Mr Richard Kirk Iyavoo and Mrs Belinda Davila Iyavoo

TreeTops Residential Care Home

Inspection report

Overton
Timber Hill
Lyme Regis
Dorset
DT7 3HQ

Tel: 01297443821
Website: www.tree-tops.org.uk

Date of inspection visit:
08 January 2019
10 January 2019

Date of publication:
26 March 2019

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?	Inadequate

Summary of findings

Overall summary

This inspection took place on 8 January 2019 and was unannounced. The inspection continued on 10 January 2019 and was announced.

TreeTops is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

TreeTops is registered to provide accommodation and residential care for up to 18 people. At the time of our inspection there were seven people living at the home, some of whom were living with a diagnosis of dementia. The home is set out over three floors. Access to the first floor is by stairs or chair lift. The ground floor provides access to a secure garden area. The third floor was not in use at the time of our inspection.

This inspection was brought forward because concerns had been expressed about the safety of people living at the service. We shared those concerns with the local authority and the fire service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Quality monitoring and audits had not been completed which meant areas of the service being provided were not meeting the requirements of the regulations. There was a lack of consistent and effective management and leadership, which coupled with ineffective quality assurance systems meant issues were not identified or resolved.

There was inadequate information about people's risk of falls as records relating to this did not contain sufficient detail. Where people were at risk of falls staff tried to encourage them to remain seated unless supported by staff. Risk assessments for people's individual care needs were not accurate and lacked detail. Systems in place did not always consider the least restrictive options, which put people at risk of losing their independence and freedom of movement.

Serious incidents had not been reported to the appropriate authorities. Accidents and incidents were not fully documented and followed up on continuing risk.

Managing risk in regard to the safety of the home was not robust. Fire safety checks such as weekly alarm testing had not taken place since October 2017, and new staff had not received fire training. Following our inspection, we made an immediate referral to the Fire safety team who have since visited the service. Essential checks on the safety of water temperatures were not in place, this meant there was a risk of legionella.

People did not always receive their medicines safely by staff who had been trained to administer them. Staff were not always clear about their responsibilities and role in relation to medicines. People were not encouraged to remain independent in the management of their medicines. Lessons were not always learnt or shared with staff when errors occurred. When health care professionals had given the provider specific instructions on how to care and support people, these were not consistently followed putting people at risk of unsafe or inappropriate care

Policies and procedures in relation to infection control and fire were not up to date or being monitored by the provider. Measures to prevent and reduce the risk of infection control had not always been taken. Staff did not always wear Personal Protective Equipment [PPE] such as gloves and aprons when supporting people with personal care or dealing with soiled laundry. Staff were unable to explain how to ensure people remained safe from infection spreading within the home. Staff had not received infection control training, or their training they had previously received was out of date.

Systems, processes and practices did not keep people safe from harm. The service did not always provide staff that had the right mix of skills, competence or experience to support people to stay safe. Staff had not completed induction training, or had not been kept up to date with training the service deemed essential.

Staff had not had individual supervision or had their competencies assessed. New staff informed us they had not had the opportunity to read people's care plans before supporting them, but had a good knowledge of their needs which they had gained from working with other staff.

People were not safeguarded against the risk of being cared for by staff that were unsuitable to work in a care home. The staff recruitment files evidenced, and staff informed us, they started work before suitable checks had taken place such as the Disclosure and Barring Service (DBS), which includes criminal records checks. Files did not contain reference checks or previous employment histories.

People were not involved in day to day decisions about their care and treatment and staff lacked knowledge about the importance and guidance around making a decision in a person's best interest. Where people were deprived of their liberty, records relating to this had not been completed in line with the Mental Capacity Act 2005 (MCA). Deprivation of Liberty Safeguards (DoLS) authorisations were out of date and had not been reapplied for. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

People's care plans and associated records did not detail their most current care needs and some documents had not been reviewed. Where records had been reviewed, this process was not thorough and did not identify any changes. People's preferences and choices for their end of life care were not recorded, the registered manager told us they had not considered people's end of life wishes.

