Lett's Care Ltd

Hamilton's Residential Home

Inspection report

26 Island Road, Upstreet, Canterbury, Kent CT3 4DA
Tel: 01227860128
Website:

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This was an unannounced inspection, carried out on 8 and 9 December 2014.

Hamilton's Residential Home provides accommodation for up to 17 people who need support with their personal care. The service provides support for older people and people living with dementia. The service is a large, converted domestic property. Accommodation is arranged over two floors; the two first floor areas are not connected and are accessed by separate stair cases. Lifts or stair lifts are not available to assist people to get to the upper floors. The service has 15 single bedrooms and one double room, which two people can choose to share. There were 17 people living at the service at the time of our inspection, 14 people were living with dementia and 3 people had memory problems.

There was registered manager working at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Summary of findings

We received concerns about the care received by people living at Hamilton's Residential Home from the local authority safeguarding team, so we inspected the service to make sure people were receiving safe, responsive and effective care and support.

We last inspected Hamilton's Residential Home in April 2014. At that inspection we found the service had taken action to meet the regulations that they were not meeting at our inspection in January 2014. The regulations related to the number of staff employed, staff training and support, assessing and monitoring the quality of service and record keeping.

During this inspection we observed care and support in communal areas, spoke with people and their relatives in private. We looked at five people's care records and 17 people's medicine records We looked at management records including four staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes.

Some people had behaviours that staff and others found challenging. Support for people to manage their behaviour was not planned and two people were at risk of being punished and isolated because of their behaviour.

Staff had not received all the training they needed to provide safe and appropriate care to people. Staff did not show an understanding of dementia when providing people's care including giving reassurance when they became anxious or unsure. Processes were not in place to ensure that sufficient numbers of staff were on duty to meet people's care and support needs. At lunchtime one staff member supported two people to eat at the same time while serving others. People spent long periods of time without any meaningful contact from staff. Staff were not thoroughly checked before they started working at the service.

Staff usually only spent time with people when they provided their care. Staff did not ask people questions in a way they could understand or give people time to respond to the questions they were asked.

Plans were not in place to help people to safely leave the building in an emergency such as a fire.

People's ability to make different types of decisions had not been properly assessed and they were not helped to make decisions in ways that they understood. People had received medical treatment, such as influenza vaccinations, without their agreement. Where people were unable to give their agreement, decisions had not been made in people's best interests.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager was unaware of their responsibilities under Deprivation of Liberty Safeguards (DoLS). DoLS authorisations and applications had not been completed when needed and there was a risk that people were unlawfully deprived of their liberty. Guidance was not available to staff about how to support people to remain as independent as possible and to ensure that restrictions placed upon them were not excessive.

People were not always offered choices or were not offered choices in ways that they understood. Staff did not always respond to what people told them, and people did not always get the information they wanted. Staff did not always speak to people respectfully and did not always respect people's privacy. People had not been involved in planning their end of life care and plans did not contain information about people's cultural or spiritual wishes.

People's care was not assessed and planned when they began to receive care at the service and they were at risk of receiving care which was unsafe. Care was not always planned and delivered to support people to remain as independent as possible. Guidance was not given to staff about how to safely provide people's care, such as the equipment and techniques to be used when lifting and moving people.

People were not supported to continue with interests and hobbies they enjoyed before moving into the service. A programme of activities for people to choose from was not in place and people did not take part in day to day household activities. People were at risk of isolation because they could not hear or see well or they did not leave their bedroom.

The registered manager and provider were not aware of the shortfalls in the quality of the service found at the inspection. Systems were in place to check safety of the service but checks had not been completed on the

Summary of findings

quality of the care people received. The provider and registered manager had not obtained information from people, their relatives and staff about their experiences of the care.

The registered manager and staff did not know what the aims and objectives of the service were. Care and support was not provided in the way described in the provider's statement of purpose including respecting people's privacy and dignity, encouraging people to be independent and making sure people received a good quality service.

Important events that affected people's welfare, health and safety had not been reported to the Care Quality Commission without delay so that, were needed, we could take action.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People's behaviour was not managed and people had been punished because of their behaviour. Staff knew how to recognise signs of abuse but had not realised that people were at risk because their behaviour was not managed.

Checks were not completed to make sure that new staff did not pose a risk to people. There were not enough staff on duty to make sure people's care and support needs were fully met.

Risks to people were not assessed and managed. Plans were not in place to support people to safely leave the building in an emergency such as a fire.

Inadequate

Is the service effective?
The service was not effective.

People's ability to make different types of decisions had not been properly assessed and they were not helped to make decisions in ways that they understood.

The registered manager was unaware of their responsibilities under Deprivation of Liberty Safeguards (DoLS). Guidance was not given to staff about how to support people to remain as independent as possible.

