The Shaw Foundation Limited

Treetops

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 caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 16 January 2015 and was unannounced. We returned on 19 January 2015 to complete the inspection.

At the time of the inspection the service did not have a registered manager. However, the new manager in post had applied to the Care Quality Commission to become the registered 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 and associated Regulations about how the service is run.

Treetops is a care home which provides accommodation and nursing care for up to 24 adults, some of whom are living with dementia.

People told us they felt safe in the home and we saw there were systems and processes in place to protect people. However, there were times throughout the day when there were not enough staff available to support each person appropriately. Some people did not receive their morning medicines on time due to a lack of staff to dispense the medicines.

Summary of findings

Staff were recruited through safe recruitment practices and staff were knowledgeable about what constituted abuse and how to safeguard people. The service had made applications for Deprivation of Liberty Safeguards (DoLS) for some people in the home.

We had concerns around safety through poor infection control and through slip and trip hazards. Not all staff followed safe food handling practices. Appropriate measures were not in place to sterilise crockery and utensils. The environment was not safe. The garden had several areas which were not safe, there was a trip risk of uneven paving and slip risks through surface mould. The garden had not been fully risk assessed for potential risks of injury and harm.

The manager confirmed that staff supervision and appraisals had fallen behind and an action plan was in place to address this. Staff and health professionals thought that staff were skilled and adequately trained to do their job. People told us they thought staff were very skilled and understood their needs.

We observed interactions between staff and people living in the home and staff were kind and respectful to people when they supported them. People looked comfortable in the company of staff. The activities co-ordinator was working to support people to engage with hobbies and interests which were meaningful to them.

Record keeping was not of a consistent standard to ensure that staff had sufficient detail about people's care needs.

Relatives told us they had no complaints and knew who to complain to if they needed to. Complaints procedures were in place and people said they knew how to make a complaint.

There were systems in place to monitor and improve the quality of the service provided; however, staffing numbers were not calculated according to the needs of people who use the service. There were no audits in place to monitor this.

Staff felt that the manager was approachable and had an open door policy. Staff told us they would have no issues in raising any concerns they may have with the manager.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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. Some people did not receive their morning medicines on time.

During the lunchtime period, there was insufficient staff to be able to fully meet each person's needs. Not all staff followed safe hygiene practices which could put people at risk of infection.

People and their relatives told us they felt safe living in the home.

Is the service effective?

Requires Improvement

The service was not effective. There was a lack of information in the mental capacity assessment to be assured that robust efforts had been made to engage people in the decision making process.

People spoke positively about the food on offer. One person said “I like the food, there is a good choice”.

Is the service caring?

Requires Improvement

The service was not caring. People's independence was not fully promoted as some toilets and bathrooms were locked and people could not freely access them. Some staff practice did not respect people's dignity and privacy.

People said the staff were caring and kind. We observed that staff listened to people and engaged in helping people to make decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was not responsive. Care records were not consistently completed to an appropriate standard and information was missing or ambiguous.

Relatives felt they could visit the home at any time and felt welcomed.

Is the service well-led?

Requires Improvement

The service was not well led. There was no system in place to audit if the staffing numbers set by the provider were meeting the needs of people who lived at the home.

Healthcare professionals felt that the changes in management leadership over the last two years had been detrimental to building a professional relationship with the home.

The manager was working to a development plan in order to make improvements to the service.

Treetops

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 took place over two days, 16 and 19 January 2015 and was unannounced. The inspection was carried out by two inspectors 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.

Before the visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This enabled us to ensure we were addressing potential areas of concern.

We spoke with 10 of the 23 people living at Treetops. We spoke with five visiting relatives about their views on the quality of the care and support being provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to assist us to understand the experiences of the people who could not talk with us. We spent time observing people in the dining and communal areas.

During our inspection we spoke with the regional manager, the manager, the lead registered general nurse (RGN), one team leader, five care workers, the chef, kitchen staff and the housekeeper.

Before our visit we contacted people who visit the home to find out what they thought about this service. We contacted the Bath and North East Somerset commissioning team for adult social care, a GP and a two other healthcare professionals.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking to people, their relatives, looking at documents and records that related to people's support and care and the management of the service. We reviewed the care records of six people. We looked at staff records relating to recruitment, supervision and appraisal. In addition, medicine administration records, information on notice boards, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices throughout the day.

Inadequate

Is the service safe?

