

Handsale Limited

Handsale Limited - Treelands Care Home

Inspection report

Westerhill Road
Fitton Hill
Oldham
Lancashire
OL8 2QH

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17 January 2017
18 January 2017

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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

This inspection took place on 11, 17 and 18 January 2017. Our visit on 11 January was unannounced. We last inspected the home in October 2015. At that time we rated the service 'Good' overall.

Treelands Care Home is a purpose built care home, registered to provide accommodation and care, including nursing care, for a maximum of 80 people. At the time of our inspection there were 72 people living at the home. The accommodation is provided on two floors and is divided into four units: Sycamore unit provides care and support to people requiring residential care, Beech unit provides care for younger adults with more complex needs, Oak unit provides residential and nursing care and Elm unit provides care and support for people living with varying levels of dementia. The home is set within a large garden and there is a car park available for visitors.

At the time of our inspection the registered manager had been suspended, pending an investigation and the deputy manager had temporarily taken over the role of manager. 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 deputy manager was being supported in their role, temporarily, by a consultant from a private organisation which provides quality assurance support to healthcare providers.

Following concerns raised by the local NHS Clinical Commissioning Group (CCG) the provider had been instructed to submit an action plan to the CCG which showed how they planned to address the concerns and make improvements to the service. During our inspection we saw that the owners of the home had taken actions to address the concerns. They had enlisted help from both a consultant, and a registered manager from one of their sister homes, to help work through the action plan and implement improvements throughout the home. We saw that a considerable number of improvements had been made, but some were still on-going.

During our inspection we identified breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to cleanliness, risk assessments, training, supervision, staff induction, weight monitoring, Deprivation of Liberty Safeguards, care plans and governance. You can see what action we told the provider to take at the back of the full version of this report.

We made one recommendation. This was in relation to seeking feedback from people who use the service and their relatives.

Although the home was generally well-maintained and decorated, we found that the kitchenette areas on two units and some equipment were not cleaned to a high standard.

We reviewed risk assessments, which help to identify potential harm to people, such as bed-rail risk assessments and those which identify if a person is at risk of developing pressure sores. However, these were not always in place or correct. This meant we could not be sure that risks to people's health were being safely managed.

During our inspection staffing levels were sufficient to meet the needs of people using the service.

Arrangements were in place to safeguard people from harm and abuse and recruitment processes were sufficiently robust to protect people who used the service from the risk of unsuitable staff being employed to care for them.

Medicines were stored and administered safely.

Through our review of staff records we found that staff had not received supervision on a regular basis. However, a new schedule for supervision had been devised and some supervision had recently taken place. No information about induction programmes for new staff was available so we could not be sure that new staff had received an adequate induction to their role.

There was limited information available about the training people had undertaken, although a training matrix giving overall insight into training was being compiled. Where gaps in training were identified the provider was taking steps to arrange the appropriate training sessions.

Staff sought consent to care and treatment from people they supported. However, Deprivation of Liberty Safeguards (DoLS) were not always in place, or up-to-date, when required. This meant the home was not working within the requirements of the Mental Capacity Act (2005).

On Sycamore unit some people had not had their weight regularly monitored. This meant there was a risk that people with problematic weight loss would not be identified promptly and the appropriate action taken. We brought this to the attention of the deputy manager and he took immediate steps to rectify this.

We received complimentary comments from people who lived at the home and from relatives about the staff and about the care and support they provided to people who lived at Treelands. People's dignity and privacy were respected and staff helped people to maintain their independence if they were able.

The care documentation we reviewed did not always reflect the current needs of individuals and some care plans were out of date. However, we saw examples that showed staff had been responsive to the individual needs of people who lived at the home, for example the introduction of a smoking cessation project.

There was a varied programme of activities at the home and there had been a recent initiative to encourage staff to take people to different units to take part in activities they might enjoy. However, on Oak unit we found that many people remained in bed throughout the day and risked becoming socially isolated.

People we spoke with knew about the complaints process and felt they could make a complaint if they needed to.

