Shaftesbury Care GRP Limited

Hamilton House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Hamilton House is a nursing home which provides accommodation, personal care and nursing care to 60 older people, some of whom were living with dementia. The home has three floors, with a passenger lift which gave access to all floors and all bedrooms had en-suite facilities. At the time of the inspection, 55 people were living at the home.

The inspection was unannounced and took place on 4 and 6 September 2017.

There was not a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The provider had recruited a new manager who was due to start work four weeks after the inspection. At the time of the inspection, the service was being managed by an interim manager who had been in post for four weeks.

At our last inspection, in August 2016, we identified breaches of Regulation 12 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 'As required' medicines were not managed appropriately and quality assurance systems were not always effective. At this inspection we found continued breaches of these regulations, together with other concerns.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There were widespread and systemic failings identified during the inspection. Quality and safety monitoring systems had not been fully effective in identifying and directing the service to act upon risks to people who used the service and ensuring the quality of service provision. The service has a history of not being able to make and sustain improvement and has been in continual breach of regulations since first being registered with CQC in 2011.

A comprehensive review of the service by the provider's governance team, in July 2017, had identified widespread deficiencies. This had led to the development of an action plan that was being implemented by the interim manager. However, we could not be assured that the work started by the interim manager would be continued under the leadership of the new manager.

Staff had not always notified CQC of significant events that occurred in the home. Neither had they followed legislation that required them to act in an open and transparent way when people came to harm.

Staff did not always provide appropriate support to ensure people received their medicines as prescribed. Some medicines were not stored safely and other medicines were not given in a safe or caring way.

Risks to people were not always managed effectively. Clear plans and records were not in place for people at risk of pressure injuries or choking on their food. Essential equipment needed to support people was not checked or maintained regularly. Infection control procedures and hand hygiene guidance were not always followed by staff.

Allegations of abuse were not always reported to the relevant authorities or investigated by management. Pre-employment recruitment checks were not always conducted to help ensure staff were suitable to work with the people they supported.

Not all staff had completed training in line with the provider's policy. Nurses were not always knowledgeable about pressure area care, diabetes care or medicines storage requirements.
Staff sought verbal consent from people, before providing support, but did not always follow legislation designed to protect people's rights when making decisions on their behalf.

People's care plans were not always up to date and did not always reflect people's current needs. Staff did not always respond effectively to changes in people's needs, for example when their blood sugar levels were too low, when they were in pain or when they became anxious.

Feedback from people was sought and there was a complaints procedure in place. However, staff did not always respond to the feedback and relatives were not confident their concerns would be addressed effectively by the management. Records showed concerns raised by staff were also not addressed.

People were supported to access other healthcare services when needed. They enjoyed the meals and received support to eat and drink enough. However, choice was not offered in a meaningful way for people living with dementia.

Although people described staff as "lovely", "friendly" and "helpful", some family members felt some staff had "an edge" and were not as compassionate as others. Most interactions we observed between staff and people were positive although, on occasions, staff did not treat people with consideration.

In most cases, people's privacy and dignity were usually respected. Staff encouraged people to remain as independent as possible and involved them in most decisions about their care.

Risks posed by the environment were managed appropriately and staff knew what to do in the event of a fire. The home was visibly clean and staff used protective equipment when needed.

Enough staff were deployed to meet people's needs. Staff were appropriately supported in their role.

A range of activities was provided to people based on their individual interests and people were encouraged to make choices about how and where they spent their day.

We identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Registration Regulations 2009. Full information about the commission's regulatory response to the breaches will be added to the report after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not always stored or administered safely. People were not always supported to receive their prescribed medicines.

Individual risks to people were not always managed appropriately. Essential equipment was not regularly maintained. Staff did not always follow infection control guidance.

People were not protected from the risk of abuse as allegations of abuse were not always reported to the relevant authorities or investigated.

Safe recruitment procedures were not followed as pre-employment checks were not always conducted before staff started working at the home.

There were enough staff deployed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was not up to date and some staff lacked essential knowledge to enable them to support people effectively.

Staff did not always follow legislation designed to protect people's rights.

Staff were appropriately supported in their role and arrangements had recently been put in place for them to receive annual appraisals.

People were supported to eat and drink enough; however, choice was not always offered in a meaningful way for people living with dementia.

People were supported to access other healthcare services when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People and relatives expressed mixed views about the way staff treated them.

Whilst most interactions between staff and people were positive, we observed that staff did not always treat people with consideration.

In most cases, people's privacy and dignity were protected and their cultural needs considered.

People were encouraged to remain as independent as possible and were involved in decisions about their care and treatment.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Care plans were not always up to date and staff did not always respond promptly to people's individual needs.

There was a complaints procedure in place, but relatives were not confident that concerns would always be addressed effectively.

A range of activities was provided to meet people's interests. People were supported to make choices about how and where they spent their day.

Is the service well-led?

Inadequate

The service was not well-led.

An effective quality assurance system was not in place. This had led to breaches of multiple regulations. The service had not met all fundamental standards of quality and safety since first being registered with the Care Quality Commission in 2011.

Audits conducted by the previous management team had not been robust. A recent review of the service by the provider had led to a comprehensive action plan which was being implemented, but we could not be assured that this work would be completed or embedded in practice.

