Voyage 1 Limited

Glen Eldon

Inspection report

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Ratings

Overall rating for this service	Good
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 14 and 15 January 2016. We found appropriate arrangements were not in place to ensure people's legal rights would always be protected by the proper implementation of the Mental Capacity Act 2005 (MCA). This had been a breach of Regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on the 7 June 2017 to check that they had followed their plan and to confirm that they now met the legal requirements of this regulation.

This report only covers our findings in relation to this legal requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Glen Eldon' on our website at www.cqc.org.uk.

Glen Eldon is a care home registered to provide accommodation and personal care for nine adults with learning disabilities or an autistic spectrum disorder. Five people were living at Glen Eldon, although two of them were away at the time of the inspection.

The service had a 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 2008 and associated Regulations about how the service is run.

At our focused inspection on the 7 June 2017, we found that the provider had followed their plan which they had told us would be completed by the 31 March 2016 and the legal requirements in relation to obtaining people's consent had been met.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective?

Requires Improvement

We found action had been taken to improve the effectiveness of the service.

People's human rights had been protected where they lacked the capacity to make specific decisions about their lives as legal requirements had been met and records demonstrated how these decisions had been reached.

The provider is now meeting this legal requirement.

We will review our rating for effective at the next comprehensive inspection.

Glen Eldon

Detailed findings

Background to this inspection

We undertook a focused inspection of Glen Eldon on 7 June 2017. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 14 and 15 January 2016 had been made.

The inspection was undertaken by one inspector. Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

People living at Glen Eldon were unable to speak with us. During the inspection we spoke with one care staff and the registered manager. Following the inspection we spoke with a person's relative. We reviewed records which included three people's care plans.

Requires Improvement

Is the service effective?

Our findings

At our comprehensive inspection of Glen Eldon on 14 and 15 January 2016 we found appropriate arrangements were not in place to ensure people's legal rights would always be protected by proper implementation of the Mental Capacity Act 2005 (MCA 2005). This was a beach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection of 7 June 2017 we found the provider had completed the action plan they had written in order to meet the shortfalls identified in relation to the requirements of Regulation 11 as described above.

The MCA 2005 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager had ensured that the required improvements had been made to the way the service assessed and recorded a person's mental capacity to agree to the decision to use CCTV surveillance to monitor their seizure activity at night. Following the last inspection a mental capacity assessment to show the person lacked the capacity to make this decision and a best interest decision had been documented on their behalf, to provide written evidence of the assessment and decision that had previously been made, but not sufficiently recorded. This demonstrated that the person's social worker and relatives had been consulted; we spoke with one of the person's relatives who confirmed this discussion had taken place. The registered manager was able to demonstrate as required by the MCA 2005, whether other less restrictive options had been considered in the making of this decision, and how the impact of this monitoring on the person's privacy had been taken into account. Records demonstrated the registered manager had assured themselves that this person could not consent to this type of surveillance which the local authority agreed was required as part of the person's DoLS authorisation. This person's human rights had been protected as legal requirements had been met and records demonstrated how decisions made on their behalf had been reached.

Records showed the provider had checked and recorded the legal authority that people's relatives and representatives may hold to make decisions on the person's behalf. For example, if they were appointed as a deputy by the Court of Protection, which authorises the deputy to make certain decisions on behalf of a person who lacks the capacity to make their own decision. People's human rights were protected as the provider had made the relevant checks.

The registered manager told us and records confirmed that they ensured the service continued to meet

legal requirements in relation to the MCA 2005 and DoLS through staff training. Records showed 100% of staff were up to date with this training, reflective practice sessions with staff in relation to the use of the MCA 2005 in the service and regular internal and external audits which incorporated the MCA 2005. Processes were in place to ensure the service continued to meet the requirements of this regulation.