We have made a recommendation regarding involving people in end of life discussions.

The service took cultural, ethical and religious needs into consideration. People told us they had opportunities to follow their faith. People's relatives and friends could visit the home whenever they choose. They told us staff were kind and caring. There was a complaints process in place and people and their relatives told us they would speak with the registered manager if they had any concerns.

People told us they enjoyed the food and were able to make choices in regard their meals. One person told us they liked to eat later in the day, and staff respected this wish. Where people had allergies or specific nutritional needs the staff and chef were aware.

People's information was stored confidentially in locked areas of the home. Daily charts and basic information about people was kept in the staff office and completed by staff at intervals throughout the day.

During our inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were at risk as accidents and incidents were not analysed to reduce risks.

People were at risk as recruitment processes were not safe. The provider had not completed full employment checks before staff began to work with people.

People were not safe in regards the administration of their medicines as some staff had not received the relevant training or competencies checks.

People were not protected from the risk of infection as staff did not follow infection control good practice.

Staff understood the signs of abuse and how to raise concerns.

Lessons were not learned and shared amongst the team. When errors occurred, professional guidance was not followed.

Is the service effective?

Requires Improvement

The service was not always effective

People's rights were not respected under the Mental Capacity Act 2005.

People's Deprivation of Liberty authorisations had expired and applications had not been made in advance of the expiry date.

People were supported by staff who had not received training to ensure they had the correct knowledge and skills to meet their needs.

People were supported by staff who did not receive regular support or supervisions.

People could choose what to eat from a choice of freshly prepared food.

People had access to external healthcare professionals when they needed them.

Is the service caring?

Requires Improvement

The service was not always caring

People were treated with dignity, but were not always spoken to in a respectful manner.

People's information was stored confidentially in locked areas of the home.

People and their relatives spoke highly of the staff supporting them and told us they knew staff well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always provided with information in formats that helped them to communicate their needs.

People and families were not involved in reviewing their care and support.

People's care plans were not updated and did not reflect people's changing needs.

People did not have access to activities which met their preferences or their needs.

People and their relatives told us they knew how to make a complaint and would feel comfortable making complaints.

Is the service well-led?

Inadequate

The service was not well led

Systems for identifying and managing risks were ineffective. People remained at risk in the event of an emergency evacuation as records were not up to date.

The provider did not ensure that audits were maintained and records kept up to date to monitor the quality of the service.

Notifications were not sent with the Care Quality Commission as legally required.

Leadership was visible and the management promoted an open-door approach.

Care Quality Commission

TreeTops Residential 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection site visit started on 8 January 2019 and was unannounced. The inspection continued on 10 January 2019 and was announced. The inspection was carried out by two inspectors on the first day and by an inspector and assistant inspector on the second day. We brought forward this inspection as we had received concerns about the management of falls, staffing and leadership of the service.

Before the inspection we reviewed all the information we held about the service. We did not request a Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during the inspection.

During the inspection we spoke with seven people who used the service, one visitor and two relatives. We also spoke with five members of staff, the provider, registered manager and cook. We spoke with three professionals who had knowledge of the service. Some people were unable to share their experience of the service with us, so we spent time observing their day.

We looked at a range of records during the inspection, these included five care records. We also asked to see other records such as supervision, and information relating to the management of the service including quality assurance audits, health and safety records, policies, risk assessments, and staff training records. We looked at five staff files and the recruitment process. Some of these records requested were not available for us to view as the provider had not maintained their records.

We requested that the registered manager send us a further information in regards recruitment and their Statement of Purpose by the 14 January 2019. This information was sent to us as requested.

Requires Improvement

Is the service safe?

Our findings

Risk assessments did not provide staff with guidance about the individual risks people faced or how to mitigate or manage these risks. For example, where people were at risk of falls, daily records evidenced a number of falls. There were no management plans or assessments in place to guide staff on how to manage these risks. Care plans stated that two people could mobilise with the support of a walking aid. We observed the two people did not have these aids by their sides on both days of the inspection.

