SRG
Care Consultancy
& Training

AUDIT REPORT

TreeHaven Bungalow West Runton

Date of Visit: 15th & 16th January 2024

Private & Confidential
SRG CARE CONSULTANCY

Contents:

Service Name: TreeHaven Bungalow **Provider: Liaise**

Address of Service:

Date of Last CQC Inspection: 22nd July 2021

CQC Rating: Requires Improvement

Ratings

SRG Overall Rating for this Service Requires Improvement

Is the service safe?	Requires Improvement
Is the service Effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall Review Summary

INTRODUCTION

An audit, based on CQC KLoE, was undertaken by one SRG Consultant over two days on 15th and 16th January 2024 The purpose of this review was to highlight in a purely advisory capacity, any areas of the service operation which should or could be addressed in order to improve the provision and recording of care and increase overall efficiency and compliance with CQC Standards and Regulatory Requirements .

Comprehensive inspections take an in-depth and holistic view across the whole service. Inspectors look at all five key questions to consider if the service is safe, effective, caring, responsive and well-led. We give a rating of outstanding, good, requires improvement or inadequate for each key question, as well as an overall rating for the service.

METHODOLOGY

Several different methods were used to help understand the experiences of residents who used the service. These included observation of interactions between residents and staff, conversations with the Manager, Deputy Manager, discussions with staff, discussions with residents a tour of the building and review of key documentation.

SUMMARY OF OUTCOME

Treehaven Bungalows is registered with CQC and provides accommodation for persons who require nursing or personal care. It's category of registration is a Care Home and has specialisms/services in; Caring for adults with Learning disabilities and Physical disabilities. The service provides accommodation for up to 11 residents, of which are supported in small purpose built building across 2 areas each with an upstairs flat in each area for one resident , there are also extensive garden and grounds. At the time of this audit the home had an occupancy 10 residents. Due to one resident needs two rooms were knocked into one hence full occupancy of 10 residents.

Treehaven Bungalows have been taken over by Liaise in April 23 and there has been a change of Registered Manager.

Some of the residents at Treehaven Bungalows have communication difficulties and/or cognitive impairments; therefore, we observed some interactions between staff and residents to ensure they were comfortable with the support/engagement that they were having. We read care plans for three residents, we checked four staff recruitment files and records to confirm staff training and supervisions had occurred appropriately. We checked medicine records and the records pertaining to the operation of the service, including quality assurance audits, minutes of staff meetings, H&S and Fire related documentation.

Treehaven Bungalows have typed care plans at present but will be transferring the information to Blissful in the near future Staff input daily occurrences via iPads daily notes on another electronic system. Once the full transition of notes are on Blissful this system will no longer be used Care Plans were seen in files. Treehaven currently use the Select HR Software for staffing records and the My Hippo platform for e-learning that staff complete.

There was no registered Manager in place as the previous registered Manager had left. There was an Operation Manager who was taking charge from November 2023 and there had been some significant changes during this time.

DISCLAIMER

The matters raised in this report are only those that came to the attention of the reviewer during this visit. The work undertaken is advisory in nature and should not be relied upon wholly or in isolation for assurance about CQC compliance.

RATINGS

It is the overall view of the consultant undertaking this review that while several recommendations are made, subject to these being acted upon and concluded that the service would likely achieve those CQC KLoE ratings as specified within each section of the report. Ratings are applied as per those conditions set out within the CQC KLoE Prompts and Ratings Scales.

Please note that this is the opinion of the reviewer carrying out each audit based on the evidence gained during the review visit and using this to evaluate compliance against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