Staff had not received all the training they needed to provide safe and appropriate care to people.

Inadequate

Is the service caring?
The service was not caring.

People were not always offered choices or were not offered choices in ways that they understood. Staff did not ask people questions in ways they understood or give people time to respond to questions they had been asked.

People's privacy was not respected and staff did not always speak to people respectfully.

People had not been involved in planning the care they received. People had not been involved in planning the care they would prefer at the end of their life and their cultural and spiritual needs had not been considered.

Inadequate

Is the service responsive?
The service was not responsive.

People's care was not assessed and planned when they began to receive care at the service and they were at risk of receiving care which was unsafe.

Care was not always planned and delivered to support people to remain as independent as possible. Guidance was not given to staff about how to safely provide people's care.

Inadequate

Summary of findings

People were not supported to continue with interests and hobbies they enjoyed before moving into the service. A programme of activities for people to choose from was not in place and people did not take part in day to day household activities.

People were at risk of isolation because they could not hear or see well or they did not leave their bedroom.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager and provider were not aware of the shortfalls in the quality of the service found at the inspection. People, their relatives and staff were not asked about their experiences of the care.

The registered manager and staff did not know what the aims and objectives of the service were. Care and support was not provided in the way described in the provider's statement of purpose, and people were not encouraged to be independent and involved in the running of the service. There was no clear set of values and behaviours for staff.

Important events that affected people's welfare, health and safety had not been reported to the Care Quality Commission so that, were needed, we could take action.

Hamilton's Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 and 9 December 2014 and was unannounced. The inspection team consisted of two inspectors and a specialist professional advisor, whose specialism was in dementia care.

We normally ask the provider to complete 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 improvements they plan to make. On this occasion we did not ask the provider do this as we were responding quickly to information and concerns that had been raised.

We looked at the care of and support that people received. We looked at people's bedrooms, with their permission, we looked at care records and associated risk assessments for five people who needed a lot of care and support. We observed medicines being administered and inspected 17 medicine administration records (MAR). We observed a lunchtime period in the dining room and observed people being helped with their meals in their bedrooms. We used the Short Observational Framework for Inspection (SOFI) because most of the people receiving care at the service had dementia. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we spoke with five people, two relatives, four staff and the registered manager. We spoke with a nurse and physiotherapist who visited people to provide treatment during our inspection.

Before our inspection we looked at all the information we held about the care people received. We looked at previous inspection reports and notifications received by the Care Quality Commission. Notifications are information we receive from the service when a significant events happened at the service, like a death or a serious injury.

We spoke with the local authority safeguarding manager who was leading the investigations into quality and safeguarding concerns and case managers who had met with people living at the service the week before our inspection. They told us they were concerned about people's end of life plans, decisions being made on people's behalf and Deprivation of Liberty Safeguards. We also spoke with commissioners who had completed a contract monitoring visit in November 2014 and had raised concerns with the registered manager about staff training and the environment. We obtained information from community nurses who provided treatment to people, they told us they had previously had concerns around how people were lifted and moved. We looked at all these areas during our inspection.

Inadequate

Is the service safe?

Our findings

Some people had behaviours that staff and others found challenging. Care plans instructed staff not to respond to people's behaviour but this meant that people did not get the help and reassurance they needed. One staff member, who had completed dementia training, said that it was not necessary to have agreed ways to respond to people's behaviour, as each staff member acted in a different way depending on how the person responded to them. People did not get the consistent support they needed in the way that suited them best at all times.

People had behaviour that staff said 'upset other people'. These people spent all or most of their time in their bedrooms and spent little or no time with staff or other people. The registered manager told us that she had decided the people should spend their time in their rooms to reduce the impact of their behaviour on others. Staff had not considered looking at ways to try and understand possible causes for the people's behaviour or to develop ways to support them. Health professionals, such as the local older people's mental health team, had not been contacted to obtain support for people with their behaviour. People were at risk of being isolated in their bedrooms and had been punished by having social contact with others and time in communal areas withdrawn.

The provider had not taken steps to identify the possibility of abuse and prevent it before it occurred. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff knew the possible signs of abuse and were confident to tell the registered manager or registered provider about any concerns they had about people's care or the practice of colleagues. Staff told us they felt confident that the registered provider or registered manager would act upon any concerns they shared.

There were not sufficient numbers of staff on duty to ensure people's care and support needs were fully met. People were supported with their meals in the dining room at lunchtime. One staff member knelt on the floor between two people and supported them both with their meal at the same time. The staff member left the people on occasions to get things from the kitchen and to answer the front door. People did not get the individual support they required to eat their meals. Other people did not receive any support and struggled to eat their meal independently. One person was trying to stab food with a spoon they believed to be a fork, when this was unsuccessful the person ate their meal with their fingers.

