Domiciliary Care Providers Ltd

Hatley Court

Inspection report

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Cambridge
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Ratings

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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Hatley Court is registered to provide accommodation and non-nursing care for up to 35 people. There were 29 people living at the home when we visited. The home is divided over two floors and small units with several bedrooms sharing their own dining room. There is a large communal lounge area on the ground floor and an activities room which is also shared with the hairdresser.

This unannounced inspection took place on 02 February 2015. The previous inspection was undertaken on 04 September 2013 and we found that the regulations which we assessed were being met.

At the time of the inspection there were two registered managers in place. Only one registered manager was present in the home during the inspection. 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.

People felt safe and staff knew what actions to take if they thought anyone had been harmed in anyway.

Summary of findings

Risks to people's health and well-being had not always been identified. This meant that staff were not given the information about how those risks should be monitored or where possible reduced. This placed people at risk of receiving care that was inappropriate or unsafe.

People did not always have access to healthcare professionals in a timely manner. This meant that people were put at risk of receiving care that didn't meet their changing needs.

Not all care plans contained sufficient detail to ensure that staff were clear about how they should support people. This meant that there was a risk that staff, (especially any new or bank staff), would not being fully aware of their responsibilities.

Staff were only employed after a robust recruitment procedure to ensure they were the right person for the job. Staff received training and support from the management team to carry out their role. There were a sufficient number of staff working to meet people's needs. Staff had time to carry out their tasks and to sit and talk to people. Staff were kind and compassionate when supporting people.

Arrangements to act in accordance with people's consent were not always in place. Not all staff understood how to put the Mental Capacity Act 2005 into practice. This meant that staff sometimes thought that they were making the right decisions for people to keep them safe but had not followed the correct procedures to assess their capacity to make decisions and respond appropriately in accordance with the findings.

Staff were trained and deemed competent to administer medicines. People received their medicines as prescribed.

People enjoyed the food and always had enough to eat and drink. People were asked what their interests and hobbies were and activities were organised to meet people's preferences.

There was an effective complaints procedure in place and people knew how to complain and felt confident to do so,

Monthly audits were completed by a manager to identify what improvements needed to be made to the home. The necessary actions were taken as a result of the findings. However, people living in the home and their relatives weren't always asked for their views on the home or how it could be improved.

Notifications required by law to be made to the commission were not always completed. The managers were not aware of all of their responsibilities to inform the commission of allegations that someone had been harmed. However the allegations had been appropriately investigated and reported to the local safeguarding team.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the (Registration) Regulations 2009 . You can see what action we told the provider to take at the back of the full version of the 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?
The service was not always safe.

The risk of people experiencing harm was reduced because staff had a

thorough understanding of what abuse was and how to report it.

Risks to people's health and safety had not always been assessed. This meant measures hadn't always been taken to reduce risks.

People received their medication as prescribed

Requires improvement

Is the service effective?
The service was not always effective.

Staff did not understand how to implement the Mental Capacity Act 2005 and this meant that people were unlawfully deprived of their liberty.

Staff were supported and trained to provide people with individual care.

People did not always receive access to healthcare support in a timely manner. This meant their care was not always effective.

Requires improvement

Is the service caring?
The service was caring.

Members of staff were kind, patient and caring.

People's rights to privacy and dignity were valued.

Good

Is the service responsive?
The service was not always responsive.

The quality of the information in the care plans varied and some care plans did not contain up to date information about the support that people needed.

Staff didn't always respond to people's changing needs in a timely manner.

Activities were provided that people enjoyed.

Complaints had been dealt with appropriately.

Requires improvement

Is the service well-led?
The service was not always well-led

Staff understood their role, were happy in their work and were motivated.

Legal obligations to notify the Care Quality Commission of deaths and of allegations of abuse had not always been met.

Requires improvement

Summary of findings

People were not consistently involved in making suggestions of ways to improve the service.	

