Jeesal Residential Care Services Limited

Treehaven Bungalows

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Treehaven Bungalows is a care home providing personal care and support to people with a learning disability and /or autistic people. The service can support up to 11 people. At the time of inspection there were 10 people living in the home. Treehaven Bungalows is two conjoined bungalows with a majority of the accommodation downstairs, and each bungalow has an upstairs flat.

People's experience of using this service and what we found
Safeguarding incidents were not always reported to the relevant authorities, and systems to monitor accidents and incidents was poor and lacked comprehensive oversight. Health and safety audits failed to address concerns found within the environment.

There was a lack of effective governance systems in place to monitor and assess the quality of service being delivered. The provider did not maintain oversight of how the service was being delivered. Relatives had not been asked to provide feedback about how they thought the service had been run for a number of years.

Risks in relation to people's health and wellbeing had been identified and planned for and people were cared for by staff who understood their care needs well. There were safe systems in place around the administration and management of medicines, and staff had received training in relation to this.

People's relatives and staff spoke positively about how the service was run by the registered manager. People's relatives were complementary about how their family members were cared for and how they were supported to achieve good outcomes. Staff felt supported in their roles and felt able to put forward ideas about how to improve the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of the key questions of safe and well-led, the service showed how they were meeting some of the principles of Right support, right care, right culture. Based on our findings, the provider did not take adequate steps to report and investigate safeguarding concerns. Our observations and conversations with people's relatives and staff assured us care was delivered in a person-centred way.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 25 March 2019).

Why we inspected
This was a focused inspection to check on a specific concern we had about the provider's governance systems and oversight of the service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Treehaven Bungalows on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding service users from abuse and improper treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Treehaven Bungalows

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Treehaven Bungalows 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
People living in the service were unable to tell us verbally about their care, so we observed how staff supported people. We spoke with three relatives and six members of staff. This included the registered manager, deputy manager and four members of care staff.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

Requires improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

● There were insufficient systems in place to ensure safeguarding incidents were reported and investigated. We identified four incidents which should have been reported to the local authority safeguarding team which occurred between February and July 2021. Such incidents should be reported so they can be assessed and investigated appropriately.

This constituted a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us they would investigate the safeguarding incidents. They were also going to review their procedures in relation to reporting safeguarding incidents to ensure incidents were reported appropriately.

● All of the staff we spoke with told us they had received training in safeguarding and training records confirmed this. However, we could not be assured the training was effective due to incidents not being reported.

Assessing risk, safety monitoring and management

● People were not always protected from environmental risks. We saw one of the window restrictors on the first floor was broken, and the environmental audit had not identified this. We notified the registered manager of this and action was taken to fix the restrictor.

● The environment was in need of refurbishment. There were areas on the walls which had been plastered, but not yet painted. Carpets and flooring were coming up and looked worn. This posed a risk of people tripping and falling. An action plan for the environment detailed all of the areas in need of repair.

● People's individual risks in relation to their health and wellbeing had been thoroughly documented. Risk assessments detailed what action staff were required to take to mitigate known risks. Staff we spoke with clearly explained how they supported people who showed distressed behaviour, this included refocusing people on an enjoyable activity rather than resorting to the use of medicines. One person's relative told us how well the staff knew their family member, this included knowing when they became "frustrated" and when to know to give them space.

● Some fire safety concerns had been highlighted by a visit from the Local Authority in relation to fire doors. Whilst remedial action had been taken, this was only in response to the concerns being highlighted by

another agency.
● There was some good practice in relation to fire safety. Each person had an individualised personal emergency evacuation plan in place. These detailed what support people would require to evacuate the building in an emergency. Regular fire drills took place and were recorded.

Learning lessons when things go wrong
● Analysis of accidents and incidents was poor. There was no overview in place to give a comprehensive overview of accidents and incidents and to identify themes and trends.
● However, upon speaking with staff, it was apparent that some learning had taken place. One member of staff told us how more staff were deployed early in the morning due to an increase in incidents. This demonstrated some learning had taken place, but more robust systems were required to enable a thorough oversight and ongoing monitoring.

Staffing and recruitment
● There were enough staff to support people safely. Two relatives we spoke with told us their family members were cared for by the same members of staff who were familiar to them. One relative described this as, "Comforting."
● We observed staff were adequately deployed and were responsive to people's needs. We did not observe people showing distressed behaviour during our visit.
● Staffing rotas showed there were adequate numbers of staff to support people with their care and support needs.
● We reviewed recruitments records for three members of staff and saw the necessary pre-employment checks had been carried out to ensure they were of good character.

Using medicines safely
● Medicines were stored, administered and managed in a safe way. We reviewed a sample of medicine administration records and saw there were no gaps on the chart where staff would sign to say they had administered a medicine.
● Detailed protocols were in place for 'as required' medicines. These are medicines which people do not take regularly. This gave staff sufficient detail about when people may need these medicines, for example, when they were in pain.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

Requires improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was a lack of oversight from the provider. The provider did not complete any quality monitoring activities to assess how the service was running. Therefore, opportunities were missed to identify any shortfalls and make improvements.
- There were no formal audits of people's care records to ensure they reflected people's most current care and support needs.
- A service improvement plan was in place, but this failed to comprehensively assess the service and all of the improvements required.
- Whilst there were some audits in place for areas such as health and safety, these failed to identify areas for improvement. For example, the health and safety audit failed to identify a window restrictor was broken.
- The process to monitor and assess accidents and incidents did not provide a thorough oversight and failed to highlight incidents which had not been reported to the relevant agencies. A provider analysis of accidents and incidents only reviewed incidents between January to May in the years of 2021, 2020, and 2019. This did not allow for a thorough assessment of incidents throughout the whole year.
- Systems to monitor fire safety failed to identify concerns, and remedial action was taken when these were highlighted after a visit from the local authority.

These findings constituted a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Safeguarding incidents were not reported to the relevant agencies in line with regulatory requirements.
- Relatives we spoke with told us they were informed when their family member was involved in an incident and they were happy with the level of contact from the registered manager and staff.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Relatives we spoke with told us they used to be asked for feedback about the service, but this no longer

took place. However, they told us they had regular contact with the registered manager and felt able to raise any concerns if needed.

● The culture at the service was person-centred and positive. One relative we spoke with told us, "I believe [family member] is supported by a cohort of people who understand [family member's] essence."

● Staff we spoke with spoke about how they were like a big family at Treehaven Bungalows, and spoke positively about the people they supported.

● One relative told us how their family member has been supported by staff, "to cope with life" and how the support provided had helped their family member to become more settled.

● All of the relatives we spoke with told us how they were involved in their family member's care. One person's relative told us how they would be informed if the family member was having a review or assessment.

● Both relatives and staff we spoke with told us how the manager was approachable, they also told us they thought the service was run well.

● Staff spoke positively about their staff meetings and supervisions. They felt listened to and able to suggest ideas about how to improve the service.

Working in partnership with others

● Staff at the service worked in partnership with other professionals and agencies. These included health care professionals, and the local authority. Such partnership working ensures people's needs are met.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding incidents were not reported to the Local Authority safeguarding team. Regulation 13 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems in place to monitor and assess the quality of service being delivered. Regulation 17 (1)