The registered manager told us that there were four staff vacancies and these were being covered by existing staff. They told us that when staff could not cover the vacant shifts agency staff were employed. The registered manager also told us that there was a culture within the staff team of calling in sick and this shortfall was also covered by existing staff or agency staff. During the inspection one staff member reported sick, the registered manager did not arrange for existing staff or agency staff to cover the vacant shift.

A new staff member was working at the service. They had no experience of working in care and were shadowing an experienced staff member. When an experienced staff reported sick the new, inexperienced employee covered their duties. They were unable to provide personal care to people without the support of an experienced member of staff. This meant that the number of care staff the manager had decided were required to provide people's personal care needs were not available and people had to wait for the support they needed. Care staff were required to do the laundry and help the cook which took time away from the people they were caring for.

Staff told us that they did not feel there was sufficient staff on duty to meet people's needs. Staff did not have time to spend with people and several people in the lounge received little or no interaction from staff during the day. The registered manager did not have a system to help them decide how many staff were required to provide the care people needed. Three new people had started using the service shortly before our inspection, however, staffing levels had not been reviewed to ensure that people's care was provided safely and effectively.

Emergency plans were not in place to ensure that sufficient staff were available to work at the service in bad weather or when public transport was not available, such as over the Christmas period. There was a risk that sufficient staff would not be available to provide people's care safely and effectively as plans were not in place to manage the risk.

People's health, safety and welfare was not safeguarded because the registered provider and registered manager had not taken action to make sure, at all times, there are

Inadequate

Is the service safe?

sufficient numbers of suitably qualified, skilled and experienced staff employed to provide the service. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Plans were not in place to support people to safely leave the building in an emergency. We informed the local fire safety service of our concerns. One evacuation chair was available to support people evacuate from the two first floor parts of the building. A safety strap was not fitted to the chair and staff did not know that the strap was missing. This chair was the only equipment available to support one person to go up and down the stairs to their bedroom, they had not left their bedroom since they moved to the first floor room several weeks before the inspection.

Regular checks on the environment and equipment had been completed. Action had been taken to repair some faults or damage, however staff had not noticed the strap was missing from the evacuation chair. A handyman was available and responded quickly to repair faults. Environmental risk assessments had been completed and contained plans to manage identified risks.

Staff recruitment systems did not protect people from staff who were not safe to work in a care service. The registered manager had failed to obtain sufficiently detailed information about staff's previous employment, including a full employment history and the reasons for any gaps in employment. The conduct of staff in previous employment had not been robustly checked. Where information of concern had been received the registered manager and provider had failed to act on it. One person's reference from a previous employer stated that the person had left during a disciplinary investigation. The registered manager had spoken to the employer and noted the investigation was in relation to the staff member's involvement in a medicine error. However, they had not taken action to obtain further information and assess any potential risk posed to people.

Action had not been taken to ensure staff with cautions or convictions did not pose a risk to people. Disclosure and Barring Service (DBS) criminal records checks had been completed for staff, however, where disclosures had been made about cautions or convictions the registered manager and provider had not taken action to assess and manage any risks posed to people.

People were not protected from the risks of receiving unsafe care because the registered provider and registered manager had not taken action to make sure staff were fit and had the skills and knowledge they needed for their role. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff who had left or been dismissed from the service and may pose a risk to people had been referred to the DBS. The DBS prevent unsuitable people from working with vulnerable groups, including children and vulnerable adults.

People's medicines were stored and administered safely. People received their medicines from staff who had received training to do this safely. None of the people were responsible for taking their own medicines. Systems were in place to make sure that medicines were ordered on time and returned to the chemist if they were no longer needed. Accurate records were kept of the medicines people received. Medicines and medicines records were checked to make sure they were correct and so that any mistakes or errors could be corrected.

The service was clean and free from offensive odours. A cleaner was employed, who was supported by care staff at times, to keep the service clean. Sufficient cleaning materials and equipment were available and stocks were maintained at the service.

Infection control processes were in place including the safe storage and disposal of clinical waste. Liquid soap and paper towels were used to maintain good hand hygiene and sanitiser gel was provided at the entrance of the service for visitors to use. There had not been any outbreaks of infection at the service.

Accidents involving people were recorded. Incidents, including between people or between people and staff were also recorded. There was some evidence of incidents being investigated and action taken as required.

Inadequate

Is the service effective?

Our findings

The registered manager told us that people were not able to make any decisions for themselves. Although most people were living with dementia, we observed them making choices for themselves. Some people had some capacity and told us how they liked their care to be provided and what they liked to do. The registered manager had completed a capacity assessment for each person. The assessments were not about a specific decision, but covered a number of simple and complex decisions including, getting up and going to bed and receiving medical and dental treatment. Assessments had not been completed with the person or other people who knew them well to ensure they were personalised and included people's choices and wishes. One assessment stated that it had been completed with the person's family, although the person did not have any family. Another assessment had been signed by a person's relative; however, the relative did not have legal authority to make decisions about the person's health and welfare.