Hatley Court

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.

This inspection took place on 02 and 03 February 2015 and was unannounced. The inspection team consisted of two inspectors.

Before our inspection we reviewed the information we held about the home, including the provider information return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications the provider had sent us since our previous inspection. A notification is important information about particular events that occur at the service that the provider is required by law to tell us about. We contacted local commissioners to obtain their views about the service.

During our inspection we spoke with ten people who lived in the home, one relative, four care staff, one activities worker, two assistant managers and one of the registered managers. We observed care and support in communal areas, spoke with people in private and looked at the care records for three people. We also looked at records that related to staff recruitment and training records, health and safety records and audits.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

All people spoken with said they felt safe. One person told us, “Everything here makes me feel safe.” Another person told us, “I do feel safe here,” A relative told us, “They never leave mum on her own. There’s always someone about.”

Although some risk assessments had been completed there was not a consistent approach to ensure that, when needed, people had a risk assessment in place. For example, we saw that one person had a nutritional risk screening in place. However, we noted from another person’s care records that they had unintentionally lost weight but there was no nutritional risk assessment in place for them. The same person had also had two falls in February 2015; however, there was no falls risk assessment in place for them. This meant that risks to people’s health and welfare had not always been reduced where possible.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us and records confirmed that staff had received training in safeguarding and protecting people from harm. A safeguarding policy was available and staff told us that they had read it. Staff were knowledgeable in recognising signs of potential abuse and were able to tell us what they would do if they suspected anyone had suffered any kind of harm

A person told us, “If I use my call bell they come right away”. Another person told us, “Staff do come when you ring the bell.” A member of staff told us, “There are enough staff, new staff are always supernumerary.” We saw that staff had time to sit and talk with people. People, relatives and staff told us that there were sufficient staff working at the home.

During our inspection we noted that people’s requests for assistance were attended to promptly and staff were available in the communal areas of the home. The registered manager explained how people’s care and support needs were assessed before they moved into the home. This assessment was then used to determine the staffing levels required to keep people safe.

Staff told us about their recruitment and records confirmed that they were only employed after the necessary checks to ensure they were suitable to work in the home had been completed. Recruitment checks included the provider requesting references from previous employers and the completion of a satisfactory criminal records check.

People confirmed that they received their medicines on time. Staff told us that they had completed administration of medicines training and competency assessments. This was to ensure they had understood the training and followed the correct procedures. We looked at the administration of medicines records and saw that they were accurate and reflected what people had told us. Medicines were stored appropriately and at the correct temperature. There was a system in place for the management of controlled drugs and spot checks showed that the amount in stock reflected the records. We observed a member of staff administering medicines and saw that this was done in a safe manner. The member of staff sought consent from people before medicines were administered and checked that they had taken them before signing to say they had been administered. Staff were knowledgeable about the specific instructions that had to be followed when administering some medicines. This meant that people received their medicines as prescribed.

Requires improvement

Is the service effective?

Our findings

People told us they thought that the staff had the skills and training they required to meet their needs. One person told us, "Staff understand my needs, they know I have problems with my balance and they help me a lot."

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) sets out what must be done to make sure that the human rights of people who may lack capacity to make decisions are protected. We discussed the MCA and DoLS with the manager and staff. There was a lack of knowledge about how these should be put into practice by some staff. This was evidenced by the staff removing a bottle of wine from one person in case they "drank too much". The person had been told it was because they had been prescribed antibiotics. However, the manager confirmed that the person had capacity to make such decisions and that the antibiotics that the person was taking were not affected by alcohol. We also observed one lady requesting to leave and go home. Staff guided her to sit down in the lounge area and talked with her until she was feeling more settled. Staff told us that she would not be safe to leave the home on her own. However, no thought had been given to if this was a deprivation of her liberty.