The provider had not notified CQC of all significant events. Staff did not always act in an open and transparent way when people

came to harm.

Staff felt the service was improving. They expressed commitment to the people currently living at the home and had developed links with the community that benefitted people.

Hamilton 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 checked 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.

The inspection was unannounced and was carried out on 4 and 6 September 2017 by two inspectors, a specialist advisor in nursing care 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, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with seven people and nine relatives of people living at the home. We spoke with nine members of the care staff, three nurses, four agency care workers, a chef, two housekeepers, an administrator, two activity staff, the interim manager and the acting deputy manager. We also observed care and support being delivered to people in the communal area of the home. Prior to the inspection, we received feedback from a social care practitioner from the local authority. Following the inspection, we received feedback from a community mental health nurse working with the Older Person's Mental Health team.

We looked at care plans and associated records for seven people using the service, staff duty records and other records related to the running of the service, including staff recruitment and training records, accidents and incidents, policies and procedures and quality assurance records.

Inadequate

Is the service safe?

Our findings

At our previous inspection in August 2016, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 as people's medicines were not always managed safely. At this inspection we found medicines were still not managed safely and there was a continuing breach of this regulation.

Staff did not always provide appropriate support to ensure people received their prescribed medicines. One person had a history of declining to take their medicines. Their GP had advised that staff administer the medicines covertly. Covert administration is when medicines are hidden in small quantities of food to help ensure the person receives them. The person's medication administration records (MARs) showed that they had 'refused' some of their medicines on 12 of the 17 days leading up to our inspection, however staff had not followed the GP's instructions by trying to hide the medicines in small quantities of food. At other times, the MAR chart showed the person had been 'asleep' during the medicines round, so they had not been offered their medicines. Staff had not returned later, when the person was awake, to offer them their medicines. The person, therefore, had not been appropriately supported to receive all of their prescribed medicines.

Some people were prescribed a medicine that should be taken once a week, first thing in the morning before food or other medicines. However, the MAR charts showed this medicine was usually given at the 09:00 medicines round along with their other medicines. A nurse told us people may also have had their breakfast before receiving the medicine as this was not monitored. They knew how the medicine should be given but said the medicines round was not set up to accommodate this. This meant the medicine may not have been fully effective.

Some medicines are subject to additional controls by law and need to be stored in cabinets built to a specified standard and secured to a solid wall. We found the cabinets used to store these medicines were not fixed securely to solid walls. However, other security arrangements were in place which helped reduce the risk of them being accessed by unauthorised persons and the interim manager undertook to explore ways to bring the security arrangements up to standard.

Other medicines need to be kept refrigerated in accordance with the manufacturers' instructions. Staff monitored the temperature of the medicine fridges daily. However, when we checked the temperature records of the fridges on two of the floors, we found they had exceeded the recommended temperature of eight degrees Celsius on four days. Staff had not taken action to adjust the fridge temperatures or check the medicines were still safe to use.

Medicines were not always administered in a safe way. Although some nurses gave people their medicines in a caring way and waited to check the person had taken them, we observed one nurse tip the medicines for a person living with dementia onto their side table and say "Tablets [name of person]; let's see you take them." They then left the person without checking they had taken them all. This posed a risk that the person might not take all their tablets or that another person might take them accidentally. When the nurse returned, they saw one tablet had not been taken and had to remind the person to take it. Another person

told us the nurses did not always explain what the medicines were for; they said, "They just give them to me." Two family members were critical of the way another nurse administered medicines to their relatives. One told us, "One of the nurses [who is not approachable] brings in [my relative's] tablets but doesn't engage in conversation." The other family member confirmed this and said, "When [the nurse] brings [my relative's] tablets, [the nurse] just says 'tablets'. The other [nurse] is lovely and says, 'Here are your paracetamol'."

Most people's creams and ointments were kept in their rooms and applied by care staff. MAR charts confirmed these were applied consistently. Once opened, creams have a limited shelf life; staff told us they monitored this by recording the date of opening on the dispensing labels. However, we found the dispensing labels on some creams were missing or unreadable and staff could not tell us how long the creams had been opened. This posed a risk that they might have become contaminated by exposure to the environment and would not be fully effective.

The failure to manage people's medicines safely was a continuing breach of Regulation 12 of the Health and Social Care Act 2008.

One person self-administered their medicines and a plan was in place to help ensure this was done safely. Clear systems were in place for ordering medicines; the dates these arrived were staggered across the three floors of the home to avoid too many medicines arriving at one time. In addition, appropriate arrangements were in place for unused medicines to be returned to the pharmacy or disposed of safely.

Records showed that risks to people were not always managed consistently. Some people were at risk of developing pressure injuries. While appropriate and clear plans were in place for some of these people, other people's plans lacked essential information to ensure staff provided consistent support to mitigate the risks. For example, one person had been assessed as being at 'very high risk' of pressure injuries; we saw pressure-relieving equipment had been provided, but the person's risk assessment and care plan made no mention of this. Their care plan required staff to monitor the condition of the person's skin every day, but was saw this was only recorded on a monthly basis. The person required support to change position every two to four hours, but on one afternoon, records showed they had not been supported to reposition for 10 hours. The person required staff to apply cream to protect their skin every day, but this had not been recorded as applied on four days during the previous two weeks.