KLOE	Applicable Regulations	Comments
Safe	**Regulation 12 (f) and (g) Safe Care and Treatment** **Regulation 13: Safeguarding users from abuse and improper treatment** **Regulation 17: Good Governance** **Regulations 18 & 19: Staffing - Fit and Proper persons employed** **Regulation 20: Duty of Candour**	Safeguarding was a high priority and DBS was checked on each staff file including the new recruits both of which had started on the day of inspection. As part of their induction, they were completing online training for Safeguarding adults and children. 4 Staff files were checked online, and all documents were stored with no paper copies on site. 2 new starters had references and DBS covering the correct periods, 2 other older members of staff were on the system and were compliant, but there were signed copies of the contract. It was explained that most documents are sent out electronically and signed by DocuSign but may not have been uploaded. I would suggest an audit check of all staff to ensure these are compliant. **(SR1)** There had been no recent safeguarding that had required reporting; however, the previous Manager had not been open and transparent and therefore a closed culture had been established. However, it was evident on speaking with staff that they understood what they needed to report and to whom. All historical safeguarding's had been closed although it was unclear if any learnings from these had been shared with the staff team. No RIDDOR had been reported in the last year. There were new monthly audits in place since the takeover of Liaise and these initially had been completed by the previous manager at 100%, this clearly had not been accurately reported but now with the new management structure these are being reported correctly and added to the Service Improvement Plan where issues arise. Incidents which are now being recorded on the incidents and accidents tracker however this was not fully embedded. An incident occurred during the visit, and this was not recorded on the incident form, but in the progress notes. **(SR2)** Two staff meeting minutes were seen from October and November and there were a number of outcomes such as daily note writing not detailed enough and training to be given but this has yet to be completed by the Operations Manager due to the workload. More documented feedback is required to ensure learning is cascaded. **(SR3)**

KLOE	Applicable Regulations	Comments
		Infection control notices and PPE were evident in the service however, the staff on duty delivering medication wore gloves which were not changed between service users. Staff do not wear uniform and looked neat and tidy, but there were some staff had very long false nails which was contravening the dress code, this should be addressed. **(SR4 & SR5)** Training for the home was running 98% combined with 98% mandatory training using My Hippo as the platform. The company's requirement for quality is 95%. Face to face training is provided by an external provider for Fire, First Aid, Epilepsy and Moving and Handling. Medication training was also face to face and this needs to be completed with all staff as all our involved in medication for the service users especially as 8/10 are 121 cares. There didn't seem to be an easy way to find out how many of the staff had an NVQ qualification other than checking each file individually on Share point, however a number of staff were currently working towards level 5 and one Senior Team Leader was completing an open university degree in Health Care Management**. (SR6)** The garden was a mess and had trip hazards and old broken furniture along with other building materials that were scattered. Liaise are aware and have ordered a skip, but this is urgent and needs to be resolved. **(SR7)** Medicines management, each resident had a locked cupboard in their rom but in some cases, these were too small for the numbers of medication being stored. The Drug Trolley was not attached to the wall in either location office or in AG's room. Medication charts showed no gaps and adequate information when giving PRN was detailed. There was no covert medication being given. **(SR8)**

KLOE	Applicable Regulations	Comments
		One drug trolley in middle office contained tablets and creams for all resident's. These should be placed in a separate cupboard. **(SR9)** Washing up liquid and hands soap dispenser were left in Woody's kitchen and not in compliance with COSHH**. (SR10)** Duty of Candor letters had not been sent for any of the residents in the last 6 months as there were none to report. First Aid boxes had not been checked and were incomplete. **(SR11)** Garden access needs to be restricted until it is cleared of all obstacles and made safe. Skip had been ordered but the unsafe items remain. **(SR12)**
Outcome: Improvement is required to ensure that this service is considered as Safe. 'Safe' is defined by the CQC as meaning "**people are protected from abuse and avoidable harm".** **SRG RATING: Requires Improvement**		