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

People told us that when they needed to see a doctor or other healthcare professional this was always organised for them in a timely manner. However, staff told us that one person had been displaying behaviour that was out of character for them for several days and that there had also been previous episodes of behaviour that was out of character. The daily records were not very detailed and did not include information about the person's behaviour. No medical care had been sought. We discussed this with the manager at the time of the inspection. Staff told us that the person had been due to have a urine test the previous week as there were concerns about their health then but there was no evidence that this had been done. During the first day of the inspection we were told that five people required a urine test as they were displaying signs of being unwell. However, this had not been completed for any of the five people. This showed that people were at risk of receiving care that didn't meet their needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us and records confirmed that staff had attended training and induction when they commenced work. They also told us they had received ongoing training including safeguarding vulnerable people, infection control and administration of medicines and learning about what values are important when working with people. One staff member told us about the training they had already completed and that they had just started a six week dementia course. A care assistant told us, "I spent two weeks following the carers around and getting shown what the jobs involved. I was shown health and safety, what to do if the fire alarm went off and where the clinical waste bins get put out." Where there were gaps in staff knowledge or they were in need of refresher training the manager had organised training to address this.

Staff told us that they received regular supervisions and felt supported by the management team. One staff member said, "I am very well supported, my line manager supervises me about every two months." Another member of staff told us, "I most definitely feel supported." Another care assistant told us, "The duty managers and registered managers are brilliant. You can go to them for advice and they take the time to support you."

Staff were able to tell us about how they offered people choices and sought their consent. However, when we observed staff working with people we saw that they didn't always offer choices. For example, in the morning we saw staff ask people if they wanted a cup of tea but no alternative choice was offered and in the afternoon we saw staff just take people a cup of tea without even asking them if they would like a drink or giving them a choice. We asked one person if they always preferred tea but they told us they would like a choice as they often chose coffee. We also observed one member of staff offering some people a box of biscuits to choose from and for other people the staff member choose one and gave it to them. We saw lots of positive communication with people throughout our observations. We saw that people were encouraged to join in activities even if at first they appeared disinterested. However, we also noticed that some staff concentrated on talking to people who were themselves more vocal rather than also involving the quieter people sitting in the same area.

Requires improvement

Is the service effective?

People told us that they liked the food and said that they were given a choice of meals. We saw that there were three options of main course at lunchtime. We saw that when one person did not want what they had earlier ordered the member of staff took it back to the kitchen and provided an alternative. We saw that snacks were available for people throughout the day, such as fruit and biscuits. One person said, “The meals are superb.” Another person told us, “The food is very good. The cook is fabulous.” We saw that people were provided with sufficient quantities to eat. Where people were identified at being as risk of malnutrition, staff took appropriate action such as monitoring their weight or providing fortified meals and supplements. People could choose to have meals served in their bedrooms. We saw that people had access to jugs of fresh squash or water in their bedrooms. We observed a meal time and saw that people were given choices and offered any help that they needed.

Good

Is the service caring?

Our findings

People told us that the staff were caring. One person said told us, “The best thing about living here is just being cared for and not having to worry about anything.” Another person told us, “The carers are all very kind and caring, some are exceptional, they chat and know me well.” Another person said, “The staff are super. They are nice, very kind and polite. They are willing to help.” Staff told us, “I sit with people and try and reassure them when they are upset. I try and talk one to one.” The relative of one person told us, “It’s brilliant. You couldn’t find a better place.”

We saw that staff knew people well and treated them in a caring manner and with dignity and respect. Staff referred to each person by their name and took time to ask them how they were. We saw that people felt happy to move freely around the home and could choose if they wanted to join in with any activities that were taking place. Staff had time to sit and talk to people throughout the day. We saw that a member of staff offered one person a foot stool and took time to position their feet and make sure they were comfortable. We saw that when one person became unsettled staff took the time to walk back to the lounge area with them and sat and talked with them until they were happier. One care assistant told us, “If people were upset I would offer them a drink and a listening ear. I would try to understand what was upsetting them.”