The provider was in the process of reviewing the management of the home in order to ensure there was robust leadership. Although concerns identified by the local NHS Clinical Commissioning Group had been dealt with, during our inspection we found further concerns which had not previously been identified.

We found that there were not sufficient systems in place to monitor the quality and standard of care provided, although the provider had taken steps to implement a new programme of audits and quality checks.

There were limited opportunities for people who used the service to give feedback about care they received. The deputy manager told us a survey was planned for 2017.

The deputy manager had introduced a number of new initiatives, such as daily meetings, to improve communication and these had been well-received by staff. Staff spoke positively about the changes that were taking place within the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Some parts of the home and equipment were not cleaned to a high standard.

Risk assessments, which help to identify potential harm to people, were not always in place or reflected people's current needs.

Staffing levels were sufficient to meet the needs of people using the service.

Arrangements were in place to safeguard people from harm and abuse. Recruitment processes were sufficiently robust to protect people who used the service from the risk of unsuitable staff.

Medicines were stored and administered safely.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff had not received supervision on a regular basis. No information about induction programmes for new staff was available.

There was limited information available about the training people had undertaken, although a training matrix giving overall insight into training was being compiled at the time of this inspection.

Consent to care and treatment was sought. However, Deprivation of Liberty Safeguards were not always in place, or up-to-date, when required.

Some people had not had their weight regularly monitored in order to identify if they were at risk of developing malnutrition.

Requires Improvement ●

Is the service caring?

The service was not consistently caring.

Requires Improvement ●

People who used the service were complimentary about the staff and about the care and support they received.

People's dignity and privacy were respected and staff helped people to maintain their independence if they were able.

On Oak unit we found that many people remained in bed throughout the day and risked becoming socially isolated.

Is the service responsive?

The service was not consistently responsive.

Care documentation did not always reflect the current needs of individuals.

There was a varied programme of activities for people to enjoy. We saw examples that showed staff had been responsive to the individual needs of people who lived at the home.

There were systems in place to enable people to make a complaint about the service.

Requires Improvement 

Is the service well-led?

The service was not consistently well-led.

The provider was in the process of reviewing the management of the home in order to ensure there was robust leadership.

Although concerns identified by the local NHS Clinical Commissioning Group had been dealt with, during our inspection we found further concerns which had not previously been identified.

There were not sufficient systems in place to monitor the quality and standard of care provided.

The deputy manager had introduced a number of new initiatives to improve communication and these had been well-received by staff.

There were limited opportunities for people who used the service to give feedback about care they received.

Requires Improvement 

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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.

This was an unannounced inspection and took place on 11, 17 and 18 January 2017. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using this type of service or caring for someone who uses this type of care service.

The inspection was carried out in response to concerns raised by the local NHS Clinical Commissioning Group (CCG) over various aspects of the care and the management of the service. In response to the concerns raised by the CCG the provider had completed an action plan showing how it would address the concerns and make improvements to the service. Through discussions with the CCG prior to our inspection, and through our observations during the inspection we saw that the provider had taken steps to make improvements to the service, although these improvements were still on-going.

Prior to the inspection we reviewed information we held about the service, including the notifications the CQC had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send to us within a required timescale. We also reviewed the inspection report from the previous inspection and contacted the Local authority (LA) and CCG.

During our inspection we examined people's care records and observed care and support provided to them in the communal areas to capture their experiences. We spoke with 23 people who used the service, six relatives, and seven members of the care team. We also talked in depth with the deputy manager, owner, and the consultant commissioned by the provider.

We looked around the four units of the home, observed how staff cared for and supported people, reviewed records and looked at other information which helped us assess how peoples' care needs were met. We observed a lunchtime meal and watched the administration of medicine to check that this was carried out safely.

As part of the inspection we reviewed the care records of ten people living at the home. The records included their care plans and risk assessments. We looked at four staff files to check that the recruitment process had been carried out correctly. We also reviewed other information about the service, such as its training programme, quality assurance processes, complaints and record of accidents and incidents.

Is the service safe?