Another person returned from hospital with pressure injury to their sacrum. Photographs of the injury were taken, although the size and grade of the injury had not been recorded to allow staff to monitor it effectively; an acute care plan had been put in place, but this did not include guidance to staff about how often the person needed support to reposition or how often the person's skin should be checked. Staff told us they supported the person to reposition every two hours, although records showed this varied between half an hour and six hours. Therefore, staff could not confirm that they were doing all that was reasonably practicable to protect the person from harm.

Some people were at risk of choking on their food. In most cases, advice had been sought from speech and language therapists (SALT) to reduce the risk to people. However, one person who had been identified as at risk of choking and aspiration had not been referred to their GP or to SALT for advice and was still receiving a normal diet. A further person had been referred for a SALT assessment in July, but this had not been followed up. Therefore, staff were unable to confirm that they were doing all they could to mitigate choking risks.

Other people were diabetic and needed their blood sugar levels monitoring regularly. We saw staff did this.

However, action was not always taken when two people's blood sugar levels were very low. This is called hypoglycaemia and can lead to diabetic coma if not treated. One person had declined to receive their insulin on three days over a five-day period, but staff did not notify the person's GP or seek advice. One of the nurses we spoke with did not have a good understanding of blood sugar monitoring and we found emergency dextrose-based products were not always kept in stock to treat hypoglycaemia. This put people at risk of harm.

A further person experienced epileptic seizures. A plan was in place which required staff to conduct half hourly observations after each seizure. The person had two seizures in June, but records showed the required observations were only conducted on one of these occasions. Staff were unable to confirm that the person's health and vital signs had been monitored appropriately after the second seizure.

Essential equipment was not always checked or maintained on a regular basis. Suction machines were available on each floor of the home for use in an emergency. However, there was no maintenance procedure in place to ensure they remained fit for use. When we checked one machine, we found some of the suction tubes that connected to the machine had past their 'use by' date, so may not have been safe to use. The home had a syringe driver for administering end of life medicines to people, in a continuous way, to manage their pain and comfort. However, there was no procedure in place to ensure the machine remained clean and fit for use. This posed a risk that people might not be able to receive essential medicines to manage their symptoms.

The failure to assess and mitigate risks to people's health, safety and welfare were breaches of Regulation 12 of the Health and Social Care Act 2008.

However, for other people, comprehensive plans were in place to reduce their individual risks; they had been provided with specialist equipment where needed and staff took all necessary action to protect them from harm. For example, a family member told us their relative "now sits on an alarm mat" after experiencing a number of falls. Risks posed by the environment were also managed effectively. A programme of health and safety checks was conducted; this included regular testing of electrical equipment, hoists, call bells, hot water temperatures and fire safety. Staff were clear about the action to take in the event of a fire and people had personal emergency evacuation plans in place; these detailed the specific support each person would need if the building had to be evacuated. In addition, most staff had been trained to deliver first aid.

Safe infection control procedures were not always followed. Most staff had received training in infection control. However, some of this training needed to be refreshed, in accordance with the provider's policy, and the hand hygiene of nursing and care staff did not always follow best practice guidance. We observed one nurse did not wash their hands before they started the medicine round. When they interrupted the medicine round to support a person to mobilise, they did not wash their hands before continuing with the round. This put people at risk of cross infection.

Care staff served people's meals, supported people to eat and prepared snacks for people. However, records showed that some of them had not completed food hygiene training and others needed to refresh their training. After supporting people in the lounges to mobilise, they washed their hands; however, they used the washing up sinks, in the kitchens adjacent to the lounges on each floor, to do this as there were no hand washing sinks available. At times, the washing up sinks were filled with crockery and cutlery waiting to be cleaned, which again put people at risk of cross infection.

The failure to prevent and control the spread of infection was a breach of Regulation 12 of the Health and

Social Care Act 2008.

Other staff followed appropriate infection control procedures and the home was visibly clean. Housekeepers, who worked on each floor of the home, had clear cleaning schedules to follow; they recorded all the cleaning they had completed, including regular deep cleans of people's rooms. Staff had ready access to protective gloves and aprons and we saw these being used appropriately. Individual slings were used for people who needed to use the hoist to transfer to prevent the spread of infection. Staff were clear about how they processed soiled linen and appropriate laundry procedures were in place to prevent cross contamination.

People were not always protected from the risk of abuse. The home had experienced a series of thefts in the four months leading up to this inspection. Some staff told us money had been taken from their bags and a family member told us two rings had been taken from their relative, who was living with dementia, while they were wearing them. These, and other allegations of theft from people, had been brought to the attention of the previous registered manager. However, they had not been reported to the police or the local safeguarding authority; and the provider had not conducted an investigation to determine the extent of the thefts or identify possible suspects. This information came to light during a comprehensive audit of the service by the provider; the incidents were then reported to the relevant authorities, as required.

Staff had received training in safeguarding and most were clear about the action they would take if they suspected a person was being abused, although we found one staff member was not well informed and others were overdue refresher training. In addition, some staff cited examples of safeguarding concerns they had raised about colleagues, which they said had been "swept under the carpet" by the previous management, but they had not taken their concerns further by raising them with the provider or with the local safeguarding authority.

The failure to operate effective systems to protect people from abuse and investigate allegations of abuse was a breach of Regulation 13 of the Health and Social Care Act 2008.

