Caring Homes Healthcare Group Limited

Tall Trees

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Tall Trees is a care home providing personal and nursing care for up to 60 people. On the day of our inspection there were 29 people using the service.

People's experience of using this service and what we found
The provider did not ensure systems were effectively and consistently operated to assess, monitor and improve the quality and safety of the service and ensure regulatory requirements were met. Medicines were not always safely managed. Infection prevention control measures were not always embedded or required improvement.

Senior staff had not always taken prompt action to safeguard people from the risk of abuse. At the time of our inspection the provider informed us there was an ongoing investigation into these concerns. The provider's safeguarding policy did not provide enough clarity to staff in cases of alleged abuse.
Staff and people told us there were not always enough staff on duty. We saw occasions from records where staff on duty had not met the numbers which the provider had assessed they needed.

One person had specific conditions stipulated in their Deprivation of Liberty Safeguards (DoLS). The specific conditions had not been met by the service provider. Other than this one case we found people were supported to have maximum choice and control of their lives and staff provided them with care in the least restrictive way possible and acted in their best interests. The policies in the service promoted this practice.

People told us and records confirmed they did not always receive person-centred care. Pain assessment tools used by the service did not always allow staff to assess the pain of non-verbal people. Risks associated with people's health conditions or the use of specialist equipment were not always recognised and assessed.
Advice from healthcare professionals was not always followed by the service.

Staff told us they did not feel supported by the manager and the provider of the service. The provider told us they had engaged staff through various means, such as a listening groups, and received positive feedback from staff. However, staff we spoke with told us that those means were ineffective and issues such as the shortage of staff remained unaddressed.

Staff had not always recorded and acted upon people's complaints in line with the provider's policy.

Some issues identified during our last inspection remained unaddressed.

There were safe staff recruitment practices in place. The service was dementia friendly. The environment within the home had been adapted to meet the needs of people who lived there.

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 11 December 2020) and there were breaches relating to assessing risks to people, management of medicines and governance of the service. The provider completed an action plan after the last inspection to show what they would do and by when they were planning to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted partly due to concerns received about management of an abuse incident and management of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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 remained requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Tall Trees 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 safe care and treatment, safeguarding people and good governance.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was always not well-led.

Details are in our well-led findings below.

Tall Trees

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
This inspection was carried out by two inspectors, one specialist professional advisor whose specialism was dementia care, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

There was no registered manager in post. The service was led by a manager who had been in place since September 2020 and who had submitted an application to the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 service was run by a manager who was in process of registering with the CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We contacted the local authority commissioning team. 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 took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We reviewed a range of records. These included four people's care plans and five staff recruitment folders. We spoke to five members of staff, two registered nurses, the manager, the regional manager and the operations director. We checked a variety of records relating to the management of the service, including health and safety records, accidents/incidents logs and records related to management of medicines. We spoke to two people using the service and seven relatives of people about their experience of the care provided. Not everyone living at Tall Trees was able to speak with us and tell us about their experiences of living in the home. We therefore observed how people were supported and how staff interacted with people. We used the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

After the inspection
We received further feedback from two members of staff working at Tall Trees. Following the site visit we continued to seek clarification from the provider and request additional evidence to form our judgement. We obtained feedback from a healthcare professional working with the service.

Inadequate

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 'requires improvement'. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure the proper and safe management of medicines and assessing the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.

- Risk assessments and care plans did not always provide staff with information on how to recognise and how to act on potential risks to people. For example, instructions regarding care of percutaneous endoscopic gastrostomy tubes (PEG) lacked details. Use of PEGs can involve specific risks, such as risk of infection, PEG tube erosion, PEG leakage, or PEG tube removal. Although these were noted within the care plans, staff were not provided with information of how to recognise a tube erosion or an infection and what to do if they notice this. This means that staff were not provided with clear instructions on how to minimise those risks. Following our inspection the provider told us they had introduced a new 'assisted nutrition policy' in order to improve the quality of care.
- We found risks in association with people's oral health care procedures. Although it was against the provider's policy to use oral swabs with a foam head, we found one on a tray in one person's room. We found no risk assessment for the use of oral swabs and no oral care instructions or records were provided. Foam heads of oral swabs may detach from the stick during use which could present a choking hazard for people. Following the inspection the provider informed us that they did not find any evidence of them being ordered or used when this was brought to their attention.
- One person was assessed as 'unable to communicate' as they had difficulty verbalising their feelings and ideas due to their condition. The pain assessment tool for this person did not consider any ways to identify pain other than conversation, which included moaning and shouting. According to their care plan, the person could also indicate 'yes or 'no', but this was not assessed. This meant staff did not have effective guidance to assist identifying if people were in need of pain relief to ease their symptoms.

