Care Quality Commission

Domiciliary Care Providers Ltd

Hatley Court

Inspection report

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Ratings

Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 2 and 3 March 2015. We found five breaches of the regulations. This was because not all risks to people had been assessed, people were having their rights restricted and care had not been planned and delivered in a way that met people's individual needs. The provider had not sent notifications to the Care Quality Commission (CQC) as required by law.

After the comprehensive inspection the provider wrote to us to tell what they would do to meet the legal requirements in relation to the breaches.

We undertook this unannounced focused inspection on 2 and 8 December 2015 to check that the provider had followed their plan and to confirm that they now met the 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 Hatley Court on our website www.cqc.org.uk.

Hatley Court is registered to provide accommodation and non-nursing care for up to 35 people. There were 34 people living at the home on the days of our inspection. Accommodation is provided on two floors and the home is divided into a number of units, each with its own dining/kitchenette area. There is a large communal lounge on the ground floor.

There were two registered managers in place. They were on leave on the first day of the inspection. We returned to Hatley Court to discuss the findings of our inspection with them on the second day. A registered manager is a person who has registered with the Care Quality

Summary of findings

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 2 and 8 December 2015 we found that the provider had followed their plan, improvements had been made and legal requirements had been met.

Any potential risks to people had been assessed and guidance for staff had been put in place to minimise the risks. Staff demonstrated that they were aware of the care that they needed to provide to each person to reduce the risks of the person coming to any harm.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS), which apply to care services. People's capacity to make decisions for themselves had been assessed. Appropriate applications had been made to the relevant authority to ensure that people's rights were protected if they lacked mental capacity to make decisions for themselves. Staff knew that people had the right to make their own decisions and choices.

Systems were in place to ensure that people's healthcare needs were monitored and met. People were assisted to access other healthcare professionals when they needed to.

Care records showed that care planning was reviewed and updated so that people's changing needs were met. Staff showed that they were aware of people's changed needs and delivered appropriate care.

Notifications had been sent to CQC as required by the law.

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 safe.

Assessments of any potential risks to people had been carried out. Guidance was available to staff so that the risks would be minimised.

Whilst 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.

Requires improvement

Is the service effective?
The service was effective.

Staff were aware of people's rights to make their own decisions. Staff were also aware of their responsibilities to protect the rights of people who could not make decisions for themselves.

Systems were in place to ensure that people's healthcare needs were met.

Whilst 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 effective at the next comprehensive inspection.

Requires improvement

Is the service responsive?
The service was responsive

The planning and delivery of care met people's current needs.

Whilst 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 responsive at the next comprehensive inspection.

Requires improvement

Is the service well-led?
The service was well-led

Systems were in place to ensure that CQC was notified of deaths and other incidents in a timely manner, as required by law.

Whilst 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 well-led at the next comprehensive inspection.

Requires improvement

Hatley Court

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Hatley Court on 2 and 8 December 2015. This inspection was completed to check that the improvements to meet the legal requirements planned by the provider after our comprehensive inspection on 2 and 3 March 2015 had been made. We inspected the service against four of the five questions we ask about services: is the service safe, is the service effective, is the service responsive and is the service well-led. This is because the service was not meeting legal requirements in relation to those questions.

The inspection was undertaken by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the information that we held about the service including information received and notifications. Notifications are information on important events that happen in the service that the provider is required, by law, to notify us about. We also looked at the provider's action plan, which the provider had amended and sent to us on 25 October 2015.

During the first day of our inspection we spoke with three people who lived at the home, three members of support staff and an assistant manager. We looked at two people's care records. On the second day we spoke with the two registered managers.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Hatley Court on 2 and 3 March 2015 we found that not all risks to people had been assessed. This put people at risk of receiving care that was inappropriate or unsafe.

This was a breach of Regulation 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 2 and 8 December 2015 we found that the provider had followed their action plan to meet the shortfalls in relation to the requirements of the regulations described above. Improvements had been made.

Care records included assessments of any potential risks to people. These were comprehensive and included guidance for staff on how to provide care that would reduce risks to people. Staff demonstrated that they understood the care needed by each individual who was at risk and they were aware that care plans included risk assessments. They told us, for example, that one person who was at risk of falling had a pressure mat by their bed. This set off an alarm if the person got out of bed and staff had been instructed to attend the person immediately, which they told us they did. We saw that staff supported people to move safely.