People's falls risks were not managed safely. Three people were assessed as high risk of falls. Control measures had been put in place such as alarm mats. Staff told us the mats were ineffective as people walked around the mats and had continued to fall. One person's record stated in one section of their care plan they needed assistance from one member of staff. Another section stated they needed two members of staff to assist them. The registered manager told us the person should be supported by two staff. We observed the person being supported by one member of staff.

Some people's movements were restricted as staff were not always available to support them to move safely around the home. Two people had been assessed as needing staff support with their mobility. Staff confirmed there were times when they were not available to support people when they wished to move, which put them at risk of falls as they moved around without staff support.

A member of staff told us one person liked to use a bath chair to move when staff were busy. They told us, "They can move around which helps us when we are busy." Records evidenced the person had fallen from the bath chair. The risk of the person independently using this bath chair had not been assessed. This placed them at increased risk of falling. Another person fell in October 2018 resulting in a break to their hip. The accident form stated that four members of staff moved the person with a handling belt into a wheelchair. They did not request emergency services support for the person. A request was made for the GP to visit who requested an ambulance.

One person had a history of declining support with their personal care. There was no care plan to guide staff how to support this person when they declined assistance. Staff recorded they had been 'informed to leave the person if they refused their support'. Care records identified the person had refused support on many occasions, and was recorded in daily records at 'further risk of skin damage'. There were no referrals to other health professionals to support and assess the person's risk.

Lessons were not always learned. Although staff were aware of their responsibility to raise concerns to record safety incidents or accidents, they did not always do so. For example, when people had fallen, falls were not always recorded in the accident book, and no action was taken to seek input from health professionals to reduce the risk of reoccurrence. A medicine error was recorded in the accident book but no further action had been taken. The registered manager informed us they had not reviewed the accident forms, or taken or any further action in regards the medicine error with the staff member. They were unable to give an explanation as to why.

People did not always receive their medicines safely because staff had not always received training in how to administer medicines. Two members of staff told us they administered medicines but had not received the relevant training. They told us they worked without trained staff on a regular basis. The deputy manager told us they were in the process of providing some training in medicines administration for these staff.

People were at risk of avoidable harm because infection control processes were not understood or followed by staff. We observed three members of staff during both days of our inspection supporting people with personal care or cleaning, and moving soiled laundry without Personal Protective Equipment [PPE] such as gloves and aprons. Staff informed us they did use gloves but did not always remember to wear the aprons supplied by the provider. The registered manager told us, gloves and aprons were available but, "Staff did not always use them although they knew they should." The management of soiled laundry was not safely transferred from bedrooms to the laundry room. We observed soiled laundry left uncovered in a communal bathroom waiting to be rinsed. People, staff and visitors used this bathroom during our inspection and the lack of infection control procedures meant people were at risk.

A legionella risk assessment had been undertaken by an approved contractor in December 2016. This identified a 'Medium High' risk to people and contained recommendations that should be followed to minimise the risk of legionnaires disease. This included regular maintenance such as monitoring hot and cold-water temperatures, flushing taps that were not regularly used and cleaning and disinfecting showerheads. There were no records that evidenced any maintenance had been done or water temperatures checked. Shower heads had not been changed as per the recommendation. One shower head showed the same marks that had been highlighted on the risk assessment in 2016 identifying a risk had not been reduced or monitored. The registered manager informed us, testing of the system would take place in January 2019. This meant that people were exposed to the risk of infection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of harm as safe recruitment checks were not in place to ensure staff were suitable to work with vulnerable adults. For example, we looked at five staff files and found three of the files held no references, or exploration of the reasons for gaps in employment. Three members of staff had commenced work without the satisfactory checks being made, such as a DBS. A Disclosure and Barring Service (DBS) checks people's criminal record history and their suitability to work with vulnerable people. The registered manager told us staff had only worked for 'a number of days' without checks, however risk assessments had not been put in place to enable staff to work without supervision before their DBS was in place.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were two staff members on each shift and they both had several roles including, assisting people that required the support of two members of staff, cleaning and preparing food. Some people remained downstairs and others chose to remain in their rooms upstairs. Staff told us when they needed to support people they, "Hoped the others would be ok", another said, "We just get on with it". Staff told us they did not always work with experienced members of staff which meant there was a risk that correct action may not be taken in the event of an emergency. One member of staff told us, "We have been lucky so far as nothing serious has happened."
People using the service and their families told us, "The staff are good but there are not enough of them, they are always busy." The registered manager told us, "Staffing is a major issue in the area, but I am always around to help". One health professional told us they did not feel there were sufficient staff due to the level