We found no evidence that people had been harmed, however, systems were either not in place or were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Some people did not have care plans specific to their condition, for example diabetes. Where people were prescribed medicines which increased the blood glucose level, there were no corresponding 'when required' (PRN) instructions or a care plan to reflect. the GP's instructions. This posed a risk of lack of control over people's condition, risk of deterioration, complications and diabetic emergencies.
● We found three topical medicines not dated with the time of opening. This posed a risk of topical creams being used out of their expiry dates which may reduce effectiveness of the medicine.
● During this inspection we found insufficient improvements had been made in the areas highlighted by us after we had inspected the service in November 2020. Issues relating to the management of medicines and assessing risks remained unaddressed.

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

Systems and processes to safeguard people from the risk of abuse
● People were not always safeguarded against the risk of suspected abuse. Before our inspection we received information of an allegation of abuse. During our inspection we found prompt action had not been taken by senior staff within the home to protect people from the risk of abuse. The provider informed us that there was an ongoing investigation into this matter.
● The provider's safeguarding policy did not provide guidance on when and who should take action to suspend alleged abusers from work. Staff told us they were unsure who was responsible for taking action. This put people at risk of not being protected from potential further abuse.

This was 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.

Staffing and recruitment
● People and staff told us there were not enough staff to meet people's needs. One person told us they were left in their bed for a long period of time as staff were not available to assist them. The person told us they were unable to get hold of carers as sometimes their call bell was not working. During the inspection we found their call bell not to be pushed into the socket and outside of the person's reach. This meant the person in question could not request assistance from staff when needed.
This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service was using a dependency tool to calculate their staffing levels, however, we noticed that staffing levels were frequently lower than those recommended by the provider. We noticed that at times there was only one registered nurse for the whole service during a twelve-hour long shift.
● Staff were recruited in a safe way. All appropriate checks were carried out prior to members of staff commencing work for the service.

Preventing and controlling infection
● We were not always assured that the provider was ensuring infection outbreaks could be effectively prevented or managed.
● We were not always assured that the provider was preventing visitors from catching and spreading infections. Although the inspection team was asked to show evidence of their negative Covid-19 tests results, the inspection team was not asked to have their temperatures recorded in line with the provider's policy.
● 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 the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated 'good'. At this inspection this key question has now deteriorated to 'requires improvement'. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Records did not demonstrate people's needs were always robustly assessed. For example, there was one person with a specific condition. The person was in receipt of medical treatment but nothing in their care plan indicated they suffered from the condition or how it might be managed. There was no psychological impact of the specific condition on the resident recorded. Following our inspection the provider told us they had taken prompt action to seek specialist medical advice for this person.
- People's preferences were not always recorded. There was no evidence of any religious beliefs being assessed as a part of end of life care planning.
- The management team were aware of most best practice guidance but had not ensured this was translated into records and delivery of care in the service. For example, management of diabetes guidance released by The National Institute for Health and Care Excellence (NICE) was not incorporated into care plans.

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

- People told us their care was not always person-centred and this affected their well-being. One person told us, "I hate carers here. There is not one I really like. I lose my temper; they say to me to get back to bed." We asked the person if they felt they were being restricted and their response was, "Very much so, leaving you here most of the time." The person told us they were unable to get hold of carers as sometimes their call bell was not working. During the inspection we found their call bell had not been pushed into the socket and was outside of the person's reach. The person told us that when they tried to call for assistance verbally, they were only told to stop shouting.

Ensuring consent to care and treatment in line with law and guidance

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

● One person had a specific condition which was included in their Deprivation of Liberty Safeguards (DoLS) authorisation. We found that the condition was not met at the time of the inspection.

This was 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.

● Staff received training to help them understand their role in supporting people's day-to-day decision making. We saw they sought people's consent before carrying out their care.

● Formal mental capacity assessments and best-interests decision-making had been completed in relation to significant decisions about people's care. For example, in relation to people living at the service.

Staff support: induction, training, skills and experience

● Staff received on-going training to ensure they had the correct skills and knowledge to support people safely and effectively. However, at the time of the inspection we saw no evidence of specific training in end of life care or in the management of sepsis. Some staff told us that they would benefit from training in these areas. Following our inspection, the provider told us that the majority of staff completed training in catheter care, end of life care and emergency first aid at work.

● Staff told us they did not feel supported by the manager and the provider of the service. A member of staff told us, "There is no support from the management." The provider told us they engaged staff through various means, such as a listening group and also extensive presence of senior provider operations staff on site. However, staff told us that those means were ineffective and issues such as the shortage of staff remained unaddressed.

● Some of the registered nurses had gaps in their training records. Not all registered nurses completed annual assessments of their competencies. This means there was a risk that registered nurses were not up to date with national guidance and best practice.