Our findings

People we spoke with told us that Treelands was a safe place in which to live. One person told us " (person) has been very well looked after, we have no complaints". Staff we spoke with had a good understanding of safeguarding issues and were able to describe types of abuse, such as emotional and physical and what they would do if they had concerns that a person was being abused. All safeguarding concerns were reported to the local authority safeguarding team on a monthly basis.

Staff employed by the service had been through a thorough recruitment process. We inspected four staff files and found that they were well-organised and contained all the relevant documentation, including two references, confirmation of identification, interview questions and employment history. All staff had Disclosure and Barring (DBS) criminal record checks in place. These help the service provider make an informed decision about the person's suitability to work with vulnerable people, as they identify if a person has had any criminal convictions or cautions. All the registered nurses working at the home had up-to-date Nursing and Midwifery Council (NMC) personal identification numbers (PIN). The NMC is the regulator for all nurses and midwives in the UK. When nurses register with the NMC they are given a PIN, which is renewed every three years.

People we spoke with felt there were enough staff to meet the needs of people living at the home, and our observations during the inspection confirmed this. The home regularly used agency nurses to ensure that all the shifts were covered. However, where possible the same agency staff were used to help promote continuity.

We undertook a tour of the premises to check on the standard of maintenance, cleanliness and décor. The home had a large reception area, which had recently been reorganised, and was light, clean and tidy and attractively decorated. There was an information board displaying the home's safeguarding and complaints policies, Care Quality Commission inspection rating and information about the Mental Capacity Act and Deprivation of Liberty Safeguards. A stand displayed booklets and leaflets, including the 'service user guide', 'statement of purpose' and brochure for the home.

Elm unit was in the middle of a major refurbishment programme and was being redecorated and new flooring laid: the other three units were generally well-maintained and decorated. We looked around all areas of the home and saw the bedrooms, toilets and bathrooms, communal areas and main kitchen were clean and free from unpleasant odours. On Oak unit we saw that three mobile hoists were very dirty. We reported this to the deputy manager and the hoists were immediately cleaned. The regular cleaning of this equipment was added to the home's cleaning schedule. We checked the home's cleaning schedules and saw that these had been completed correctly.

Each unit had its own kitchenette area which was used during meal times. On Beech and Elm unit these areas were kept locked between meals due to the risk of people accessing appliances and food stuffs that might be dangerous. On both Sycamore and Oak units the kitchenette areas were not as clean as other areas in the home. Items such as toasters, microwaves and kettles were dirty and on Oak unit the radiator

and outside of the cupboards were splashed with food. We reported this to the deputy manager. Night staff were responsible for cleaning the kitchenettes and the deputy manager told us he would review their cleaning schedules to ensure these areas were cleaned regularly.

We saw that the kitchenette fridge temperatures on both Beech and Sycamore units had not been recorded during January 2017. This meant we could not be sure that food was being stored at a safe temperature to prevent food contamination.

We looked at how the provider managed risks to peoples' health, what tools they used to identify and record risk and what actions they took to try to mitigate risk. We found this to be quite variable. On Oak unit we found that risk assessments, such as for manual handling and nutrition and their associated care plans were thorough and had been reviewed regularly. However, on Elm unit we identified that one person who had bed rails in place did not have a 'bed rail risk assessment'. On Sycamore unit we identified two people who should have had bed rails risk assessments in place, who did not. The Health and Safety Executive (HSE) suggest that 'a risk assessment is carried out by a competent person taking into account the bed occupant, the bed, mattresses, bed rails and all associated equipment'. As these people did not have bed rail risk assessments in place we could not be sure it was safe to use them. We asked for these to be completed immediately. On Sycamore unit we identified that the risk assessment tool used for identifying those people who might be at risk of developing pressure sore, the 'waterlow' score, had been incorrectly completed for several people which meant their score was incorrect. However, we did not see that anyone had been adversely affected by this error. We brought this to the attention of the deputy manager, who advised us the waterlow scores would be reviewed.