of falls risks.

Staff could recognise the signs of abuse and were aware of how to report allegations of abuse. However, staff had not received updated safeguarding training.

Requires Improvement

Is the service effective?

Our findings

People were at risk of receiving inappropriate care as staff had not received the necessary training to enable them to carry out their roles effectively. Training deemed essential by the provider included safeguarding, infection control, manual handling, food hygiene and the Mental Capacity Act 2005. The registered manager informed us there had been issues with their external training provider, but were hopeful a new process to induct and train staff would be in place in 2019.

Staff were not receiving supervision and appraisals as expected by the provider and in line with their policy. Staff told us they had received supervisions in the past but not recently, and had not received any competency checks to ensure they had the correct skills and knowledge to support people. A member of staff told us, "I have not had any supervisions or checks that checked I am ok". Supervisions are mechanisms which support staff. The registered manager told us they were intending to pass some responsibilities for supervisions over to the deputy manager. The registered manager was unable to show any records of supervisions which had been held.

People were supported by staff who had not received a full induction into the service or had previous experience in care. The registered manager told us there was not an induction programme in place for new staff. One member of staff who had recently been employed at the service told us they completed one shadow shift but, they had not received training before working alone, such as, "Fire training and medicine training." They told us they were keen to receive the appropriate training to support people effectively.

This was 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 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 people lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People did not have their capacity assessed in line with the MCA. The registered manager told us that no-one currently receiving a service had a capacity assessment. We found that some people required their capacity to be considered with regards to specific decisions. For example, where people's needs changed and they had moved rooms. Although the person lacked capacity, no processes had been taken to ensure the moves were in the person's best interest, we spoke with one relative who informed us they had Lasting Power of Attorney for their loved one. They informed us they had not been consulted in regard to the change of room.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the

appropriate legal authority and were being met.

There were no systems in place to monitor whether people required a DoLS, or ensure that authorisations were applied for through the local authority. Two people had authorised DoLS which had expired. The registered manager informed us no reapplications had been made following the expired authorisations. There had not been any significant changes in how these two people were supported by the service. On the second day of the inspection, the registered manager informed us they had made the required DoLS applications and we reviewed the associated records to support the registered manager's statement.

People had their nutritional needs assessed and met, and the service considered cultural, ethical and religious needs. People were offered home cooked food that looked and smelt appetising. Comments in regards the food included, "If you don't want it and fancy something else you can have it." "The food is good. I have put on a stone since I moved in," Where people had identified food allergies or where a Speech and Language Therapist had advised a particular diet, staff and the chef were able to discuss individual needs. People could have drinks and snacks throughout the day. There was a selection of juices set out on a tray in the lounge for people to help themselves to, and hot drinks were offered frequently throughout the day. Relatives told us they were always offered drinks and could stay to lunch if they requested it. One person told us they liked to eat later in the day, and staff respected this wish.

People told us they received support from health professionals. There were mixed comments shared from health professionals. One professional raised concerns in regards staff following their instructions. For example, staff were advised to contact them if a cream prescribed did not take effect to heal a person's wound. Although staff had followed the treatment plan in regards the application of the cream, they had not followed the request to inform the health professional of the effectiveness of the cream. This meant the health professional was not able to assess the wound healing in the time limit they requested. Other health professionals told us, they had developed a good working relationship with the service.

