The Shaw Foundation Limited

Treetops

Inspection report

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Date of inspection visit:
30 March 2017

Date of publication:
26 April 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

We carried out a comprehensive inspection of Treetops on 16 and 17 January 2017. Following this inspection, we served a Warning Notice for a breach of Regulation 11 of the Health and Social Care Act 2008. We found that people were not giving their consent to care and treatment in line with the provider's policy and the Mental Capacity Act 2005 Code of Practice.

We undertook a focused inspection on 30 March 2017 to check the provider was meeting the legal requirements of the regulation they had breached and had complied with the Warning Notice. This report only covers our findings in relation to this area. You can read the report from our last comprehensive and focused inspections, by selecting the 'All reports' link for 'Treetops' on our website at www.cqc.org.uk

Treetops is a care home with nursing for up to 24 people. The home mainly provides support for older people who are living with dementia. There were 21 people living at Treetops at the time of our inspection.

A new manager had started in post in December 2016. They were not yet registered at the time of our inspection with the Care Quality Commission. 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 this inspection, we found the provider had taken action to comply with the Warning Notice.

Capacity assessments had been completed where people may be unable to make a particular decision about their care and support. Associated best interest decisions had been made to ensure this was the least restrictive option available.

Records in relation to people's capacity still showed inconsistencies which made it unclear if people had capacity or not in particular areas of their care and support. This area of work requires further development.

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

Improvements had been made in people's consent to care and treatment. Capacity assessments and best interest decisions had been completed. Documentation still showed inconsistencies. Further training needs were required for staff members on the Mental Capacity Act 2005 and completing the provider's documentation.

We could not improve the rating for this key question from requires improvement. There are additional areas for improvement required under this key question. In addition we would require a record of consistent good practice over time. We will review our rating for effective at the next comprehensive inspection.

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. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Following our inspection on 16 and 17 January 2017, we served two Warning Notices for two breaches of the regulations of the Health and Social Care Act 2008.

We undertook a focused inspection of Treetops on 30 March 2017. During this inspection we checked that the improvements required by the provider had been made in relation to the breach of regulation 11, the need for consent..

The inspection was unannounced and undertaken by one inspector. We inspected the service against one of the five questions we ask about services: is the service effective. This is because the breach found at the last inspection for which the Warning Notice was served was in relation to this question.

During our focused inspection we spoke with the regional director, the manager and the deputy manager. We looked at seven people's care and support records.

Requires Improvement

Is the service effective?

Our findings

At our comprehensive inspection of Treetops on 16 and 17 January 2017 we found that consent to care and treatment was not always sought in line with legislation and guidance. This was in relation to measures put in place for people's care and support that can be restrictive. We found that documentation within people's care records had been inconsistently completed in regards to people's consent to care and treatment. Documentation did not follow the provider's policy or the Mental Capacity Act 2005 Code of Practice.

At this inspection, we found the provider had taken sufficient action to achieve compliance with the Warning Notice.

We found that mental capacity assessments had now been completed where appropriate. Where the outcome was that a person lacked the capacity to make a particular decision an associated best interest decision had been completed. For example, we saw that these decisions had been taken in regards to people's personal care, night time safety and risk of falls. These had been completed with the involvement of other staff members and relatives. However, we did note that the majority of mental capacity assessments and best interest decisions were not dated. The manager said this would be completed.

Following our comprehensive inspection the way people were administered their medicines had been reviewed. The amount of people now receiving their medicines covertly had significantly reduced. Covert medicines are when medicines are disguised, usually in food or drink. The one person who was still receiving their medicines covertly had a mental capacity assessment and best interest decision completed. An, 'Agreement for covert medication administration' form was in place dated January 2017. This had been signed and dated by the named nurse and GP. However, this form did not have input from the pharmacist as required in the provider's policy. This is important as when medicines are crushed it can alter the way they work and it is necessary to confirm that it was safe to do so. The deputy manager instigated this process during the inspection and we were sent confirmation after the inspection that this had been completed.

We found there were still some inconsistencies in the documentation in relation to people's capacity. Each care plan asks, 'Are there any issues with the service user's mental capacity with regard to decision making and choice in this area of their care and treatment.' In some records both yes and no was ticked. This is confusing for the person reading the care record as it is unclear what the outcome should be. In two cases, yes was ticked but no following mental capacity assessment was completed as the document guided. In one case, the person was identified as having issues with capacity around the use of their catheter and the other regarding their choice of diet. The manager and deputy manager confirmed that these people did lack the mental capacity to make decisions regarding these areas of their care.

On discussion of other cases with the manager and deputy manager it was evident that people actually had capacity around areas of care that were identified in their care record as being areas they may lack capacity in and a further mental capacity assessment was not necessary. In these cases care plans described how people indicated their choices and wishes.

The regional director said that the care plan documentation used would be reviewed. The manager and deputy said further training for all staff would be arranged on the Mental Capacity Act 2005 and on completing the provider's documentation.