Our findings

There were not enough qualified, skilled and experienced staff to meet people's needs safely. Through our observations and discussions with people, we found there were not enough staff available to fully meet each person's needs in relation to the administration of medicines and around meal times. The impact of the staffing levels meant that people had to wait to receive their morning medicines which could have a detrimental effect on their health and well-being. People had to wait until care workers were available to support them and we saw this caused agitation amongst some people who used the service.

Treetop's nursing home is subdivided into three main areas, Ash, Holly and Maple units. The daytime staffing numbers for each of the units was, two care workers. This gave a total of six care workers with a registered nurse who worked across all of the units.

The Holly and Maple units each had an additional specialist agency worker who were employed by the local authority and were not part of the core staff team. The two agency workers provided twelve hours a day of one to one support for two people.

After lunch, one of the two care workers in each unit washed, dried and put away the crockery from lunch. We observed this took appropriately half an hour. During this time, it left one care worker to respond to people's needs. In the Maple unit, one person repeatedly asked to go to their room. One care worker was assisting a person to eat and the other care worker was washing the dishes from lunch. They told the person they would help them to their room after they had finished. It was 20 minutes before a member of staff was available to support this person to their room. Other people who required support to mobilise remained in the dining room and waited until staff were available.

Towards the end of the lunch time, the care workers in the Holly unit began washing up and cleaning the kitchenette. However, not everyone had finished their meal and this meant that some people who still required support were left unattended. A member of staff told us "We have to get the dishes out of the way and tidy up. If we are washing up then that takes us away from supporting people". Care workers told us they were 'not happy with the arrangement of staff having to wash up at lunch times as it put added pressure on them when people needed support.'

During both days of the inspection, when care workers took their lunch/tea breaks, this left one care worker remaining in the lounge areas. During this time, the remaining care worker could not leave the lounge as some people required constant supervision and support. This meant that people who could easily mobilise were able to leave the lounge if they wished to. However, people who required the support of staff to move around were restricted until a member of staff was available to them. In addition, one of the two care workers in the Maple and Holly units covered for the specialist agency worker when they took their break. As the person the specialist agency worker supported required one to one support, this meant that the care worker covering was not available to assist other people.

The timing of the delivery of care was determined by the number of staff available at that time which meant people had to wait in turn. In the Maple unit, one person required support with their personal care and another person wanted to 'lie down'. As two care workers were required to help the person with their personal care, another member of staff went to sit with people in the lounge. However, the person who wanted to lie down had to wait fifteen minutes until the other two members of staff had finished supporting the first person.

In people's care plans we saw the number of staff required to support people with their personal care, mobility and health care had been assessed and was documented. However, when asked, the manager told us they did not calculate how many staff they required based upon people's needs and there was no system in place to monitor and audit if the staffing levels were meeting people's needs. To their knowledge, the home had maintained a level of two care workers on each unit, for the last two years.

On the first day of our inspection we arrived at 9.15 am as the registered general nurse (RGN) was dispensing medicines to people in each of the units. The RGN finished their rounds at 11.50 am. The Medicine Administration Record sheets stated this was the morning round. As the morning round was taking 2 ½ hours, this meant that people were not receiving their medicines at the time they needed them. The RGN told us they had prioritised who

Is the service safe?

received their medicines first according to the type of medicine there were prescribed and if the person also required medication at midday. However, they did acknowledge that this was not 'an ideal situation and they did have concerns around sustaining this without the staff being available who could administer medicines'. The manager explained they had recruited for a deputy manager who would also be able to administer medicines.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Not all staff adhered to safe food hygiene practices. In each of the units, an open planned kitchen was part of the dining room. Lunch was delivered to the unit by the cook and utensils were available for staff to transfer the food to the plate. A care worker who was not wearing gloves, picked up cooked chips with their hand and placed them on the plates. We observed that the care worker had washed their hands before serving the food but were not confident they had properly sanitised their hands due to the brief time it took them to carry out this procedure. If hands are not washed adequately they may still harbour bacteria. This practice could contribute to cross contamination with food and lead to infection.

There was a lack of equipment available to assist in the control of infection. In the kitchens, a separate sink was available for hand washing and staff had access to supplies of soap and paper towels. However, the type of waste disposal bin available meant that staff had to lift the lid of the bin to dispose of paper towels. This could potentially cause bacteria to spread and cause cross contamination with food products. In addition, not all of the toilets and bathrooms had foot operated pedal bins to minimise the risk of cross infection from lifting the bin lid to dispose of paper towels.