When people moved to the home they had a choice of available rooms on admission and could decorate these as they wished. There was a garden which people had access to. Some people had doors leading to the garden and had chosen bird feeders outside their doors.

Requires Improvement

Is the service caring?

Our findings

Staff did not always speak respectfully to people. One person had an alarm mat in front of their chair to alert staff when they mobilised. We observed the person move from the chair without standing on the mat. When a staff member saw this, they said," You just walked round the mat didn't you, that's naughty isn't it." The same staff member was talking with people whilst writing notes, one person asked them what they were writing about them. The staff member did not respond in a helpful or respectful way, by suggesting they were writing negative comments about the person. The person asking the question did not seem to know if the staff member was joking or being serious.

People were not always supported by staff who knew their life history or interests. Some staff told us they were, "Unsure what interests or jobs people had." They told us they had not had time to read all the care plans and relied on other staff to tell them about histories. We spoke with two members of staff who did not know any information about people's life history and what was important to them.

People's relatives and friends could visit the home whenever they chose. We observed visitors arriving during the inspection and saw that they were welcomed and given updates about how their loved one had been. Relatives told us they felt people were treated kindly by staff, and they were made welcome when they came to visit. People told us they felt that staff were kind and caring. Comments included, "Yes the staff are very kind and caring, they can't do enough for us," and, "This is a lovely home I am very happy living here." Relatives told us they witnessed staff being caring to people when they visited the service. A relative told us they found their loved one crying as they were so happy to be at TreeTops. The Registered Manager spoke with affection about people living at the service, they told us, "I love them and love talking to them – it's my passion."

People's information was stored confidentially in locked areas of the home. Daily charts and basic information about people was kept in the staff office and completed by staff at intervals throughout the day. People told us their rights to privacy was respected. One person told us, "Staff are respectful when they come into my room and respect my personal belongings." We observed staff entering people's rooms in a respectful manner informing them what they were doing, for example. "I have brought you some more toilet rolls."

People's cultural and spiritual needs were respected and reflected in their care plans. Staff encouraged people to receive visitors in a way that reflected their own wishes and cultural norms, including time spent in privacy. One person told us it was important to them to follow their religious beliefs. On one of the days of the inspection the person received a visit from a member of their church. The member of the church told us they came in monthly to support the person with communion. Other people at the service had their religious beliefs met by a monthly church service held at the home. One regular visitor told us they came to deliver the parish Christian newsletter.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not updated to reflect changes in people's needs. Information in care plans guided staff in how to support people's assessed needs, such as diabetes. Where records had been reviewed, this process was not thorough and did not identify changes in people's needs. We looked at five care plans and found that they held information which was out of date, this may prevent people receiving appropriate care and support. For example, one person's care plan stated the person transferred with a walking aid and the assistance of one member of staff. We observed and were informed by staff the person needed two members of staff to support them to move. The registered manager confirmed the person required two members of staff, "Especially when tired". This meant five of the seven care plans were inaccurate.

The service had not fully implemented the Accessible Information Standards. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Each person's care plan detailed people's communication methods and how best to speak with and understand them. However, we found there was a lack of information for people in a format they could understand. Where people had issues with their vision, information was not shared with them in large print or coloured paper. For example, a menu card was set up on the dining table. One person told us, "I know it is there but it is so small I can't read it. But I always ask if I want to know". An activity programme was on display in the lounge, this was on a small piece of paper that could be easily missed by people. The registered manager told us people were given copies of the programme in their rooms.

People had opportunities to join in group activities, however during both days of the inspection we observed little social or individual activities taking place to stimulate and engage people who were unable to occupy themselves. For example, staff were seen to be task orientated in the mornings meaning people had little stimulation to occupy themselves. However, staff had more time in the afternoon to spend time sitting with people. When people chose not to participate in activities this was respected. Comments from people living at TreeTops included, "I walk around to try to keep busy and fit." "There was nothing to go downstairs for." "I stay in bed as I get bored." Other people told us they were happy to sit and knit and watch television, and enjoyed external entertainers now and then. An activity person was employed by the service to work two days a week. The registered manager told us there were changes planned in regards employment of a new activity coordinator as the current coordinator was retiring.