The above examples of poor cleanliness and inadequate risk assessments demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On Sycamore unit we were told that the shower unit was not working and had been out of action for the past two months. In addition, the assisted bath unit was also broken. This meant the only bath available was for those who were physically able and people requesting a shower had to be taken to other units. We spoke to the owner about this situation who told us that the delay in replacing the faulty equipment was due to problems with the supplier. He assured us that the work was scheduled for the beginning of February and would take approximately four weeks to complete.

Toilets and bathrooms contained adequate supplies of soap and paper towels, and posters showing the correct handwashing procedure were prominently displayed. Foot-operated bins enabled staff to dispose of soiled products without risking contaminating their hands. Staff understood the importance of infection control measures, such as the use of personal protective equipment (PPE) including disposable vinyl gloves and plastic aprons and we observed staff using these appropriately. All staff had received training in 'good hand washing practice' in July 2016. The home had undergone a local authority infection control inspection in December 2016 and received an overall score of 94%.

A 'Food Standards Agency' inspection had been carried out in October 2015 and the home had been awarded the highest rating of 5. We inspected the main kitchen and saw that it was clean and tidy and that the cleaning schedules had been completed thoroughly. Fridge and freezer temperatures were checked daily.

Equipment, such as electric beds and pressure relieving mattresses were in good condition and we saw records which demonstrated that equipment was regularly serviced and maintained.

The home was set within a large well-maintained garden, which was equipped with garden furniture and had secure fencing. The fencing was arranged and designed to allow each unit a separate, securable space.

We inspected the systems in place for the storage and management of medicines on Oak, Elm and Sycamore units and we observed a medicines round on Sycamore unit. Medicines were kept in locked medicines trolleys and locked cupboards within each unit's treatment room. The treatment rooms also contained controlled drug cupboards. Some prescription medicines are controlled under the Misuse of Drug legislation e.g. morphine, which means that stricter controls need to be applied to prevent them from being misused, obtained illegally and causing harm. We saw that controlled drugs were appropriately and securely stored. Fridge and room temperatures were recorded daily to ensure that medicines were stored at the correct temperature.

We looked at the Medication Administration Records (MARS) files and saw that they contained information necessary for the safe administration of medicines, such as photographs of people living at the home and signatures of nurses and carers who administer medicines and information about allergies. On Sycamore unit, one person who was receiving a weekly injection, needed to have their blood pressure checked to ensure it was within a required range to administer the injection. We saw that this had been done. From our observations during the inspection we saw that medicines management was undertaken safely at Treelands.

There were systems in place to protect staff and people who used the service from the risk of fire. Firefighting equipment, such as extinguishers and the alarm system were regularly checked. People visiting the service were requested to sign a visitors signing –in book to ensure in the event of an evacuation of the premises, all people that were in the home could be accounted for. There was a 'business continuity plan' in place that provided guidance in the event of a major failure of the lighting, heating or water systems. People who used the service had a personal evacuation escape plan (PEEP) which explained how each person would be evacuated from the building in the event of an emergency and contained information about their mobility and any communication difficulties. Plans were updated where a person's mobility or communication abilities changed.

Is the service effective?

Our findings

The service did not have an overall training matrix to show which staff were up-to-date with training, and to help identify any gaps in the training programme. The management team were in the process of compiling a matrix by reviewing each individual staff member's personnel file, and we saw that they had made some progress with this. As this was still being developed it was difficult for us to get an overall picture of the level of training at Treelands. However, we saw that the management team were taking steps to arrange training when they identified a need. For example, they had identified that staff needed a better understanding of the Deprivation of Liberty Safeguards (DoLS) and had sent a recent Department of Health leaflet about DoLS round to all units for staff to read. This was an interim measure before a full training session on DoLS could be arranged.

The home had three care 'champions' for pressure ulcer prevention. These are staff who had undertaken extra training and who used their knowledge to promote best practice among staff. The pressure sore prevention champion regularly attended meetings of the 'React to Red' campaign run by the local National Health Service (NHS) Clinical Commissioning Group (CCG). This is a national pressure ulcer prevention campaign that is committed to educating as many people as possible about the dangers of pressure ulcers and the simple steps that can be taken to avoid them.