KLOE	Regulations	Comments
Effective	**Regulation 9: Person Centred Care** **Regulation 11: The need for Consent** **Regulation 12: Providing Safe Care and Treatment** **Regulation 14: Meeting Nutrition and Hydration Needs** **Regulation 15: Premises and Equipment.** **Regulation 17: Good Governance** **Regulation 19: Staffing**	The staff some whom had been in the service a number of years clearly knew their residents very well and the care plans and care reflected this. Staff were witnessed working with residents in very difficult circumstances when medication to calm the resident was refused but with skilled handling and patience the resident agreed to have the medication this took 45 mins and consent was obtained. This had the desire effect, and the resident was much more content and was enjoying his music. Meals were individually shopped for and prepared with residents still being offered a choice at the table. Shopping was conducted 3 times a week by a member of staff alone and this was a missed opportunity where a resident could accompany and choose their own food. Choices being made by the residents were not necessarily heathy ones and other than a roast dinner on Sunday there appeared to be little in the way of fruit and fresh vegetables on the menu. I would suggest a menu review in conjunction with residents and families. **(ER1)** There was one resident who had a pureed diet, there was no evidence in his paper care plan but was one on the unit where food was prepared. This was surrounding tasters as he was also PEG fed. I could not see evidence IDDSI training for all staff although the notes on the unit were IDSI compliant. **(ER2)** IDDSI - IDDSI Framework One resident had a fluid restriction, and this was monitored and adhered to on a daily basis. The premises was purpose built but had been neglected by the previous owner and there was much redecoration to do and repair. There was a programme in place to redecorate each resident's bedroom and for them to choose where possible the colour and curtains for their room they were well on their way however they were nowhere near completion. Some resident's furniture looked very shabby and unable to keep clean these need to be replaced. **(ER3) + (ER4)** Staff supported residents with their cleaning and laundry where possible, and there were cleaning schedules and fridge temperatures recorded.

KLOE	Regulations	Comments
		Maintenance checks were in place, and records were observed for PAT, energy performance, Fire door inspection, emergency lighting, gas safety and hoists. Slings had not been recorded as to safety but currently no one was being hoisted in the building. It was discussed with the Manager regarding the need for these checks on any slings which are in the building, and also if they were required the need for individual slings. We discussed the merits of disposable as against material types. **(ER5)** Fire alarm testing should be weekly, but this had been delegated to one member of staff and when he was away these were not carried out. Fire evacuation had not been completed since June of last year and requires addressing, particularly with the new team who have joined. Lessons learnt from the fire evacuation were not recorded and therefore no learning could be passed onto the staff. There was no sign saying when the fire alarm is tested for example Tuesdays at 11am. This must be addressed. **(ER6)** There was no fire evacuation point identified, so a new sign had been ordered by the Operations Manager but had yet to arrive. This was to be situated in the car park. **(ER7)** In the laundry there was no guidance regarding washing temperatures particularly for incontinent laundry. Red bags were being used with no instruction as to the temperature. This was rectified on the day, however this needs to be embedded in the new staff induction**. (ER8)** Laundry treatments at high and low temperatures - Blood borne viruses (BBV) (hse.gov.uk) MCA was not being used appropriately and there were no care specific decisions and best interest assessments for any of the residents. We couldn't find any LPAs for any of the service users, it was explained by the Operations Manager that family's felt that as NOK they had sufficient authority. This does need to be addressed. No IMCA involvement was registered in the care plans I looked at. **(ER9)** Lasting power of attorney - Mental Capacity Act | SCIE

KLOE	Regulations	Comments
Outcome: Improvement are required to ensure that this service is considered as Effective. 'Effective' is defined by the CQC as meaning **"people's care, treatment and support, achieves good outcomes, promotes a good quality of life and based on the best available evidence"** **"Characteristics of services the CQC would rate as' Good' in this area are those displaying evidence that people's outcomes and feedback about the effectiveness of the service describes it as consistently good".** **SRG RATING:** Requires Improvement		

