Trust Care Ltd

Holly Tree Lodge EMI Care Home

Inspection report

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Ratings

Is the service safe?	Requires improvement
Is the service effective?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 13 and 14 October 2014 at which a breach of legal requirements was found. This was because arrangements relating to the management of medicines were not sufficiently robust. Also, consent for care and treatment was not always sought in accordance with legal frameworks, namely the Mental Capacity Act 2005 (MCA).

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook a focused inspection on the 4 June 2015 to check that they had followed their plan and to confirm that they now met legal requirements.

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

Holly Tree Lodge is a care home registered to provide accommodation for nursing and personal care for up to 34 older people living with a diagnosis of, or conditions relating to, dementia. There were 33 people living at the home at the time of our inspection.

The service's registered manager from our last inspection was still in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.

At our focused inspection on 4 June 2015, we found that the provider had followed their plan which they had told us would be completed by the 23 April 2015 and legal requirements had been met.

We saw that actions had been taken so that medicines were managed safely. We saw medication records had improved to capture relevant information about people's medicines and arrangements for safe storage were more robust.

We saw improvements had been made to evidence that decisions relating to care provision were made in accordance with the Mental Capacity Act 2005 where people lacked capacity. The provider needed to ensure that the principle of 'least restrictive' was always considered where potential restrictive practices were in place.

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?	**Requires improvement** 
Is the service effective?	**Requires improvement** 

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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 was 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.

We undertook a focused inspection of Holly Tree Lodge on 4 June 2015. This inspection was to check that improvements planned by the provider to meet legal requirements after our comprehensive inspection of 13 and 14 October 2014 had been made. We inspected the service against two of the five questions we ask about services: Is the service safe: Is the service effective.

The inspection was undertaken by one adult social care inspector and was unannounced which meant we did not notify the provider that we would be visiting on that date.

Before our inspection we reviewed the information we held about the service, this included the provider's action plan, which set out the action they would take to meet legal requirements.

During our inspection we spoke with the provider, the registered manager and looked at medication records, care records, the service's training matrix and the service's Deprivation of Liberty Safeguards policy, the consent police and medication policy.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Holly Tree Lodge on 13 and 14 October 2014 we found that the management of medicines was not sufficiently robust to ensure they were managed in a safe way. This was a beach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this focused inspection we found that the measures set out in the action plan submitted by the service to meet these shortfalls now met the requirements of the regulation.

The provider and registered manager told us about measures that had been implemented to address this. They told us all medication records had been reviewed to ensure that correct information was recorded for each person. We looked at the records for people who lived on the first floor. We saw that information was recorded about details of how people liked to have their medicines, details of any allergies and how the person liked to take their medicines and what level of support they needed. Each record had a photograph of the person to assist staff in order to ensure the correct person received the correct medicines.

At our last inspection we identified that refrigerator temperatures where medicines were stored were not being taken consistently, which meant there was a risk of the temperature affecting the effectiveness of the medicine. It is important that medicines are stored in accordance within safe guidelines to ensure they are safe and suitable to use. The provider and registered manager told us that temperatures were now being recorded on a daily basis. We looked at the treatment room and saw that refrigerator temperatures had been recorded on a daily basis. We found that no room temperatures were being recorded to ensure that the temperature did not exceed a safe range for storage. The registered manager assured us that she would implement daily room temperature checks immediately.

We also noted that although people's medication records documented where they took PRN (as required) medicines, the guidance about when they required these was not always clear. For example, where people were prescribed with medicines for pain, information was not provided about how the person may present with pain and how they may indicate this so that staff would be aware of when this may be required. Although the registered manager and a staff member were able to describe information about individual people's needs for PRN medicines, it is important this information is documented and clear to follow. The registered manager told us she would ensure this information was captured and recorded.

Requires improvement

Is the service effective?

Our findings

The MCA (Mental Capacity Act 2005) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and in place so that where someone is deprived of their liberty they are not subject to excessive restrictions.

At our last inspection, the registered manager told us most people's bedroom doors were locked when they were not in them. People did not have their own keys and we were told they would not have capacity to use these. There was no evidence to show that each person's capacity had been assessed in relation to this decision and whether this was in people's best interests. Staff had told us although people's doors were locked, staff enabled access for people when they wanted to access their room and we saw this in practice. However, this arrangement relied on staff being present and able to facilitate the request.

We had concerns that this could be considered a restrictive practice as people did not have opportunity, where they were able, to access their rooms freely themselves. At this inspection we discussed this again with the provider and the registered manager and how this linked in with the MCA. We saw documentation that had been introduced to show that it had been considered as to whether locking the person's door was in their best interest. From discussions with people at the home, the registered manager had discovered that one person wanted to have their door unlocked, had capacity to make the decision and requested their own key which was facilitated. The decision had been revisited to review that this still reflected the person's preferences. The assessments stated that if the person did not have capacity to make the decision, then their advocate should be consulted to ensure any decision was in the person's best interests. Although we saw that consideration had been given to the MCA 2005, the manager and staff needed to ensure the principle of 'least restrictive' options were always considered with clear information about how the decision had been reached. The registered manager told us she would ensure that all relevant information was captured in future.

We saw the service's policy for consent to care and treatment. This highlighted the need for people to have capacity to consent to their care and treatment and the need for this to be provided in people's best interests where a person did not have capacity. However, the policy did not refer to the MCA 2005 which is key legislation that all care providers and staff should adhere to. We did see evidence that staff received training in the MCA and the deprivation of liberty safeguards and had knowledge of this legislation.