People's right to be involved in discussions and make informed decisions about their end of life care had not been considered. People's preferences and choices for their end of life care were not recorded, the registered manager told us they had not considered people's end of life wishes. One member of staff told us, "It is not a subject that is nice to speak about." The registered manager told us, "We don't have end of life processes in place. It can be a difficult subject to touch on which could be why it has not been discussed on the pre- assessments. I will ensure this is done in the future."

We recommend the provider follows best practice guidance for end of life discussions.

People were supported by staff who were aware of their needs. Daily records were completed and information shared at staff handover. People were encouraged to maintain relationships with family and friends. Family and friends told us they were contacted if there were any concerns in regards their loved one.

The home had a complaints policy and procedure, this was last reviewed in May 2017. The registered manager told us there had been no complaints. People and their relatives told us if they were not happy they would inform the registered manager who they said would take action. The registered manager told us there was an open-door policy in the home, and anyone was welcome to speak with them at any time.

Inadequate

Is the service well-led?

Our findings

The service was not well led. The leadership, governance and culture of the service did not always support the delivery of high quality person centred care.

The provider did not have effective quality assurances systems to ensure people received appropriate, safe and good quality care. There was no overview of people's care records and daily records associated with their ongoing care and treatment. Some of the information in people's care plans and risk assessments was inaccurate and did not reflect people's most current care needs. There was inadequate information about people's risk of falls as records relating to this did not contain sufficient detail. Over a period of six weeks, three people had 16 recorded falls, some resulting in cuts, and the support of emergency services. Some falls were recorded in daily records, others only on handover or daily notes. These inconsistencies in records meant trends were not monitored or analysed to mitigate the risks. The registered manager explained that accident and incident records should be reviewed and analysed, but told us this had not been done over recent months. This meant it was not possible to identify any causes, wider risks, trends and preventative actions that might be needed to keep people safe.

There was lack of oversight to ensure the environment was safe for people to remain safe. Weekly fire tests had not been recorded since October 2017, however the provider told us the checks had been completed just not recorded. They advised we asked staff about the checks. Staff were unable to tell us when the last fire test had been completed. This meant we could not be sure the tests were taking place. We shared our concerns with the fire service, who took the time to visit the provider in regards their fire security. The fire service informed us they had discussed the fire exits with the provider, and arranged a return visit with them later in the year.
Ineffective governance and monitoring had failed to identify significant training shortfalls and had allowed authorisations to legally to deprive people of their liberty to expire without submitting the required reapplication

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

The provider had failed to notify Care Quality Commission [CQC] about serious injuries. For example, two people had falls resulting in broken hips, these had not been notified to us as legally required. The registered manager was unable to explain why they had not reported these serious injuries.

This is a breach of Regulation 18 of the Health and Social Care Act 2009 (Registration) Regulations 2014.

Meetings for staff and people living at the service were not taking place. These meetings give people and staff opportunities to make suggestions about the running of the service, or to address any issues or concerns in regards staffing issues. The registered manager recognised staffing was an issue at TreeTops and told us it had an impact on the successful running of the service. They told us they were currently

recruiting new staff and investing in a new training programme for existing staff.

The registered manager told us their future vision was to, "Ensure training and auditing systems were up to date to improve the overall running of the service." They told us, "I don't know what has happened or why all our audits have stopped, but I will try to get the audits back in place." They told us there had been current issues with staff and attitudes and they hoped this would improve. The registered manager provided 'hands on' support to people living at TreeTops, covering shifts and working alongside staff. Comments from people, their relatives and some health professionals were positive. One person said, "Always see [registered manager] around they always chat." A relative told us they felt the registered manager was, "Very approachable." The registered manager told us they kept their own skills and knowledge up to date by attending meetings with other providers in the area.