This was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control.

Appropriate measures were not in place to ensure people were protected from the risk of infection. After lunch, care workers were responsible for washing and drying the crockery and cutlery from the lunch time meal. However, in all of the units the kitchen's did not have the appropriate facilities to ensure that crockery and 'greasy' serving dishes were clean. As dishes were washed in a detergent and then rinsed in running water into the same sink, this could reduce the effectiveness of the detergent used to wash the remaining dishes. The temperature of the water used was 'hand hot' as staff did not wear gloves. However, the service could not be assured that the water temperature was sufficient to sterilise the crockery. This posed a potential risk to people of infection through sharing dishes which were not fully clean.

The manager informed us that the home had future plans for the refurbishment of the gardens. People had access to the gardens and we observed three people use the garden. However, the garden between the Maple and Holly units was not safe. The paving stones were uneven and covered in green moss. This was a slip and trip hazard and could cause serious injury. The hand rails were rusty in some places with paint flaking which could cause injury and infection. Next to the foot path was a clothes drier which was open. It was easily moveable with one hand as it was not firmly sited into the ground. The garden had a large pond which had been filled in with mud; however, there was no fencing around the pond to prevent people falling into it. Risk assessments were not in place to protect people from harm, particularly for those people who have a sensory impairment or who lack spacial awareness.

As part of the laundry process, people's clean undergarments were stored in plastic boxes. These boxes were then placed on the floor outside of the person's room for the care worker or person to put away. These boxes cluttered what was otherwise a clear thoroughfare and posed a risk of people tripping over them.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All of the people and relatives we spoke with were positive about safety. One person said "Nothing but good here. I feel very safe and well cared for". Another person told us "Staff are marvellous and look after me, yes, I feel safe". A relative remarked "my husband has not been here very long but the home seems to be very safe and I know that he is being well looked after.

There were clear recruitment processes in place to ensure that new staff were safe to work with people. We looked at the employment files of two members of staff. Each file had evidence that an application form had been completed and contained documents relating to the person's employment history. In addition, a Disclosure and Barring Service check (DBS) had been carried out before

Inadequate

Is the service safe?

employment began. The Disclosure and Barring Service helps an employer make safer recruitment decisions and prevents unsuitable people from working with people who may be vulnerable.

Staff had received training in safeguarding to protect people from abuse and training records confirmed this. Staff were able to describe what may constitute as abuse. There were safeguarding and whistleblowing policies and procedures in place which provided guidance on the agencies to report concerns to. People and relatives told us they would be willing to pass on any concerns if they had any issues around their care and treatment by staff.

Whistleblowing is when a worker reports suspected wrongdoing at work in relation to the care and welfare of people they care for.

Documents evidenced that the management team reported concerns to the local authority safeguarding team and notifications were made to the Care Quality Commission as required. Incident and accidents were monitored for each person and referrals made to the appropriate agencies for support. Incidents were analysed centrally by the Trust to inform risk management.

There were procedures in place for the administration of medicines. We looked at three people's records for the administration of their medicines. People received their medicines, stock levels were accurate and the form had been initialled and dated as required. Medicines were stored correctly and safely and records evidenced that stock levels were checked when medicines were delivered and disposed of.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Out of the five care records we looked at, four people had undergone a mental capacity assessment. However, in all of the records, there was insufficient detail. There was a lack of information which evidenced that robust measures had been taken to ensure everything had been done to engage the person in the process. For example, the strategies used and communication needs, when was the best time to speak with the person, how often staff had tried to engage the person and important people who should be involved. There was a lack of information on when the assessments should be reviewed.

Staff demonstrated they were knowledgeable about actions which were taken in the person's best interest, however, a lack of written information may impact on how other staff such as agency workers or new staff communicate with people and understand their needs. In three out of five care records there was no information around best interest decisions which had been made.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Throughout the day there were drinks and snacks available to people and although people had glasses of drink to hand, the levels remained the same for a number of hours. We did not see people being encouraged by staff to drink fluids. We reviewed the records of three people who were at risk of malnutrition and dehydration. The amount of fluid the person had drunk was recorded on the fluid chart; however, none of the charts had been totalled or initialled to say that the records were being monitored to ensure people were drinking enough fluids. Staff were advised to contact a senior member of staff if the total fluid amount fell below 500 ml. There was no reference on one chart that this had been done. There was no indication on the chart if 500ml was an adequate level of hydration for that individual.