There was no information available to show us what level of induction new staff received when they started employment at Treelands. We looked at the records of a person who had started work in November 2016. We saw that they had received training in fire safety, moving and handling and health and safety. However, there was no record of what other information and guidance they had received, or if anyone had assessed them as being competent to care for people at the home. The carer in question had worked previously in a care setting, so would have some knowledge of the skills needed for their role. However, lack of induction records meant that we could not be sure newly recruited staff had received the appropriate level of induction for their role.

We checked supervision records for three staff and found that they had not received any supervision during 2016. One of the records showed the person had received an annual appraisal during 2016, but the other two had not. The deputy manager was unable to confirm how many staff had received supervision during the past year. Supervisions and appraisals are important as they provide opportunities for staff to review their performance, discuss any work related problems and identify any support they need. The deputy manager was in the process of carrying out supervision sessions with all staff and had recently devised a new supervision planner to ensure that supervision was carried out six times per year with each staff member.

Issues in relation to training, induction and supervision demonstrate a 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.

During our inspection we saw that staff sought people's consent before undertaking any care or support task. However, we found systems and processes in place at the home were not robust to ensure the home acted in accordance with the MCA.

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 Deprivation of Liberty Safeguards (DoLS). By law, the Care Quality Commission (CQC) must monitor the operation of any deprivations and report on what we find. During our review of the care records on Oak and Elm units we found several DoLS had expired. We were told by the management team that they had recently identified that a number of people living at the home required DoLS. These had not previously been applied for, even though the people needed this authorisation to be in place. They were also aware that several DoLS had been allowed to lapse and were in the process of rectifying this matter. They had been in contact with the local authority DoLS team to seek guidance on submitting the required DoLS for urgent authorisations and at the time of our inspection had already submitted a number of DoLS applications to the local authority for authorisation.

Failing to have appropriate DoLS authorisations in place was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home's four-weekly menu plan, which offered a choice of meals, was in the process of being revised to incorporate more suggestions made by people who used the service. Meals were pre-prepared by a professional catering company, and delivered frozen to the home in individual tin-foil containers, which were then re-heated in food catering trolleys on each unit. Culturally appropriate foods could be ordered for those people who required them, for example, Halal and Kosher meals and meals for people with special dietary needs, such as pureed meals, were available. Kitchen staff prepared desserts and sandwiches and had recently prepared the Christmas meal, which was well received.

People we spoke with told us they thought the food was good and were satisfied with the choice. One visitor told us that her relative always had a beaker of juice on their table within easy reach. Some staff, however, told us they were concerned about the repetition of the meals and the quality of the food. The owner told us that they were in the process of looking at the possibility of cooking meals on-site, rather than ordering through a catering company and kitchen staff we spoke with were keen to take on this role, if further kitchen equipment was purchased.

We reviewed the weight monitoring records on Oak unit and saw that both monthly and weekly weights were up-to-date. On Sycamore unit we reviewed the monthly weight monitoring records and saw that four people had not been weighed since July 2016. One person had been weighed in August 2016, but not again until December 2016. All these people had been identified as needing to be weighed monthly. Staff had recorded that some people had 'refused' to be weighed. However, they had not used any other methods to try identify if people were losing or gaining weight, such as by measuring the mid upper arm circumference or by assessing whether their clothing had become loose fitting. Measuring the mid upper arm circumference (MUAC) is a way of estimating a person's body mass index (BMI) when it is not possible to weigh them. Because people had not been regularly weighed we could not be sure that they were not at risk of malnutrition. We raised a safeguarding alert with the local safeguarding team over this matter. We spoke with the deputy manager and asked them to take steps to rectify the situation, which they did. Subsequent to our inspection we received information which showed that everyone on Sycamore unit had been weighed and where people had lost weight they had been referred to their doctor or dietician. The deputy manager

also produced an action plan for the all units to ensure that management and oversight of weight management was improved.