Although effective systems were not in place, people told us they felt safe at Hamilton House. For example, one person said they felt safe because "there's lots of people around me". Other staff were knowledgeable about protecting people from abuse. One staff member described the different ways a person could experience abuse and said, "If I thought someone was being abused, I would tell the manager."

The provider had clear recruitment processes in place. However, we found these had not always been followed by the previous management team. We identified a staff member who had been recruited by the previous management team and had started work before references and a check with the disclosure and barring service (DBS) had been completed. DBS checks are designed to help employers make safer recruitment decisions by checking whether the applicant has previous convictions. In addition, a full employment history was not available for all applicants, so the provider was unable to confirm that the applicants were suitable and had the necessary skills and experience. We discussed this with the interim manager, who told us they had reviewed and tightened up recruitment procedures since their appointment four weeks previously.

The failure to operate effective recruitment procedures was a repeated breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were enough staff deployed to meet people's needs, although we received mixed views from people about this. For example, one person told us, "There's only three staff on [one of the floors] today which isn't

really good enough. It's not enough. I could [need urgent support due to a medical condition], but when you call and no one comes you don't feel safe." However, a family member told us, "There is always someone [staff] around. [My relative's] had a couple of falls, but staff have been there straight away."

A nurse and a set number of care staff were deployed to support people on each floor of the home during the day. At night, two nurses and a set number of care staff were available to support people throughout the home. In addition, catering, housekeeping, activity and administrative staff were available throughout the day. Each person's needs were calculated using a 'dependency score'. However, this information was not used to help determine staffing levels. The interim manager told us they were planning to introduce a more robust tool, to calculate the staffing levels, to help ensure there were sufficient staff deployed at all times.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who had not always received the appropriate training to meet their needs. Most staff training was delivered by e-learning on a computer. Each topic included a knowledge check to help ensure staff had gained the necessary learning. However, records showed that a significant number of staff needed to be repeat their training, in line with the provider's policy, and staff told us they had been given a deadline of 30 September 2017 to complete this. For example, of the 85 care staff employed, 27 staff who supported people with their meals needed to refresh their food hygiene training; 33 staff who supported people to move needed to refresh their moving and handling training; 28 staff needed to refresh their health and safety training; 30 staff needed to refresh their safeguarding training; and 32 needed to refresh their infection control training.

One nurse demonstrated a poor understanding of pressure area care and we saw their training should have been refreshed two years previously. Another nurse showed us their training certificate for diabetes; but when we discussed diabetes with them, they did not demonstrate a good understanding of diabetes and people's care records showed that they had not implemented their training in practice.

Nurses had been trained to administer medicines and had had their competence to do this assessed by a previous registered manager; however, one nurse did not demonstrate a good understanding of medicines storage requirements and nurses on two of the three floors of the home did not know how to monitor the temperature of the medicines fridges effectively.

A staff member told us, "Training slipped [before the interim manager arrived], as did [staff's] knowledge and skills, as did compassion." Another staff member told us the e-learning had not helped them support people with specific conditions and felt there should be "more training around the practical aspects [of people's care]". The interim manager acknowledged that the quality of the e-learning was "poor"; they said they would review this in conjunction with the new manager when they arrived.

The provider had failed to ensure staff and nurses received support and professional development as is necessary to enable them to carry out the duties they were employed to perform, No staff member had received an annual appraisal to assess their performance and identify development objectives. In addition, nurses had not taken part in clinical supervisions to reflect on their practice.

The failure to ensure staff received appropriate training to enable them to carry out their roles effectively was a breach of Regulation 18 of the Health and Social Care Act 2008.

Arrangements were not in place for staff who were new to care to complete training that met the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. However, the interim manager told us they were seeking ways to provide this training for staff in the future.

Nurses told us they received additional training relevant to their role, including end of life care and the use of

syringe drivers. They said they received some support from the provider to enable them to re-validate their registration with the Nursing and Midwifery Council when needed, but mainly supported each other to complete this process.

There were arrangements in place for new staff to complete an induction into the home. Newer staff, including agency staff, had completed this training and had spent time shadowing experienced staff. One staff member told us, "I did an induction with [a senior staff member] and my training is nearly up to date. It's helped me understand how [people living with dementia] think. For example, when I have a chat with them I don't use long sentences, but use short questions so it's easy for them to respond." Another staff member said, "I had three days of induction and on the fourth day I felt confident."

We spoke with four agency workers who told us they felt supported when they worked at Hamilton House and received an appropriate induction. One said they had been made to feel like "part of the team", as they always worked alongside a permanent member of staff.

The interim manager told us several systems had been in place to provide support to staff and they had combined these to provide more consistency. Arrangements for appraisals and clinical supervisions had been put in place for the coming year and we saw dates had been set for these. All staff members had received at least one session of supervision with a manager to discuss their training needs, identify any concerns, and offer support. Most spoke positively about the support they had received from the interim manager on a day-to-day basis. For example, one told us they felt appreciated and were being supported to obtain a level three vocational qualification relevant to their role. Another staff member told us they felt "well supported" and gave an example of when they had sought and received advice about a complex issue. They added, "I am happy at work at present. I can talk to my unit manager, who is supportive and motivating."

