whilst there were some staff who undertook activities with people, we saw they often had to provide care too because of the lack of knowledgeable staff. Two people told us they would like to go out but were unable to because staff did not have time to take them. The service was very close to Epping town centre, shops and community centres, but when we asked, no one could tell us the last time they had been there.

This is an ongoing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

Inadequate

Is the service well-led?

Our findings

The inspection in June 2017 found that improvements had not been sustained or built upon since the previous inspection in October 2016. This inspection in August, September and October 2017 identified continued deterioration in the quality of the service which put people at significant risk of harm. This raised serious questions about the ability of the provider to ensure the service was being run in the best interests of the people living there.

Prior to this inspection concerns were raised about a lack of adequate resources to provide safe and good quality care. On 16 August 2017 the NI confirmed there were monies and outstanding invoices unpaid pertaining to seven external staffing agencies, five utility services, four professional/consultancy services and numerous suppliers. There was no explanation as to whether this was due to financial constraints and/or poor financial planning. We were therefore concerned about how the provider could demonstrate that this did not affect their ability to provide or carry on the regulated activity at Treetops Care Home. The NI stated the provider was financially viable as they had other companies and assets so as to support Treetops Care Home. An assurance was provided that immediate financial arrangements would be put in place to pay or negotiate the debts outstanding. However over the following weeks and visits to the service we found ongoing financial issues including representatives of one creditor arrived at the service causing anxiety and disruption for people using the service and staff. As our concerns continued with regards to financial viability we returned to the service on 6 October 2017 because we had been passed information that staff would not be provided by external agencies due to non-payment of invoices. The NI was asked to provide bank statements and records to demonstrate they were able to staff the service. The NI and accounting staff were unable to demonstrate that they had effective oversight of the finances or that they knew how much money was owed to creditors.

Documents showed both the registered manager and external consultant had communicated with the NI on numerous occasions throughout July, August and September 2017 to make them aware of the concerns around staff provision, monies owed and outstanding invoices. The NI was unable to provide when asked, a clear explanation as to how they intended to manage the current debts so as to ensure people at the service were not affected by the financial situation. The consultant and registered manager advised that they had no control over any budgets, there is no petty cash available to them and that all purchases have to go through the NI. They advised us that the arrangements for this had not been effective and that both had used their own money to purchase equipment to be reimbursed at a later date. Examples include everyday items like stamps, paying for taxis for people to get to health care appointments and larger purchases including a hoist.

Equipment to support the administration required for the service were not adequate. There was only one working computer in the registered manager's office and access to this to complete audits and update care records was limited. By failing to provide suitable access to this kind of resource the senior management team were limited in their ability to delegate tasks to others, and effectively manage their time to ensure they had full oversight. They confirmed the provider had no quality audit system in place to assure themselves that those they had delegated responsibility to (the registered manager and consultant) were

doing the job as expected. There was no system in place for the provider to assure themselves the service was being run in way which meets the requirements of the regulations. Another example included the lack of accurate log of equipment being used at the service. Slings, wheelchair and walking frame audits could not be found. The registered manager and consultant confirmed no record was in place of all equipment needed and therefore audits were not in place for regular review. It is a potential risk if these items are used inappropriately, not for the person they are assessed for or are poorly maintained.

The Registered Manager and Consultant expressed concern with us that they did not have the resources or capacity themselves to ensure that staff were making the changes they asked for. They expressed concern about the skills and competency of permanent staff and did not have confidence that all Team Leaders were good role models for others as they could not guarantee they used best practice, followed management instruction and effected improvement in the quality of the care. The NI repeatedly told us they delegated the responsibility for all these issues to the Registered Manager and the consultant. However both had already advised them in front of inspectors that they did not have any more capacity and needed high level managerial support.

It was clear that the NI did not understand the provider's responsibility to ensure action was being taken to improve the situation. On 18 September 2017 the NI took no action to ensure people and staff would be safe overnight given the situation with the lifts being out of action. They left the consultant and registered manager to set up the new temporary kitchens including buying the necessary equipment with their own money. This showed a serious lack of understanding by the NI about the significant concerns at the service and their responsibility to fix it.

Multiple failures in regulations had not been recognised or addressed and failings included concerns across all areas of the service including care planning, care delivery, staffing levels, nutritional support of people, their social and wellbeing needs and property related concerns. The service was being managed poorly and the widespread failings meant that people were placed a significant risk. The provider did not have the oversight required to ensure improvements were made and sustained.

This is an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

As a result of these concerns the Commission took urgent action to restrict admissions to the service and impose conditions with a view to having proper oversight to ensure people are cared for safely.

Essex County Council have since supported all those living at Treetops to move to alternative accommodation. The home has been empty since 13 October 2017.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Poor communication, record keeping and person centred caring planning put people at risk of not receiving appropriate safe care that met their needs and preferences.

The enforcement action we took:

Urgent Notice of Decision to Impose Positive Conditions and restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always supported in a caring and respectful manner. This impacted on their physical and emotional wellbeing.

The enforcement action we took:

Urgent Notice of Decision to Impose Positive Conditions and restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's choices were not always being listen to, or acted on.

The enforcement action we took:

Urgent Notice of Decision to Impose Positive Conditions and restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's care had not been co-ordinated or managed to ensure their specific needs were being met safely.

The enforcement action we took:

Urgent Notice of Decision to Impose Positive Conditions and restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Robust and sustainable audit and monitoring systems were not in place to assess, monitor and mitigate risks to the health, safety and / or welfare of people who use the service.

The enforcement action we took:

Urgent Notice of Decision to Impose Positive Conditions and restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of competent, skilled staff deployed to meet people's needs.

The enforcement action we took:

Urgent Notice of Decision to Impose Positive Conditions and restrict admissions.