Staff told us they had received supervision but not on a regular basis and records evidenced this was the case. The manager explained that in the absence of a registered manager since May 2014, supervision had fallen behind. The supervision matrix documented when staff had last received supervision and the manager was in the process of setting up planned dates. The clinical staff reported they had received clinical supervision as required by their nursing registration. With the exception of two members of staff, annual appraisal had not been routinely carried out.

Supervision and appraisals are processes which offer support, assurance and develop the knowledge, skills and values of an individual, group or team. The purpose is to help staff to improve the quality of the work they do, to achieve agreed objectives and outcomes.

Staff said they were happy with the training offered by the provider and felt they had received sufficient training for their role. The training matrix documented when staff had last completed the mandatory training and when follow up training was required. Staff undertook specific training which was relevant to the needs of the people they supported, such as epilepsy or managing diabetes.

Healthcare professionals told us that staff were 'very patient orientated in their approach, provided a person centred service and supported people to access correct health care'. 'Staff know the people they are supporting and have received the correct training to do so'.

People expressed confidence in the ability of the staff. One person said "staff seem to know what they are doing. They are very careful and take their time when they move me". Staff were knowledgeable about safe moving and handling practice. They were able to explain the techniques associated with the process of using a hoist to re-locate a person. Staff had the right first aid skills and professional knowledge and applied this when a choking emergency occurred. We witnessed an incident which became serious when the person's airway became blocked. Staff responded quickly and appropriately. Staff were able to tell us this person's wishes in relation to resuscitation.

Care records evidenced that health and social care professionals, such as the mental health team, speech and language therapy and podiatry services were involved in people's care. People were referred to professionals by the staff to assess and review their health needs. Staff told us they provided specific guidance to support the effective

Requires Improvement

Is the service effective?

delivery of care. We observed one person who was agitated and verbally abusing a care worker. The care worker reassured the person and prevented the situation from escalating. The information about how to support this person in particular situations was given in the person's care records.

People spoke positively about the food on offer. One person said "I like the food, there is a good choice". A relative told us "I have my meal here every day and it's a godsend for me. There is a good choice on offer". We saw that the food was well presented, looked appetising and the portions size varied according to the requirements of the person. Specialised diets were catered for such as, pureed, gluten free, bite size food or vegetarian and this information was available to the chef and cook.

Most people had their meal in the dining area. When care workers supported people to eat and drink they focused on the person, talking them through what was happening and waiting before giving the next mouthful. We saw that staff worked hard to respond to people's needs as quickly as they could. However, on one occasion a care worker had to leave the person during their meal to support another person. Although the staff member was away for no more than five minutes, this interruption caused the meal to get cold and did not promote a person centred approach to supporting people.

The design and layout of the building enabled people to move around freely. The building was fully wheelchair accessible. The hallways in each of the units were wide enough that people could walk unsupervised along the hallways if they wished. There were grab rails at waist height in each of hallways to offer support when walking and support rails were strategically placed in the toilets and bathrooms.

All staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff recognised their responsibilities in ensuring people's human rights were protected. They described how people could be deprived of their liberty and what could be considered as a restraint. Staff told us they did not use any form of restraint.

We looked at whether the service was applying the Deprivation of Liberty Safeguards appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. Within people's care records we saw some people had an authorised DoL's in place in relation to consent to care and support. The manager told us they had recently made further applications which they were waiting to hear the outcome of. DoL's applications were now being considered as part of the admission process to the home to ensure that staff acted in accordance with the law and people received care in their best interests.

Requires Improvement

Is the service caring?

Our findings

People's independence, privacy and dignity was compromised due to restricted access to the communal toilet and bathroom in each of the units and staff practice. Some of the toilets and bathrooms were locked and the key placed above the door.

A staff member explained this was put into place to protect one person from the risk of harm. There was a risk assessment in place, however, this did not consider the rights of other people in the home to have free access to these facilities. If people could not reach the key or did not have the manual dexterity to use the key, this restricted their choice to be able to use the toilet or bathroom.

There were no signs or symbols on the toilet or bathrooms doors which informed people if the room was in use. We saw a senior member of staff open a toilet door (without knocking) to find a care worker was inside supporting a person. The care worker had not locked the door from the inside which compromised the dignity of the person they were supporting.

During our observations we saw that the majority of care staff interacted in a way that made people feel valued. However, not all care staff had the same approach. We saw that an agency worker was reluctant to interact unless prompted by other members of the team. We discussed this with the manager who told us this was an 'issue already raised with the agency and most agency workers interacted really well'.