KLOE	Regulations	Comments
Caring	**Regulation 9: Person-centred care** **Regulation 10: Dignity and respect**	3 care plans were looked at in depth and the same issues were noted with each, these were lengthy and well written identifying the care needs of each service user but were repetitive and much information could be cross referenced. For example, the positive behaviour support plan gave great information and was clear how to care for each service user, but this information was repeated for all other aspects of care such as communication, personal care and activities. In some areas the information was missing such as with continence there was not enough detail stated such as what type of pad should be used. The care plans were typed but had no date as to when they were written or who by this led to a problem of updating. They need to be transferred to Blissful Care plans as dictated by new provider. **(CR1)** Staff approach to residents was very good and all service users were treated with dignity and respect. Individual activities outside the home were seen, such as a trip on the train to a local town, coffee in a specific coffee shop and a table, this was relayed to me but there were not photographic evidence and the care notes following this trip did not reflect the pleasure and well-being which was given to this resident. **(CR2)** It was also noted trip to the local shops to buy extra chocolate and other confectionery. Money was made available from their individual cash accounts held in the Managers office. Striving-for-outstanding-checklist.docx (live.com) Other activities were carried out on a one-to-one basis, but some residents needed more stimulation. An activity organiser has recently been recruited and would be tasked with different group activities to stimulate where appropriate residents to enhance their lives.
Outcome: The service is considered as Caring. 'Caring' is defined by the CQC as meaning **"that the service involves and treats people with compassion, kindness, dignity and respect"** **"Characteristics of services the CQC would rate as 'Good' in this area are those displaying evidence that people are supported and treated with dignity and respect and are involved as partners in their care".**		

KLOE	Regulations	Comments
SRG RATING: Good		

KLOE	Regulations	Comments
Responsive	**Regulation 9: Person Centred Care** **Regulation 12: Providing Safe Care and Treatment** **Regulation 16: Receiving and Acting on Complaints**	I spoke with 3 families about the care their loved ones were given, and all were satisfied with the care. There were some assumptions that many of the staff had left following change of management but only 2 staff in fact had left. One mentioned they wanted more activities and how barren his room was. This is being addressed by having redecoration carried out and by the appointment of a new activities organiser. One mentioned that their loved one was often only wearing a T-Shirt under his coat when they took him out. This was handed back to the staff team to address. **(RR1)** All families were complimentary of the caring nature of the staff and how their loved ones didn't want to be anywhere else. One mother had been asked to move her son from the facility due to his complex health needs by the local hospital, but the team didn't want him to move nor his mother and so the team had specialist training and competency in order to accommodate him permanently with his PEG. He had been in the facility for 20 plus years and responded well to the staff. I had the impression from these conversations that the staff did call to speak with families about the care and changes medically of their loves ones but didn't necessarily engage with them over matters such as LPA, consent and what the new company was bringing to the bungalows. Some families were weekly visitors but some due to distance would visit once every 3 months. There had been no relatives' meetings. There had been no complaints documented in the last year that we could see but due to the closed nature of the service before the new management changeover it is unclear if this is completely accurate. There are currently no residents who are end of life.
Outcome: The service is considered as Responsive. Responsive is defined by the CQC as meaning "that the service meets people's needs". **"Characteristics of services the CQC would rate as 'Good', are those that people's needs are met through the way services are organised and delivered".**		

KLOE	Regulations	Comments
SRG RATING: Good		

KLOE	Regulations	Comments
Well led	**Regulation 12: Providing Safe Care and Treatment** **Regulation 17: Good governance / Record Keeping** **Regulation 19 - Fit and Proper persons employed**	There was no registered Manager in place but the Operation Manager for the area was basing herself in the service since November 23 and had made significant positive changes to the service in a short time. She was aware of many of the service improvements required and hope to carry the se forward in the coming months before handing over to a new Registered Manager. Interviews were taking place for this role with good candidate's applications. **(WLR1)** Since the new company had taken over there was a computerised system for monitoring Governance called Radar. This provides an audit process which is now being followed. A service Improvement Plan (SIP) is in place and all actions form this report will be actioned on this plan. Care Plans will be moving to a new system called Blissful which has been used by the providers in many other services. The care plan transfer requires all the plan to be rewritten rather than a cut and paste approach which will hopefully ensure there is no further duplication of information. Staffing was based on 8 one-to-one carers during the day and the home ran with 10 staff on a 12-hour period and 3 waking staff at night. This was well managed. There is very good community links with the GP and LD Nurse at the local hospital, whom support the home with issues and problems. The team had sought advice but had not heard anything due to the Christmas period and it was urged during the visit to communicate to seek an answer. **(WLR2)** There were no surveys which were witnessed for either staff, families, or external providers**. (WLR3**) Provider assessment and market management solution (PAMMS) was carried out by Norfolk SS in July which gave a good outcome with some recommendations, many of which are repeated in this report .