Staff also described the care they provided to people who were at risk of malnutrition or at risk of developing pressure sores. One member of staff, when describing the care provided to a person at risk of losing weight, said, “She is weighed weekly, has ‘build-up’ (fortified) drinks, has her food liquidised and we help her to eat.” Staff had completed a chart to show what this person had eaten and drunk, which had been discussed with a dietician.

Requires improvement

Is the service effective?

Our findings

At our comprehensive inspection of Hatley Court on 2 and 3 March 2015 we found that people were having their rights and liberty restricted without the necessary procedures being followed. This meant that restrictions were not always in the person's best interests or in line with legal requirements.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan in July 2015, stating they would have met the requirements of the regulations by October 2015. The provider had updated their action plan on 25 October 2015, with a revised completion date of December 2015. The provider told us that this was because they had encountered problems in accessing training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) for all staff. This meant that at our focused inspection on 2 and 8 December 2015 we found that their action plan had not been fully completed. However, some improvements had been made and the provider was no longer in breach of the regulation.

The 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 DoLS.

We checked whether the service was working within the principles of the MCA. The registered managers told us that they had undertaken advanced training on the MCA and DoLS. They were cascading their knowledge to staff. We found there was a varying level in the staffs' understanding of this area of care. However, the registered managers were fully aware of the requirements of the legislation and were undertaking assessments, when needed, of people's capacity to make decisions. Applications for authorisation to deprive people of their liberty, when necessary to keep people safe, had been made to the relevant authority. This meant that people's rights in this area were protected.

People confirmed that staff gave them choices in all aspects of their daily lives and respected their decisions. We saw this in practice. One person told us, "I decide when I want to get up. I ring my buzzer and they come and help." Another person said, "I spend my time in my room. I prefer my own company."

We also noted that staff recognised that people who did not lack mental capacity had the right to make all their own decisions, even if staff felt those decisions were not in their best interests. At the previous inspection we noted that one person had had their bottle of drink taken from them. At this inspection we found that the registered managers had discussed people's rights with staff and this person's right to make their own decisions was no longer restricted.

At our comprehensive inspection of Hatley Court on 2 and 3 March 2015 we found that people's healthcare needs were not always met in a timely manner.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 2 and 8 December 2015 we found that the provider had followed their action plan to meet the shortfalls in relation to the requirements of the regulations described above. Improvements had been made.

People told us that a doctor would be called on request. One person said, "If I ask for one [a doctor] they arrange it." Another person told us, "The chiropodist calls every six weeks and the optician once a year." Staff told us that communication across the whole staff team had improved so that people's healthcare needs were dealt with immediately. For example, if someone was not well and a specimen of their urine needed to be tested, there was a system in place to make sure this happened on the day it was required.

Requires improvement

Is the service responsive?

Our findings

At our comprehensive inspection of Hatley Court on 2 and 3 March 2015 we found that care had not been planned and delivered in a way that met people's current needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 2 and 8 December 2015 we found that the provider had followed their action plan to meet the shortfalls in relation to the requirements of the regulations described above. Improvements had been made.

Staff told us that one of the assistant managers had been allocated time each week to review and update people's care plans. The registered managers told us that this had helped to ensure care plans reflected people's current needs. They said that care plans were put in place more quickly for people new to the home and updated when any changes took place. We saw that one person's care plan relating to mouth care had been amended with new information as soon as they returned from a visit to their dentist. Another person's health had deteriorated and they had become at increased risk of developing pressure sores. Their care plan relating to pressure area care had been amended to reflect this and gave staff updated guidance on the care they needed to provide.

Staff were clear about changes to the care people required. They told us that they relied on the 'handovers' where staff finishing their shift discussed any issues with the staff starting the next shift. Staff agreed that their knowledge could be further improved if they were given time to read people's care plans thoroughly.

Requires improvement

Is the service well-led?

Our findings

At our comprehensive inspection of Hatley Court on 2 and 3 March 2015 we found that the Care Quality Commission (CQC) had not been notified of deaths or other incidents, including allegations of abuse that had occurred in the home.

This was a breach of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009.

At our focused inspection on 2 and 8 December 2015 we found that the provider had followed their action plan to meet the shortfalls in relation to the requirements of the regulations described above. Improvements had been made.

Records showed that, following the inspection, all incidents and deaths had been reported as required to CQC. Staff told us that a system had been put in place to ensure that CQC was notified in a timely manner as required. One member of staff gave an example of a death that had recently occurred and showed us that this had been reported promptly. They said the system was “much more robust now.”