Failure to adequately monitor people's weight was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the units where people were living with dementia we saw that some adaptations, such as the use of dementia signage, had been made to the environment to help make it more 'dementia friendly'. Elm unit was in the process of being refurbished. There was a 'memory walk' between Oak and Elm units where items and pictures from decades past, were attractively displayed. We discussed the possibility of this being moved into Elm unit itself to enable the display to be viewed more easily by people living on the unit. The deputy manager agreed they would consider this once the refurbishment programme was completed. People were encouraged to decorate their bedrooms with personal effects, such as furniture, pictures, televisions and photographs to help them feel at home. Internet access was available for people's personal use.

Care records we reviewed indicated that people using the service had access to other healthcare professionals, such as community nurses, mental health practitioners and dieticians. This ensured that their health and social needs were met fully.

Is the service caring?

Our findings

People who used the service and their relatives were complimentary about the staff and we received positive comments about their caring approach and conduct. One relative told us "The staff work in a very challenging environment but do a great job. The staff are what makes it work so well". A person living on Beech unit told us "I like it here. The staff are very special, very nice people" and a person living on Oak unit told us "I'm very happy here".

We saw that people in the home looked cared for: their clothes and appearance were clean. One person told us that their relative's "nails and hands are always clean". Another person told us "Little touches, like putting lipstick on (name) in the morning show that the carers care". We observed one person, who could not communicate verbally, was having their hair brushed by a carer. We asked the person if they were well looked after and they showed us their newly painted nails. The carer told us " (name) likes having their nails done". Later in the day the same person sought us out and showed us that their nails had been painted again, a different colour. One carer told us about a person who loved wearing makeup and how they helped her apply it each morning.

We observed staff interactions with people in the home and overheard conversations which showed that staff treated people with dignity and respect and where possible helped to maintain their independence. For example, we saw that a person had soiled their clothes while drinking and asked for help. A member of staff obtained a tissue saying "Do you want to do it or should I help you?". When a person wanted to move from a wheel chair to a lounge chair a carer asked "Would you like me to help you? Which side would you like me to be on?". Staff we spoke with were able to describe ways in which they would help promote a person's dignity, such using a towel to cover a person during personal care.

During our inspection of Oak unit we saw that there were a large number of people who remained in their rooms in bed throughout the day. There was no indication in their care plans that this was how they had chosen to spend their time and there was a risk that these people could become socially isolated and withdrawn, as they were unable to take part in group activities and had few people to talk to. We brought this to the attention of the deputy manager who told us that this situation had already been identified and that they were taking steps to address it. They had started to implement a 'positive goals plan' which would look at ways in which people could be encouraged to sit out of bed where appropriate

From reviewing the care files we saw that consideration was made about 'end of life' care, where this was appropriate. For example, we saw information around a best interests meeting that had been held to discuss the implementation of a 'do not attempt cardiopulmonary resuscitation'. In another file we saw that a note had been made that it was not yet appropriate to discuss end of life plans with a particular person or their family. Another person who was approaching the end of their life had an appropriate care plan in place, which identified their wishes. The deputy manager told us they had developed links with the local hospice, where they could seek advice about end of life care when needed.

Information about advocacy services was prominently displayed on a notice board in the foyer. Advocacy

services support people to express their views, access information and help people to make important decisions about their lives.

Is the service responsive?

Our findings

Prior to moving into the home a pre-admission assessment was carried out by the deputy manager and a senior staff member from the appropriate unit. This ensured the home was able to meet the care and support needs of the person. Where an admission was the result of a crisis and the person needed to be admitted immediately, the support plan provided by the person's social worker was used. This ensured their care needs could be responded to from the moment they arrived at the home.

We reviewed the care records of two people on Elm unit, three people on Oak unit, three people on Sycamore unit and two people on Beech unit. We found the level of detail and accuracy of the information varied between units.

On Oak unit the care files we viewed had recently been re-written and contained up-to-date risk assessments and care plans that were detailed and person-centred. For example, one file contained a care plan for 'catheter care', which described when the catheter bag and catheter should be changed and information about the use of aseptic technique. Aseptic technique refers to a procedure that is performed under sterile conditions in order to minimise the risk of infection.