Supporting people to eat and drink enough to maintain a balanced diet

● People provided us with mixed opinions about food. One person told us they were given muesli when they wanted to eat porridge. The person told us referring to their breakfast, "I don't eat muesli, I eat porridge." Another person told us they enjoyed the food, and that they were supposed to get a snack which sometimes did not happen.

● The home monitored people's weight with the frequency being determined by the nutritional screening tool in use.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The service was regularly visited by the local GP to monitor people's health. Other professionals such as speech and language therapists and tissue viability nurses also visited the service to provide additional support when needed. However, information provided by healthcare professionals was not always incorporated into people's care plans. For example, we noted that one person's sleeping care plan and a pressure ulceration risk assessment had not been updated to reflect the instructions from a healthcare professional.

● People's care files included details of their medical history to help staff understand people's health needs. However, some people's care plans lacked information in relation to the management of long-term health conditions.

Adapting service, design, decoration to meet people's needs

● The home's purpose-built environment provided people with enough space to self-isolate, participate in recreational activities, eat in comfort, receive visitors or spend time alone if they chose.

● The service was dementia friendly. The environment within the home had been adapted to meet the needs of people who lived there. The communal areas were brightly painted, with contrasting coloured handrails, which helped ensure the rails could be identified.

● Accessibility was good throughout the home and people could choose to sit in peace or enjoy company in the social areas. People and their relatives had access to a well-maintained garden area. However, one person told us they had difficulties accessing the garden. They showed us an accessible area outside the dining room where the pavement was uneven and access through the door was difficult due to a slight slope and a raised door frame.

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 'requires improvement'. At this inspection this key question has remained requires improvement. This meant there were shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider did not have effective systems in place to monitor and improve the quality of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- People living at the home were not protected and supported to be safe as the provider did not have a full oversight of the service. Systems and processes were not effectively operated to monitor and improve the quality and safety of support provided. Audits which had taken place did not mitigate some risks relating to the health, welfare and safety of people who lived at the home.

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

- We found that staff did not always follow the provider's policies which were also not always up to date and did not always contain correct information. For example, policies on complaints, management of diabetes and infection control procedures were not always followed by staff. This meant that people's health and well-being could be compromised and their complaints were not always listened to or acted upon.
- Personal records were not always stored securely. During our inspection we saw that some personal records were displayed on a computer at the reception area. The computer was left unlocked and personal data were displayed on the screen. There were no staff in this area so anyone could access personal records.

Continuous learning and improving care; Working in partnership with others

- The provider failed to meet their action plan produced after our last inspection in November 2020. Issues relating to the leadership of the service and to the management of medicines remained unaddressed.
- At our previous inspection we had identified two breaches of regulations. At this inspection we found the provider continued to be in breach of those two regulations.
- The management team did liaise regularly with health and social care professionals regarding people's needs as they arose but the service did not always introduce changes suggested by them.

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

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

● During our inspection one person complained to us about multiple issues such as a shortage of staff and difficulties in accessing the garden. We asked staff if they were aware of the complaints raised by the person in question. A member of staff told us that sadly no one took notice of the complaints raised by this person. According to the provider's policy, all complaints, including complaints raised verbally, were to be recorded and investigated. We checked the log of complaints and there were no records of complaints raised by the person to be investigated by the provider.

● Management were not always visible in the service. Some people told us that although they had a good opinion about the manager, they were not always available to speak to people. One person explained that they had asked lots of times to see the manager, however, they were eventually unable to speak to them. The person told us, "I never see her".

● Staff told us they had negative opinions on the support they received from the manager and from the provider of the service. Staff told us they felt unable to raise their concerns and were not listened to by the manager and regional manager. The provider told us they facilitated meetings between staff and human resources to address this issue and had received positive feedback from staff during these events. The provider also told us senior regional staff members were regularly present on site and available for staff to speak to. We asked staff if they were able to discuss the issues regarding the management and the culture of the provider at one of the meetings led by an HR representative and the provider's Clinical Director. They told us about a visit from a person from the head office saying, "We told them about the problems, including [the manager], but at the next staff meeting [the manager] told us we were 'acting like kids' and nothing was done." Following our inspection the provider told us they are continuing to support their staff through listening groups.

● We found that the culture within the service did not consistently promote providing people with safe, effective, person-centred care. A member of staff told us, "This is a poor culture on a higher level, and I do not blame one person, one manager."

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

● The provider understood their responsibility under the Duty of Candour. However, we found the manager had provided inaccurate information regarding an incident which meant a family had not been provided with a transparent response to a safeguarding incident.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure assess the risks to the health and safety of service users of receiving care or treatment. The provider failed to ensure the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to establish and operate effectively systems and processes to prevent abuse of service users. The provider failed to establish and operate effectively systems and processes to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. the provider failed to ensure that service users are not deprived of their liberty for the purpose of receiving care or treatment without lawful authority.