Staff did not always follow the Mental Capacity Act, 2005 (MCA). 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

People's care plans included assessments of people's capacity to make certain decisions, such as to receive personal care or a modified diet. However, these were not in place for all decisions. For example, staff were managing and administering people's medicines, but their capacity to agree to this support had not been assessed, including for one person whose medicines were being hidden in their food. Where assessments had been completed and indicated that people lacked capacity to make decisions, staff had made and recorded the decisions they had taken in the person's best interests; however, the views of family members and professionals involved in the person's care were not always sought or recorded. In addition, the MCA assessment for one person was unclear as the words "yes" and "no" were both ticked in answers to questions about the person's ability to retain, weigh up and communicate information. The assessment concluded the person had capacity, but we saw staff had then made best interests decisions on behalf of the person. If the person had capacity, then decisions should not have been made on their behalf as this would have compromised their rights.

The failure to ensure people only received care and treatment with the consent of the relevant person was a breach of Regulation 11 of the Health and Social Care Act 2008.

Staff told us they had received training in the MCA and described how they sought verbal consent from

people before providing care or treatment. A staff member told us, "Everything we do, we do in their best interests, like medicines, diet, personal hygiene." Staff were also able to describe what they would do if a person declined care or support.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service was following the necessary requirements. DoLS authorisations had been obtained, or were in progress where needed, and staff followed any conditions that had been applied; for example, a condition applied to one person's DoLS authorisation was to review the need for them to receive covert medicines and we saw this had been done in conjunction with their GP.

People told us they received effective care from staff. One person said, "Staff know what they are doing." A family member echoed this comment and described staff as "very good". Another family member said, "Staff do their best; some are better than others, but they're pretty good with care." A third family member told us, "[My relative] used to be in a different home and [the staff there] couldn't cope, so she came here and they seem to be able to [meet her needs]."

People spoke positively about the meals, describing them as "good" and "lovely". People also said they could choose where they took their meals. Details of people's likes, dislikes and preferences were recorded in their care records with a copy kept in the kitchen. These were used to help ensure people received meals they enjoyed. However, we found people living with dementia were not offered meal choices in a meaningful way. They were asked to select their menu choices the day before, so they could not remember what they had ordered. Although staff told us some photographs were available to help people choose their meals, they told us these were not used. One person living with dementia did not realise there was a choice of meals, although they told us the food was "alright".

If people did not want the meal they had selected, staff told us they could make an alternative choice; for example, one person did not want the cottage pie they had ordered, but accepted scrambled eggs on toast. Another person told us they often asked for salads and always received them. In addition to the main meals, snacks were available throughout the day, including biscuits, cakes and ice cream. One person asked for some fruit as a snack. A staff member gave them a plate of fruit, but did not offer the person a choice of fruit or suggest any alternatives.

Staff were on hand to support people to eat. Most people just needed occasional prompting to eat and we saw this was done in a supportive way. Some people needed full support to eat and this was provided on a one-to-one basis. Other people needed a pureed diet and we saw they received this consistently.

People had access to drinks at all times and were encouraged to drink often. Staff knew which people needed thickening powder in their drinks to reduce the risk of them choking and thickening powder was available in each kitchen for this purpose.

Each person had a nutritional care plan and staff monitored people's weight regularly. If people experienced unplanned weight loss, staff took appropriate action, including referring people to GPs and dieticians, fortifying their meals with extra calories and offering prescribed food supplements.

People were generally supported to access other healthcare services. However there were occasions when appropriate referrals to healthcare services had not been made; this is covered in the 'Safe' section of this

report. People regularly saw doctors, specialist nurses and mental health professionals. One person had been referred to an occupational therapist following a reduction in their mobility and another person had been referred to a dentist. A community mental health nurse said of the staff, "They involve other professionals appropriately, and appear to work well with GPs."

Requires Improvement

Is the service caring?

Our findings

We received mixed views from people and their relatives about the staff. One person told us, "I have a good relationship with staff, they're lovely. One [staff member] brought her daughter in to show me before her first day of school; she was in her uniform, it was lovely." Other positive comments included: "I like one of two of the [staff] and we get on very well"; "Most are friendly and helpful"; and "Staff are so nice, they pop in for a chat when [my relative] is awake". However, another person told us senior staff "don't really make you feel welcome"; and a family member told us some staff had "an edge" and were not as compassionate as others. A community mental health nurse said of the staff, "Are they caring? Very much so. This is one of their strengths. They try very hard to put residents first, and any dialogue I have with staff, it is obvious they are very caring."

Most interactions we observed between staff and people were positive. However we also observed instances when they were not. In one of the lounges a staff member put the radio on without checking people wanted it on and then selected a channel appropriate to their age and choice rather than the age or choice of the people in the room. At lunchtime, one person living with dementia did not eat their main course and said that they did not like cabbage, but no staff member acknowledged their comment or offered to remove it from their plate. During an activity session, a person who was at risk of losing weight asked if they could have some ice cream. The staff member repeated the person's request, but did not get them any ice cream. We later enquired why the person had not been given any ice cream; the staff member said they had forgotten as there had been "too much happening". They then gave the person a bowl of ice cream which they ate.

Whilst the privacy and dignity of most people were protected, there were occasions when this did not happen. A family member told us their relative's dignity was not always respected as they were "sometimes dressed in other people's clothes". A message on a notice board in a kitchen/dining room that was regularly used by people contained information about a person's dietary needs; and during lunch, we overheard staff talking loudly, in front of people, about how much one person had had to eat. This compromised people's privacy. The interim manager acknowledged that further improvement was needed to ensure people's privacy and dignity were protected consistently.