On Beech unit, although care plans had been reviewed regularly and the information up-dated, some files still contained the original care plans dating from the person's admission. For example, we saw one person's file contained their original care plans which were dated 2012, although these had been reviewed since that date. This could potentially cause confusion to those reading them.

On both Elm and Sycamore units some care plans we reviewed did not reflect the current needs of the person. For example a care plan, which had been reviewed monthly, stated that a person required their blood pressure monitoring every week. However, when we checked the blood pressure chart we saw that this had not been done. We asked staff about this and they told us the person's blood pressure was only checked when they felt unwell. This meant their care plan did not accurately reflect their current need. On Elm unit where risk assessments had indicated a person was 'high risk', for example, of developing pressure sores, a corresponding care plan detailing how the risk should be managed had not been put in place.

The above examples of poor record keeping demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

We were told of, and observed during our inspection several examples where staff had responded well to the different needs of people living at Treelands. On Oak unit we observed one person who spent their time pacing up and down the corridor and we were told that this person often refused to sit down to eat. This put them at risk of malnutrition. Staff had found however that by encouraging the person to eat their meals alongside the carers, they ate sufficient quantities.

Two people who lived on Beech unit told us they were football fans and enjoyed watching football on 'Sky' TV. However, this was not available in the communal lounge. A member of staff told us that they would bring

their own personal iPad onto the unit to enable people to watch football matches. The deputy manager told us they would look into providing 'Sky' if this was something that would be appreciated.

We were told that the service had recently started a 'Smoking Cessation' initiative to help people reduce their levels of smoking. This was being carried out in conjunction with a local doctor and was part of a wider project looking at smoking within the home.

The home employed two activities coordinators, one full-time and the other part-time who provided a range of activities on all units. These included coffee mornings, bingo, reminiscence times, film shows and arts and crafts. The home had a well-stocked crafts room. One person told us "I like sewing in the craft room and going to the coffee mornings". Both activities co-ordinators who were trained in Reiki and therapeutic hand massage held one-to-one sessions with people who stayed predominantly in their own rooms. Staff commented to us during our inspection that there had been a recent emphasis on improving access to activities so that if an activity was happening on one unit, people from other units could be taken to join in. The '11am meetings', held by staff, had been used to remind staff to improve access to activities for people who used the service. One visitor told us that they had had to request that their relative be taken to activities on other units, as this did not automatically happen.

On Sycamore unit a small library had recently been set up in a quiet area of the unit and this contained a varied selection of books. We observed several people using the area to look at books or just sit quietly.

For those people who wanted to continue practising their faith a monthly communion service was held by a local Church of England priest. The home contacted a local Catholic priest when needed. There was no one from a different faith currently living at the home, but the deputy manager told us he would be able to renew links with the local Muslim community if required.

We saw that 'handover' meetings were held on each unit and all staff members were given a handover sheet which contained information about each person living on that unit, such as their dietary needs and equipment needed to assist with mobility. This helped to ensure that any alterations in a person's health or care needs were communicated between staff.

The home had a complaints policy which was on display in the reception area. People we spoke with were aware of how to make a complaint and felt confident their concerns would be dealt with. We looked at the 'Complaints File' and saw that a recent complaint had been handled appropriately. Information about the complaint, when response letters and replies had been received, findings of the investigation and considerations for future preventive action were all recorded in the file. A 'holding letter' was always sent to a complainant immediately upon receipt of a complaint. This explained that their concern was being investigated and that a response would be sent as soon as the investigation was completed.

Is the service well-led?

Our findings

We carried out this inspection in response to concerns raised by the local NHS Clinical Commissioning Group (CCG) over various aspects of the care at Treelands and the management of the service. In response to the concerns raised by the CCG the provider had completed an action plan showing how it would address the concerns, make improvements to the service and improve the overall management of the home. Through discussions with the CCG prior to our inspection, and through our observations during the inspection we saw that the provider had taken steps to make improvements to the service, although these improvements were still on-going.