We observed a target game in the afternoon in the main lounge and saw that everyone in the area was encouraged to take part. People were smiling and laughing and seemed to enjoy taking part. Staff took the time to make adjustments to the game so everyone could join in. They also and gave people the time they needed when it was their turn. As well as the activities worker who had organised the activity other staff also cheered people on and they responded by laughing and smiling back at them.

We saw that staff asked people their permission before moving any of their belongings such as a walking frame. Staff also explained to people what they were doing when they helped them with their mobility such as carefully guiding them to sit down in to a chair.

People told us that they could choose when they got up and went to bed and were they would like to spend their time. One person told us, “Staff know what my preferences are, they [the staff] ask me a lot of questions.”

People confirmed that staff treated them with respect and knocked on their bedroom doors before entering. One person stated, “I feel staff treat me with respect. When they help me to have a bath they keep me covered up with a towel to protect my modesty.”

The manager had provided an area in the lounge with children’s toys so that when people had visitors with children they could stay longer as their children had toys to play with.

The home was set out into small units with bedrooms and a dining room. Staff told us that this worked well and encouraged small communities within the home so that people could get to know each other. We observed a lunch time in two dining rooms and saw that people knew each other well and chatted to each other whilst they were having lunch. The dining tables were set with clothes, napkins, condiments and fresh flowers. This helped to give it a homely feeling throughout the home.

Requires improvement

Is the service responsive?

Our findings

One person told us, "Staff just know me, they know how I like things done." One person told us that they were aware of their care plan but didn't want to see it as they staff supported her in the way she wanted them to. Another person told us that their keyworker had talked to them about their care plan and asked them if they are happy with everything.

We looked at three care plans and found that they varied in how much information was included. For example, the first care plan that we looked did not contain any information about the person's life history, family or interests or hobbies. The second care plan included information about their family history, occupation and how they liked to spend their spare time. We saw that care plans were written in a way to promote people's choices and independence. We saw contradictory information in one care plan. In one section in stated that the person didn't have a hearing aid and in another section it stated that they had two hearing aids. The manager was aware of the variance in quality of the care plans and had assigned one of the assistant managers to ensure they were improved and all brought up to an acceptable standard. Although the manager expected care plans to be reviewed monthly to ensure that the information they contained was accurate this had also varied. Care plans being out of date or not containing accurate information puts people at risk of receiving inconsistent care or they may not need the care and support they need.

We found that staff weren't always responsive to people's current needs. For example, we saw that one person's care records showed that they had lost 16llbs in four months. We asked the member of staff who had reviewed the person's care plan what had been done in response to this considerable weight loss. They stated that they had not noticed the weight loss so no action had been taken. The care plan also contained an entry made by one of the assistant managers in January 2015, on the recommendation of a health care assistant, suggesting that the person should have their fluid intake monitored. Although there was a fluid intake chart in use for this person the plan did not reflect the need that the person's fluid intake should be monitored or why or who should be monitoring it and when they should take any further action.

The records showed that the same person had fallen twice in February 2015. However, there was no care plan stating how staff could reduce the risk of them falling again or what action should be taken if they continued to have more falls. When we talked to the person we noticed that they had bruising to one hand. Staff had not reported the bruising to the manager or made a record of it. The person told us that the bruising was not new and that they didn't know how it had occurred. This meant that people were at risk of receiving care that was unsafe or inappropriate.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the beginning of each shift there was a handover from the previous staff. This included information about how each person was and any issues staff needed to be aware of. Staff told us this meant that they were aware if anyone needed any extra support or if they were unwell.

People's social care needs, and choices of what they wanted to take part in, were taken into account and acted on. We saw how this had promoted people's sense of wellbeing and had reduced the risk of isolation and boredom. One relative told us, "There's loads going on here." There was a list on each dining table of the planned activities for the week. We saw two group activities on the first day of the inspection. People were enjoying themselves and were engaged in the activity. Visitors had been made to feel welcome. One person told us how their husband regularly visited and had they been able to have Christmas dinner together in the home. One person told us how they were supported to grow plants and flowers in their room. One person had requested a video player for their room and this had been provided.