One staff member was a 'dignity champion'. They had completed extra dignity training and their role was to work with other staff to promote people's dignity. They told us, "I try to get [other staff] to walk in the residents' shoes. I will challenge [poor attitudes] and have done. For example, I've stopped staff saying 'pad round' [when they are supporting people with their continence]." Another staff member told us, "I'm hot on the terminology [staff] use. For example 'feed'. You feed a dog, not a person. I challenge them when they use the word 'feed'." Signs were hung from each person's door saying, "This is my home, knock before entering my room", and we saw most staff did this. Some people had expressed a preference to receive personal care from a female staff member and we saw this was accommodated. A male staff member was clear that they did not provide personal care to these people.

Staff knew people well. For example, when supporting a person in the lounge, the staff member asked them,

"Are you wearing your hearing aid?" The person replied, "I don't know, am I?" The staff member checked and said, "This one is missing, I will go and get it." On returning, the staff member helped the person put it in place and checked the person could hear properly.

When another person became distressed, they were encouraged to interact with a doll that brought them comfort; and when the staff member noted the person's napkin was dirty, they gave them a fresh one. When a further person said they were cold, a staff member fetched them a blanket and helped the person to snuggle down into a lounge chair with it. In one of the lounges, we heard staff talking to people about films they would like to watch and supporting them to choose a musical they knew people liked. The staff member checked people could hear the sound properly and started singing along to some of the songs, which one person joined in with.

People's care plans included background information and a life history of the person. When we spoke with staff, we found they were familiar with this information and made use of it when supporting people. For example, they knew that one person used to keep birds, so encouraged them to interact with the home's budgerigar. A staff member told us, "[The person] becomes withdrawn and low in mood, but cheers up when he sees the bird."

Staff explored people's cultural and diversity needs during pre-admission assessments and included people's specific needs in their care plans. For example, staff talked about people they had supported with particular dietary needs based on their culture. Staff also supported people to follow their faith. One person told us, "The church people come and visit and we have a service; and I encourage staff to tell us about their cultural background, I find it really interesting."

Staff encouraged people to remain as independent as possible. They encouraged people to mobilise at their own pace, using patient, supportive words and praising people for the effort they made. One person told us, "[Staff] are very respectful of the fact I like to do things for myself. They offer help with things, but if I say I'm fine, they're okay with that." Another person said, "On a good day I can walk [to a local shopping area]. I Just tell [staff] where I'm going. We have a book I fill in so they know."

Staff involved people and their families, where appropriate, in most decisions about their care and treatment. Care records showed that a family member had attended reviews of their relative's care and they had been included in a discussion about the best way to support their relative's continence needs. Family members told us they were always updated when their relative's needs changed. All communication with family members, together with their views, was recorded.

Requires Improvement

Is the service responsive?

Our findings

Assessments of people's care needs were completed by one of the nurses before people moved to the home. This information was then used to develop appropriate care plans, in conjunction with the person or, when appropriate, their families. However, we found people's care plans were not always up to date and records showed staff did not always respond promptly when people's needs changed.

For example, some people, who were living with dementia, were unable to tell staff when they were in pain. Some indicators of pain were included within their care plans to help staff identify when pain relief might be needed. However, a pain assessment tool was not being used to enable staff to assess the level of people's pain and the effectiveness of any pain relief that was given. The interim manager told us they were trying to introduce a nationally recognised pain assessment tool for this purpose, but said staff needed more training to understand how to use it properly.

Staff told us that one person experienced pain and anxiety during personal care. They said the person had been prescribed a regular medicine to reduce their anxiety and pain, but this had recently been stopped and was now only prescribed on an 'as required' (PRN) basis. There was no plan in place to advise staff how to reduce the person's anxiety and minimise their pain during personal care. There was no guidance about when the PRN medicine should be given and records showed the person had not received it for at least the previous 17 days. Staff told us that the person continued to experience discomfort and anxiety during personal care, which caused them to "shout, pinch and grab" at staff. We discussed this with one of the nurses, but they were unable to explain why the person had not been offered this medicine when they had experienced anxiety and pain. The interim manager told us they would review the person's medicines with their GP.

The care records for a different person noted that they were "presenting challenging behaviour, pinching and biting staff during personal care". A care staff member told us, "The usual practice if [the person] refuses personal care is to go away and try later, then inform the nurse. Sometimes a new face works." However, no guidance was available to staff and a care plan had not been developed to help ensure staff supported the person in a consistent way when they declined personal care.

Care plans were reviewed each month by nominated nurses. When changes were needed, these were noted in an 'evaluation' sheet, but the care plan itself was not updated. For example, one person's continence needs had changed; these were noted in the evaluation sheet, but the person's care plan had not been changed. Staff told us they had to scroll through all the evaluation sheets, as well as the person's care plan, to identify the care and support the person needed. This posed a risk that staff might follow out of date guidance when supporting the person.

The failure to ensure people received appropriate care and support that met their individual needs was a breach of Regulation 9 of the Health and Social Care Act 2008.