At the time of our inspection the registered manager had been suspended, pending an investigation and the deputy manager had 'stepped up' to manage the home. The home owners had put in place a management team to support them in this new role, made up of a registered manager from one of their sister homes and a care consultant from a private organisation which provides quality assurance support to healthcare providers. In addition, the home owners were regularly visiting the home to check on the progress of improvements and to support the management team.

The providers were in the process of reviewing the management and staffing levels at the home with a view to introducing a new role of 'Lead Nurse' on each unit. The aim of this change was to help to improve oversight of the quality of care, maintain standards and provide a clear line of accountability.

Since temporarily taking over the management of the home, the deputy manager had introduced a number of new initiatives to help improve general administration and communication and to provide better oversight of the day-to-day management of each unit.

At the start of each day the deputy manager conducted a 'walk around' of the building, visiting each unit and going outside the building to look at the garden area. This enabled him to check on the environment and staffing levels and to identify any potential problems so that they could be dealt with promptly. It also gave people who used the service an opportunity to see him on an informal basis. However, recent 'walk arounds' had not identified some of the issues we found during this inspection.

The deputy manager had introduced an '11am meeting' with the aim of giving staff the 'bigger picture' of what was happening in the home. The meeting consisted of a daily team briefing for all key staff from the different departments, such as housekeeping, maintenance, administration and the units themselves. We observed one meeting during our inspection and saw that the atmosphere was positive and staff were praised. Each staff member had an opportunity to describe what was happening in their work area and to bring up any concerns they had for discussion within the group. All staff we spoke with during our inspection talked positively about the introduction of this meeting and of other recent changes in the home. One person said "The daily staff meetings are very useful. We feel like we are respected and being listened to". Another person told us "Coming to work is now a pleasure".

The deputy manager told us that he had identified that staff who had payroll queries were contacting the

administrator at home, out of work hours, instead of during the working day. To rectify this problem he had introduced a set time during which the administrator could be contacted, which had proved successful.

During our inspection we found that there were insufficient systems in place to regularly monitor the quality of the service provided at Treelands. We found very little evidence to show that checks had been made in areas such as medicines, infection control and the writing of care documentation. Lack of regular and consistent auditing had already been identified by the new management team and steps had been taken to commence audits in a number of areas and develop an auditing programme for the future.

During our inspection we identified that DoLS authorisations were not in place for a number of people who required them and that some authorisations already in place had expired. We saw that there was inadequate oversight of the level of training that staff had undertaken and that regular supervision of staff had not taken place during 2016. We could not find evidence that newly recruited staff had undertaken a thorough induction programme. We identified some problems with cleanliness in the home, in particular in the kitchenette areas, and found that risk assessments, such as for the use of bed rails, were not always completed. On one unit we found that monthly monitoring of peoples' weight had not been carried out fully.

These issues demonstrate multiple breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

We looked at how the provider obtained feedback about the service from people who used the service and their relatives. We saw that a relatives and friends meeting had been held in December 2016, although the attendance had been poor. People at the meeting had commented that they were happy and satisfied with the care their relative was receiving. There were plans to hold meetings twice a year. No surveys had been conducted in the past year. We were told that a survey would be held during 2017.

We recommend that the provider take steps to improve ways to obtain feedback from people who use the service and their families; so that this can be used to influence and drive forward improvements to the service.

The provider produced a monthly newsletter 'The Treeland Times' which provided people living at the home and their relatives with information about events and other items of interest. It also contained photographs of recent activities that had taken place at the home.

Accidents and incidents were recorded and reviewed when they occurred and a monthly log of all accidents and incidents was submitted to the providers on a monthly basis for analysis. This helped to ensure risks to people were minimised. Notifications of incidents occurring at the home had been made to the CQC appropriately and in line with their registration requirements.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
	The provider had failed to ensure a high standard of cleanliness.
	The provider had failed to ensure risk assessments were in place.
	The provider had failed to ensure people had their weight monitored regularly.
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
	The provider was not working within the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
	Systems in place to monitor and improve the safety and quality of the service were not effective.
	Complete and accurate records of care and support provided were not consistently maintained.
Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to ensure an adequate level of induction, training and supervision of staff.