KLOE	Regulations	Comments
		Observation – there is no handover time allocated to the staff. Staff come in their own time to ensure the outgoing staff leave on time. 12-hour shifts for all staff including the Senior Team Leaders**. (WLR4)** The new interim Manager had great impact on the service since she started in November and improvements were evident with the premises and staff outlook. Staff spoke very highly of her and were very willing to change practices and move forward as a unanimous team.

Outcome: This services requires improvement to be considered as being well led.

Well Led is defined by the CQC as meaning **"that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture".**

Characteristics of services the CQC would rate as Good, are those where **"the service is consistently well- managed and led. The leadership, governance and culture promote the delivery of high-quality, person-centered care, and the service has clear, consistent and effective governance, management and accountability arrangements"**

SRG RATING: **Requires Improvement**

ACTION PLAN:

CQC KLoE SAFE By safe, we mean people are protected from abuse and avoidable harm.								
Reference Point	**Date Identified**	**Recommendation Made**	**Action to be taken**	**Who By**	**Date to Complete by**	**Evidence of Completion**	**RAG Status**	**Comment**
SR1		Audit Staff files to ensure compliance with signed contracts, references and DBS.						
SR2		Accident and Incident reporting need to be clearly explained to all staff to ensure they are recording these correctly.						
SR3		Learning from incidents/accidents need to be disseminated to the team.						
SR4		Staff on duty delivering medication wore gloves which she did not change between service users.						

CQC KLoE SAFE **By safe, we mean people are protected from abuse and avoidable harm.**								
SR5		Dress code needs to be adhered to and false nails need to be addressed for infection control.						
SR6		List of staff with NVQ to be created so this information is easy to find.						
SR7		Garden to be made safe and a usable space.						
SR8		Drug Trolley needs to be secured against the wall in both cases.						
SR9		Extra storage needs to be found to separate creams from tablet medication in one trolley.						
SR10		COSHH products need to be stored safely away from residents.						

CQC KLoE SAFE **By safe, we mean people are protected from abuse and avoidable harm.**								
SR11		First Aid boxes need to be checked regularly.						
SR12		Until the garden is cleared residents should not have access to the garden.						

CQC KLoE EFFECTIVE

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Reference Point	Date Identified	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
ER1		Menu review with residents and dietitian for nutritional value.						
ER2		IDSI training to be completed and evidences for all staff.						
ER3		Redecoration of the unit and resident's rooms.						
ER4		Residents' furniture looked shabby with chairs needing to be replaced.						
ER5		Slings stored with hoists were not numbered or labelled and therefore were not checked regularly for wear and tear or for use in emergency.						

ER7		No fire evacuation point identified.						
ER8		Laundry temperatures for incontinence clothing were not displayed to ensure the staff when using a red bag correctly washed this for infection control purposes.						

CQC KLoE CARING

By caring, we mean that the service involves and treats people with compassion, kindness, dignity and respect.

Reference Point	Date Identified	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
CR1		Transfer as soon as possible all care plans to the blissful system.						
CR2		Create an evidence file of photographs to show the good practice you are giving especially when taking out residents in the community. This could be your outstanding CQC file.						

CQC KLoE RESPONSIVE

By responsive, we mean that services meet people's needs.

Reference Point	Date Identified	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
RR1	16/1/24	Activity Organiser to inspire the care team to look at residents and develop new skills.	**Appoint a new activity organizer to encourage greater depth of care . Appointment made due to start ?**	**Ops Manager**	**1/3/24**	**New starter**	**Amber**	

CQC KLoE WELL LED

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

Reference Point	Date Identified	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
WLR1		Appoint a registered manager with a vision to carry the service forward.						
WLR2		Staff to chase health providers when awaiting decisions on their residents and be proactive.						
WLR3		Surveys on staff, families and other interested parties could be undertaken to have a 360 degrees look at the service.						
WLR4		Handover time to be considered by the company to ensure a correct flow of information.						