In our conversations with people and their relatives, they constantly referred to staff as being caring and supportive. One person told us "the carers deserve a 1000% pay rise, they are marvellous" and a relative said "they are very caring here, I can't fault the staff". Before staff carried out any personal care or intervention they asked the person's permission and explained what they were about to do. Some people in the home could not verbalise their wishes. Staff told us they knew from the person's body language, sounds they may make or facial expressions, what their wishes were.

Staff protected people's dignity by carrying out personal care in the privacy of the person's bedroom. Staff respected people's privacy by knocking on their bedroom door and waiting until being invited in. Staff said they 'fully respected people's privacy if they wished to stay in their room with their door closed'. When staff entered the communal rooms, they acknowledged and spoke with people in a respectful and friendly manner and used the person's preferred name. There were pictorial signs on the bathroom, toilet and lounge doors which helped people to orientate themselves and maintain their independence.

People who live in the home came from different cultural backgrounds. Upon speaking with care staff, we found they were knowledgeable about the people in their care, including their cultural background and how people expressed themselves through their faith, language, food and music.

We saw many examples of where staff responded in such a way which enabled the person to be involved in making decisions. Such as asking for permission before they carried out care tasks, explaining to people what choices were available and taking the time to listen and respond at the person's own pace. One person told us "I am involved in seeing my care plan and staff talk to me about things that might need changing". Relatives told us they had been kept fully informed about their family members care.

Requires Improvement

Is the service responsive?

Our findings

We checked whether people received care that was responsive to their needs. The manager explained they were in the process of updating care records and audits had highlighted areas which needed to be improved. Each person had a care plan in place along with the relevant risk assessments. We observed that people looked well cared for and staff demonstrated a sound knowledge of their care needs. However, the care records did not accurately reflect the care being provided. The manager acknowledged that whereas they felt staff knew the care people required and this was being delivered, this was not always documented within the care records and was an area for development.

The quality of recording within the care records was inconsistent. Some sections of the forms were blank, lacked sufficient detail or did not give adequate explanation. There were sections within five care plans which had not been completed. Such as, the life map explaining the person's background and important events in their life, things I like to do outside of the home, end of life wishes, personal care and dressing sections and the needs and strengths of the person.

The guidance for staff contained within some of the care plans lacked sufficient description. If staff knew the person well, they would understand what the statements referred to, however, a lack of robust information could affect the way in which new staff or agency workers responded to an incident. One statement said 'Staff to be aware of facial expressions and body language' there was a lack of detail around the types of facial expressions and body language staff should be aware of.

In one person's daily activity report, it stated 'X has been quite aggressive' but gave no description of what 'quite aggressive' was. Another record for this person stated 'X in bed showing signs of frustration, banging walls and pulling quilt'. There was no other information about what action was taken to reduce this person's frustration or what had preceded the incident. Statements were used in record keeping to describe behaviours. Such as, 'X very short tempered and often displays verbal and physical aggression'. This lacked any description of how the behaviour presented itself or actions staff had taken in response.

Standard statements were used when recording care and observation which were not descriptive, such as 'X was happy today', 'X wanders', and 'staff to encourage'. A lack of recording which describes behaviours or actions taken may prevent staff sharing important information and good practice and assist in minimising future incidents.

In one person's risk assessment for falls it stated that if the person received a number of falls and was taking more than four medicines, then a referral should be made to the falls clinic. The person has sustained five falls yet there was no documentary evidence that a referral had been made. The falls risk assessment also stated to 'ensure hearing aids are functioning and glasses are clean'. This had been a contributory factor towards the person falling. In the daily notes it stated this person was not wearing their hearing aid or glasses. The risk assessment did not say what action to take if this was the case. We spoke to a member of staff who said the person had been referred to the falls clinic but this 'probably had not been recorded'.

Information given in some of the care records was ambiguous. In one person's care plan it stated that they should be on 15 minute observations. We saw this person was not being monitored and asked a member of staff why. They responded this person was now on hourly monitoring. In another person's care record they were recorded as requiring hourly checks, however, the checks were no longer required. The records had not been updated to reflect the changes or cross referenced to a changes brought about through a review of their care and support. This meant that staff did not have access to up to date information which may result in the person not receiving the care they require to keep them safe and well.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that visitors and relatives were welcomed into the home and were not restricted in their visiting times. During our two day inspection we found that people either sat in the lounge, went out with their family or wandered around the home.