People told us they received personalised care and support. One person said of the staff, "They help me with

whatever I want. I like a good old scrub [when they wash my hair] and they do it just how I like it." A family member told us, "Things have improved. [My wife] gets chest infections and as soon as [staff] spot it, they call the doctor. It's really good." A community mental health professional told us, "Where [staff] have felt they have needed extra support for residents that are more challenging, they have sought this using appropriate means."

There was a complaints procedure in place, although some family members lacked confidence that concerns would be addressed effectively. For example, the relative of a person whose property had gone missing told us, "It went missing in May, but we haven't heard anything from anyone about it." Another person's care records included a complaint from a family member about staff not supporting their relative to clean their teeth. In response, the person's care records included a direction to staff to "document and record all [oral] care given". The person had their own teeth and we saw they had a toothbrush and toothpaste in their en-suite bathroom. However, when we checked the records of care provided, they showed the person had not been supported to brush their teeth on the previous three days. A nurse, who regularly supported the person, thought the person had false teeth, which was not the case. However, a member of the care staff told us, "[The person] has her own teeth; if you give them a toothbrush, they will swish it around." We discussed this with the interim manager, who took steps to ensure the person would be supported consistently in future.

A range of activities was provided to people based on their individual interests. This was coordinated by three activities coordinators, but all staff took part in an initiative introduced by the interim manager called 'Two o'clock stop'. At two o'clock each afternoon, every staff member stopped doing their usual job and spent time interacting with people. This included managers, nurses, care staff, ancillary staff and administrative staff. Each person was supported to do whatever they wished to do. Some took part in arranged group activities, such as baking; some interacted on a one-to-one basis by talking about current affairs; and others used the time to reminisce, for example by talking about the area they lived when they were growing up.

One person enjoyed gardening and was supported to use a greenhouse in the home's garden to grow produce. They told us, "I love it. It's changed my life; it's such an interest for me. Sometimes I go in the evenings and just sit in [the greenhouse]; I'm so lucky to have it." Another person had dolls to "look after" and kept them in an area with prams and cots, which they clearly enjoyed. The home also operated a wheelchair-accessible minibus which activity staff used to take people on weekly trips to local attractions.

People were supported and encouraged to make choices and decisions about how and where they spent their day, including when they got up and went to bed, and where they took their meals. We observed staff repeatedly offering and accommodating people's wishes during the inspection. For example, staff had planned to support people to bake during the morning, but some people had asked to do this in the afternoon instead, so the time was changed. Another person chose to do a jigsaw rather than bake and staff supported them to do this. When we spoke with staff, we found most were aware of people's likes, dislikes and personal preferences. One staff member told us, "People are different on different days, but we still give choice."

Inadequate

Is the service well-led?

Our findings

A registered manager was not in post at the time of 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. The previous registered manager and the previous deputy manager had left the service a few weeks before the inspection. At the time of the inspection, the service was being managed by an interim manager who had been in post for four weeks and a senior staff member who was acting as the deputy manager. The provider had recruited a new manager who was due to start work four weeks after the inspection; they were also in the process of recruiting a permanent deputy manager.

The provider's quality assurance systems were ineffective in assessing where the service required improvement and implementing and sustaining improvement effectively within a reasonable timescale. There were widespread and systemic failings identified during the inspection.

Since our last comprehensive inspection there had been no improvement in the level of service provided and some areas had deteriorated. Our findings from previous inspections have shown a history of non-compliance with the regulations. This has covered a range of areas, and when improvements had been made, these had not always been sustained. At this inspection we identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Registration Regulations 2009; two of these were repeated breaches from the last comprehensive inspection of the service. Breaches of regulations had been identified at every comprehensive inspection of the service since its initial registration with the Commission in 2011, often followed by repeated breaches of the same regulation at the follow-up inspection. This demonstrated the provider had failed to take sufficient action in response to shortfalls previously identified. As at other inspections, a number of the shortfalls related to matters which had been brought to the provider's attention on previous occasions. These related to key aspects of the service, such as safe care and treatment and good governance.

Some of the key failings of the service had started to be addressed by the interim manager; however further improvement was clearly required and time would be needed for recent changes to be implemented fully and become embedded in practice. A new manager was due to start at the service shortly after the inspection and we could not be assured that they would continue the work that the interim manager had started.

At our previous inspection, in August 2016, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 as the provider had not operated effective systems to assess, monitor and improve people's care plans. At this inspection we found quality assurance systems were still not operating effectively and there was a continuing breach of this regulation.

The previous management team had failed to operate an effective quality assurance system. Although a range of audits of key aspects of the service had been conducted, these had not always been robust and had

not been used consistently to drive improvement. For example, nutritional audits of two floors of the home were fully completed and showed action was taken when people were identified as losing weight; however, the nutritional audit for the third floor of the home was limited to a list of people's weights without any analysis. Care plans had been reviewed monthly, but the reviews had not ensured that people's care plans were complete, up to date and reflected their current needs. For example, a care plan audit for one person, in March 2017, identified that a photo of the person was needed. A further audit of the same person, in August 2017, showed this had not been addressed and the photo was still missing, although it had since been put in place following a further audit by the interim manager. Staff training had been monitored through the use of a training matrix; however, this had not been effective in ensuring staff remained up to date with essential training. We found multiple examples of staff training being overdue, including food hygiene, moving and handling and safeguarding.

