Barchester Healthcare Homes Limited

High Habberley House

Inspection report

Habberley Road
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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 23 March 2015 at which a breach of a legal requirement was found. We asked the provider to take action to make improvements to how they obtained people's consent when people could not make their own decisions. This was to make sure people's rights were protected and specific decisions were consistently made in people's best interests by people who had the authority to do this.

After our comprehensive inspection on, 23 March 2015, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. They sent us an action plan setting out what they would do to make the improvements and meet the legal requirements and when their actions would be completed by.

We undertook this focused inspection on 9 December 2015 to check the provider had followed their plan and to confirm they now met the legal requirements. This report only covers our findings in relation to those requirements.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for High Habberley House on our website at www.cqc.org.uk.

The provider of High Habberley House is registered to provide accommodation and nursing care for up to 45 people who have nursing needs. At the time of this inspection 31 people lived at the home.

There was a registered manager at the home who was present at the time of this 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.

At our focused inspection on the 9 December 2015, we found that the provider had taken action and legal requirements had been met. This is because where people were unable to give their consent and make specific decisions either verbally or in writing about their care and treatment, actions had been taken in people's best interests. This was with the involvement of people who had the authority to do so and knew people well in order to protect people's rights as outlined in the Mental Capacity Act 2005.

People were encouraged and supported to make their own decisions and choices about their care and treatment which were respected by staff. Staff made sure people's right to consent was upheld as they assisted and supported people. This was achieved by staff checking and making sure people understood what was said to them.

Staff used their knowledge around the MCA by supporting people to meet their needs as safely as possible in

the least restrictive way.

We will review our rating for this service at our next comprehensive inspection to make sure the improvements made and planned, continue to be implemented by staff in a consistent way.

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 that action had been taken to improve the effectiveness of the service around implementation of the MCA.

People were supported to consent to their care and treatment and make their own specific decisions. Where people did not have the mental capacity to make specific decisions, actions were taken to ensure these were made in their best interests.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

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

High Habberley House

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 was an unannounced focused inspection which was undertaken on 9 December 2015 by one inspector. The purpose of our inspection was to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 23 March 2015 had been made. We inspected against one of the five questions we ask about services; 'Is the service effective?' This is because the provider was previously not meeting some legal requirements in relation to this question.

We checked the information we held about the service and the provider. This included the provider's action plan, which set out the action they would take to meet legal requirements. We requested information about the service from the local authority. They have responsibility for funding people who used the service and monitoring its quality. In addition to this we received information from Healthwatch, who are an independent consumer champion who promote the views and experiences of people who use health and social care.

We spoke with seven people who agreed to talk with us. We saw the care and support offered to people in the communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who use the service. We also spoke with the registered manager and three staff members.

We looked at four people's care records. This was to specifically focus upon assessments around obtaining people's consent and the decisions made on behalf of people's best interests.

Requires Improvement

Is the service effective?

Our findings

At our comprehensive inspection on 23 March 2015, we found people received care, treatment or support that they had not consented to. This meant proper application of the Mental Capacity Act (MCA) 2005 had not been followed to show that the decision done for or on behalf of each was in their best interests. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which since the change in legislation on 1 April 2015 now corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this focused inspection the provider had made the required improvements to ensure they were meeting the law around Regulation 11.

The Mental Capacity Act 2005 (MCA) 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).

We saw staff incorporated the principles of the MCA into their caring roles as they asked people for their consent regarding their daily care needs. Staff offered people choices about where they wanted to sit, what they wanted to do, and what they wanted to eat and drink. We heard staff asked people before they proceeded to assist and or support people. Staff used people's preferred style of communication so that people were able to make their own decisions around what meals they would like. For example, staff took clues from people's body language as well as verbal communication around gaining people's choices and where they wanted to be. Staff were seen to know people well and understood each person so that their choices and decisions were met. The staff practices we saw were confirmed by people we spoke with. One person told us how they were supported, "I can stay in my room or join other people if I choose to. I have my call bell here and if I need anything I know staff will always come. I can make my own bed and do other things so I feel totally free to do anything I choose, when I want to." Another person said, "There's lots of choice" and they were involved in their care. "I can choose what I like" and "If I don't want what is on the menu I can have an alternative." A further person told us, "I can choose what I like" and "If I don't want what is on the menu I can have an alternative."

Staff we spoke with had a clear understanding of how the MCA affected their practice and what specific care decisions they needed to support people with. They were able to tell us where people did not have the capacity, the registered manager had ensured decisions made on people's behalf. This included full consultation with them and their family and were taken in their best interest. We saw where mental capacity assessments had been completed, where it was suspected people were unable to consent to aspects of their care. These decisions had been made on behalf of people in their best interests by people who had the authority to do so as defined by the principles of the MCA. The registered showed they knew where areas of

further improvements were needed in regards to documentation. For example, making sure it was easier to find where the recordings of best interest decisions agreed, were written in people's care records where this had been made on behalf of the person.

Staff told us they had information about people's specific choices about whether they wanted to be resuscitated in the event of a medical emergency. We saw this was the case in some people's care records we looked at. Where people had made arrangements to protect their choices such as Do Not Attempt Resuscitation [DNAR] this was documented in the person's care records. There was also advanced care plans, which held information about people's end of life wishes so that staff knew what action to take or who to contact about the decisions made.

The registered manager had made applications under a DoLs for some people who lived at the home which had been submitted to the local authority for authorisation. The registered manager told us about some of the practices which were in place to make sure people's movements were not restricted, such as, the safety procedures in place for the main entrance door to the home. They told us, "We make sure we are not depriving them of their liberty and have the least restrictive way of managing people's safety." Staff were able to tell us how they made sure their practices did not restrict people's liberty or freedom. A staff member told us, "We don't restrict people where there are bed rails these are there to make sure people are safe." We spoke with one person to ascertain if any restrictions had been placed on their movements. They spoke highly of staff and the care they received and had no complaints about their treatment. We asked them about the bed rails they had in place and they told us these kept them safe whilst in bed.

We looked at the care records for one person who had a DoLS authorisation in place. This person's care records included relevant information about the DoLS authorisation and what this meant for this person. There was guidance for staff to follow so that support offered was personalised for this person which staff told us assisted in making sure it was the least restrictive way to meet this person's needs and keep them safe. People's representatives were involved in the decisions made which led up to DoLS applications being made so that people's best interests were at the heart of this process.