The activities co-ordinator was new in post and was developing the range of activities on offer, including using the mini-bus to go on day trips. There was a two week activities programme in place which included amongst other things, bingo, movement and exercise, karaoke and a film afternoon. The timetable also included one to one

Requires Improvement

Is the service responsive?

time with people. However, not all of the activities offered were suitable for people with a dementia and we observed that some people sat for periods of time without any social stimulation. The activities co-ordinator told us they had started to engage with people to talk about their hobbies and interests and planned to develop this to offer activities which were more meaningful to the person.

Some people who were able to voice their opinion told us they would make a complaint if they needed to. Relatives told us that they understood the complaints policy and would not hesitate to complain should the need arise. A relative told us they had raised a complaint before and felt that the complaint was taken seriously and addressed. They had not needed to complain since. A copy of the complaints policy and procedure was available in the foyer of the home.

Requires Improvement

Is the service well-led?

Our findings

Regular audits had been completed by the regional manager and other representatives of the provider not directly working at the home. Actions plans were in place to address the issues identified in these audits. The manager completed daily checks regarding the environment and we saw audits of care records took place. There was a development plan in place to address issues raised through the audits, such as supervision, appraisals and activities.

The provider had failed to recognise two shortcomings in their audits. The lack of systems in place to calculate staff numbers according to people's needs. Monitoring that staffing levels were appropriate when people's needs changed or when new people moved into the home and subsequent auditing of staffing numbers. There were no clinical audits of the 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) forms to ensure they had been completed in line with current legislation and the decisions made were appropriate and lawful.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Provider Information Return (PIR) was returned to us on 8 December 2014 and had been completed by a senior member of the Shaw Foundation Limited.

We consulted with health and social care professionals for their opinion regarding the quality of the care and support offered by the service. Feedback on the care offered was positive, however, concerns were raised that continuity and building relationships had been very difficult, due to the frequent number of management changes in the last two years.

We looked at the processes in place for responding to incidents, accidents and complaints. We saw that incident and accident forms were completed and actions were identified and taken. We saw that safeguarding concerns were also responded to appropriately and appropriate notifications were made to us where required by law. We saw that the provider monitored levels of incidents, accidents and safeguarding to identify patterns of concerns. This meant there were effective arrangements to continually review safeguarding concerns, accidents and incidents and the service learned from this.

Staff told us the new manager who had been in post since November 2014 was very approachable and had an open door policy. They felt supported and the team morale had improved. Team meetings had been held and staff were able to voice their opinion regarding issues relating to staffing numbers and the use of agency workers. The manager told us they were reviewing the role of the team leader to ensure each one had the necessary skills to perform their role. There had recently a meeting with the team leaders which looked at the expectations of their role, their skill mix and goals.

The manager had clear visions for the future of the service such through working towards the goals set in the development plan. They acknowledged there was work to be done and saw this phase as transitional.

As part of the quality assurance system, an annual questionnaire was completed by people using the service and their relatives. The latest questionnaire carried out during November 2014 was still to be collated. Relatives were encouraged to take part in the relatives meetings and minutes of the meetings evidenced they had been able to put forward their views of the quality of the service provided. At this time, the manager confirmed that no resident meetings were being held but they hoped to set these up in the future.

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 did not take formal enforcement action at this stage. 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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Some areas of the physical environment of Treetops were not safe. Not all potential risks had been identified. The provider had not ensured people were protected from unsafe or unsuitable premises.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Systems were not in place to ensure there were enough qualified, skilled and experienced staff to meet people's needs safely. There were not enough staff available for the administration of medicines and around meal times.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The provider did not have appropriate arrangements in place to ensure that medicines were dispensed to people at the times they needed them.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **People were put at risk of infection due to unsafe food handling practices. There was a lack of equipment to assist in the control and spread of infection.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider had failed to ensure that suitable arrangements were in place for obtaining and acting in accordance with, the consent of the person using services in relation to the care and treatment provided for them. There was a lack of documentary evidence that people had been given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision making process. For people who lacked capacity there was a lack of documentation which evidenced that best interest meetings had been held.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People who used the service were not protected against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Care records were ambiguous, lacked detail and were not complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider had failed to identify, assess and manage risks relating to appropriate staffing numbers in order to meet people's needs. There were no clinical audits of the 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) forms to ensure they had been completed in line with current legislation and the decisions made were appropriate and lawful.