People we spoke with told us they if they had any complaints about the home they would talk to the manager about it. Staff told us that they would report any complaints to the manager to be investigated. There had been three complaints received in the six months and they had been dealt with appropriately and in line with the home's procedure. This showed us that the service responded to complaints as a way of improving the service it provided.

Recent cards received from relatives showed that they appreciated the care their relative had received whilst living at Hatley court.

Requires improvement

Is the service well-led?

Our findings

There were two registered managers at Hatley Court who were supported by a team of assistant managers. The manager told us that there was regular support and contact with the provider and a meeting was held at least monthly with him when they discussed all people living in the home and any issues that needed action.

The Care Quality Commission had not been notified of all of the deaths of people living in the home in the last year. The manager was unaware that we had not been notified of all deaths. We had also not been notified of any safeguarding allegations in the home. The manager was not aware that all allegations must be reported to the commission and not just those that were found to be substantiated. The records showed that the registered manager had investigated all reported safeguarding allegations and had reported them to the local safeguarding team.

This was a breach of Regulation 17 and 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The registered managers completed a monthly audit of the home which included finances, maintenance, health and safety, the environment, staffing, issues relating to people living in the home and activities. Any areas for action were recorded and this had been effective in making improvements to the home. For example, the audit carried out in October 2014 highlighted that not all of the call bells were working. The manager told us that as a result of the audit findings new call bells had been purchased.

There had been minimal involvement of people living in the home in making suggestions about how the home could be improved. There had only been one "Resident's meeting" in the last year. Although there was a system that keyworkers should have a monthly meeting with individuals to review their care plans and ask if any improvements could be made this had not consistently happened. The manager was aware of this and had appointed an assistant manager who was responsible for ensuring that the care plans were updated and people were asked for their views. The manager told us that questionnaires were normally sent out yearly to ask people about the activities but this had been due in February 2015 but hadn't yet been arranged.

There was a training plan in place for all staff for the coming year. The manager showed us the new training matrix that had been completed so that it would be clearer when staff refresher training was due. The manager had recognised that some people living in the home were becoming more confused and had arranged dementia training for staff. This would mean that they were aware of how best to meet the needs of people living with dementia. The manager delivered values based training to all staff during their induction so that they are aware of how people should be treated. The manager stated that core values also underpinned all of the other training and it was also discussed during supervisions. The manager was in the process of arranging a meeting with Skills for Care (a training organisation) to plan how they could improve their training to ensure it was in line with new guidance.

All the staff we talked with were positive about their roles at Hatley Court. One care assistant told us, "It is good teamwork." Another person working in the home told us, "I love Hatley Court". Staff understood their right to share any concerns about the care at the home. All the staff we spoke with were aware of the provider's whistle-blowing policy and they told us they would confidently report any concerns in accordance with the policy. Staff were encouraged to share their views and ideas to improve the home at staff meetings. For example, the minutes for a recent staff meeting showed that the night staff had stated that from 6:00 am it was very busy and it would help if morning staff started their shift earlier. We discussed this with staff and they confirmed that this had happened and one care assistant told us it had been a great improvement.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Not all risks to people had been assessed. Regulation 9(1)(a) which corresponds to Regulation 12 (2)(a) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **People were having their rights and liberty restricted without the necessary procedures being followed to ensure that this was in done their best interests and in line with legal requirements. Regulation 18 which corresponds to Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **We had not been notified of all deaths in the home. Regulation 18(2)(b)(I)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Action we have told the provider to take

We had not been notified of allegations of abuse within the home. Regulation 18(2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Care had not been planned and delivered in a way that met people's individual needs. Regulation 9(1)(b) which corresponds to Regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.