Some audits had also contained inaccurate information caused by duplication. For example, the accident audit and the accident list contained conflicting information about the number of people who had fallen in July 2017; one showed there had been two accidents and the other showed there had been four. This meant the management was not able to use the information to analyse accidents effectively.

The audits conducted by the previous management concluded that most aspects of the service were running satisfactorily and that no improvement was needed. This conflicted with a comprehensive review of the service conducted by staff from the provider's governance team in July 2017. This review had been prompted by a series of safeguarding reports and identified widespread deficiencies in the service. It had led to the development of a comprehensive action plan that the interim manager was implementing and which they were continuing to develop as further concerns were identified.

People were asked for their views, including during monthly 'residents' meetings' and staff responded to these where possible. For example, the chef told us they sought feedback from people about the menu and this had led to the introduction of more vegetarian dishes. However, records showed that other concerns raised during residents' meetings had not been responded to. For example, minutes of the meetings included concerns about staffing levels, call bell response times and continence support given to people, but there was no record of any action being taken.

Records of staff meetings with the previous management showed staff were able to raise concerns during staff meetings and did so regularly. However, there was no record of any action being taken in response to these concerns. Action plans were not developed and the minutes of subsequent meetings did not indicate that the issues had been resolved. A staff member told us, "There's no point going to any manager as nothing gets done, it never does. Carers are not listened to; no one stands up for us."

The provider's failure to operate effective systems to ensure compliance with the regulations was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager had started undertaking additional quality assurance audits and we saw these were accurate and robust. For example, their medicine audit identified 29 action points, each of which had either been completed or was in progress. The interim manager told us, "Audits [conducted by the previous management team] were just tick lists. We are being more brutal now."

Providers are required to notify CQC of significant events that occur in the home. These include incidents or allegations of abuse. We identified two allegations of theft from people living at Hamilton House that had not been notified to CQC as required. Therefore, we were not able to use the information as part of our

regulatory duty to monitor events that occurred in the home.

The failure to notify CQC of incidents or allegations of abuse was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Providers are required to act in an open and transparent way when people come to harm. The interim manager told us the provider was developing a duty of candour policy for staff to follow, but this was not yet in place. We identified examples of where people had received serious injuries following falls, but there were no records to confirm that they or their relatives had been given information, support or an apology about the incident, as required by the regulation.

The failure to act in an open and transparent way when people came to harm was a breach of Regulation 20 of the Health and Social Care Act 2008.

People told us they were happy with the way the service was run. One person told us, "This place, I would say, is one of the best [care homes in the area]." A family member described Hamilton House as "wonderful". They added, "The atmosphere, the staff, the accommodation are lovely. What more could you ask for. I am going to come here when my time comes." Other family members said the current management of the home, under the interim manager, as "good" and "brilliant".

Staff maintained records of the care they had delivered which confirmed that most people's individual needs had been met and that any concerns had been escalated to nurses or senior staff. However, care staff were critical of some of the recording practices in the home and they told us there was "a lot of duplication" and a range of different forms for recording the same information. For example, there were three different forms available for staff to record when they supported someone to reposition. A staff member said, "There's too much recording. They've introduced lots of extra forms, but not taken any away. There's lots of duplication." Another staff member told us, "There are so many new charts in place it's difficult to keep up." The interim manager acknowledged that recording practices needed to be simplified and said they were exploring ways to do this

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Most staff felt the quality of the service had improved under the leadership and direction of the interim manager. For example, a staff member told us, "There's good communication between the [interim] manager and staff. The [interim] manager is approachable." Another said, "Things weren't organised before. Now they are and [staff] are happier and are just getting on with it." All the staff expressed commitment to the people living at Hamilton House. They used expressions such as "I love the residents"; I love my job"; "I like working with the residents and caring for them" and "I love to see [people] smile".

The provider's vision for the service included: "It is our aim at all times to afford each and every one of our service users and enhanced, meaningful and purposeful lifestyle." The interim manager described how they

were working towards this by trying to "change the culture" of the service by "reinforcing good practice" and "trying to get staff to take ownership" of their responsibilities. They had introduced new 'dignity champions' and had used the provider's disciplinary procedures for staff whose attitudes and behaviours were not in line with the provider's values. They had also introduced a new sickness reporting procedure in an effort to reduce staff absence. This required staff to contact the interim manager directly if they wished to report sick; they were then prohibited from picking up any extra shifts in that payroll period and received a return to work interview with the interim manager to discuss any welfare needs.

Arrangements were in place to share information between the staff. Meetings were held at the start of each shift to handover information about people's current needs and key information about this was recorded on a handover sheet. 'Flash meetings' were held each morning with the heads of each department and a senior staff member or nurse from each floor of the home. These were short and business-like to enable the interim manager to pick up current issues quickly. One person told us, "The [interim] manager has reduced the number of people that go to meetings. Before, it left very few staff on the floor, but I brought it up and have been assured that it won't happen."

The previous CQC rating was prominently displayed in the entrance hall to the home and on the provider's website. The interim manager was open and transparent throughout the inspection. They shared the provider's review of the service with us and responded promptly to all the concerns we identified. To further enhance the openness of the service, links with the community had been developed with community groups to the benefit of people. These included visits by children from two local primary schools who visited and spent time with people and a local dance school whose pupils danced for people.