People had received medical treatment, such as influenza vaccinations, without their consent. Where people were unable to consent, staff from the service had not met with the person's doctor and others who knew them well to make a decision in the person's best interests.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The service was not meeting the requirements of DoLS. The registered manager was unaware of their responsibilities under DoLS. They told us that they had completed urgent DoLS authorisations, urgent DoLS authorisation extensions and standard authorisation applications for most people and was planning to send them to the local authority DoLS office. They told us that the urgent DoLS authorisations were not in place yet as they had not been authorised by the DoLS office. They did not understand that they had the lawful authority to deprive a person of their liberty for seven days, in an emergency situation.

Before our inspection we received a notification from the registered manager informing us that a DoLS authorisation was in place for one person. Guidance was not available to staff about how to support the person to remain as independent as possible and make sure that restrictions placed upon them were not excessive.

The registered provider and registered manager did not have arrangements in place to obtain and act on people's decisions or the decisions of people's relatives/friends who were lawfully able to make decisions on people's behalf. The registered provider and registered manager had not made sure they took action, with others, in people's best interests. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When staff first started to work at the service they received an induction so they got to know the people and the care and support that they needed. The induction was not detailed enough to make sure that staff developed all the skills and knowledge they needed to perform their role when they began working at the service. The provider's induction policy required staff to complete a three month Skills for Care induction, Skills for Care is the workforce development body for adult social care in England. However, the registered manager was not aware of this induction process and new staff had not completed an induction which included the Skills for Care Common Induction Standards. People could not be confident that new staff had developed the skills and knowledge to provide care safely and effectively.

Most staff had completed basic training including moving and handling and infection control, however not all staff had completed this training. Staff had not developed knowledge and skills to meet people's individual needs, such as sensory impairments or diabetes. People with sensory impairments were not supported to be as independent as possible. One person with a visual impairment sat at a table with a highly patterned table cloth to eat their meal, making cutlery, crockery and food difficult for them to distinguish.

Staff had completed online dementia care training but did not demonstrate an understanding of dementia when providing people's care and support. Staff did not provide information to people in ways that they could understand and provide reassurance when they became anxious or unsure. One staff member who had completed dementia training told a person that they were "going home now". The person became excited and stood up. The staff member told us they were taking the person to the toilet;

Is the service effective?

this was different to what they had told the person. The person remembered this incident for a long period into the afternoon and kept repeating they were going home and walked around the corridor waiting.

The provider had failed to enable staff to deliver care to an appropriate standard as staff had not received appropriate training. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff met with the registered manager regularly to talk about their role and the people they provided care and support to. Staff appraisals had not been completed since the provider purchased the service in November 2013. A process was being developed at the time of the inspection.

One person had a loose front tooth. Staff had not noticed that the person had a loose tooth and were not clear when we asked, if the person had their own teeth or dentures. The person last saw a dentist in December 2013. The staff had not identified that the person had mouth and dental care needs and had not arranged the right support for the person.

People's community nurses told us that the service communication with them had improved recently and they received requests to visit people if the staff had concerns about people's health. Other community nurses told us that the service did not always contact them in a timely way when people required specialist support with their medicines. A record maintained by the staff contained information about visits people had received from health care professionals such as their doctor or a nurse, however changes in the care the people needed was not recorded in people's plans of care and there was a risk care would not be provided as prescribed by the doctor or nurse.

The provider had failed to assess people's needs and plan their care to protect them from the risks of receiving care which was inappropriate or unsafe. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Visiting health care professionals told us communication from the staff had improved and staff contacted them when people needed treatment to keep them healthy. A community matron told us that at times there had been a delay in the staff contacting them for support to administer specialist medicines and they were working with the service to ensure contact was made in a timely way.

People said they liked the food provided at the service. One person told us, "The food is normal like you would get at home," another person told us "I like the food here". Meals included fresh vegetables and homemade foods such as pies, puddings and cakes. Low sugar foods were available for people with diabetes and food with additional calories was made for people who were at risk of losing weight. Food was served hot and looked appetising. People had enough to eat and were offered more if they wanted it. People were weighed and recorded. When people lost weight they were referred to appropriate health care professionals such as people's doctors or a dietician. People were offered the care recommended by the health care professionals such as food supplements.

Inadequate

Is the service caring?

Our findings

Interactions between staff and people were limited to when staff were providing care to people. Staff acknowledged people as they passed by in the lounge-diner. However, this interaction was not meaningful and people did not always react to staff due to the way staff spoke to them. For example, on several occasions we observed staff walked past a person and asked, 'Are you OK?", then the staff member continued to walk past the person so did not stop for a reply. Staff did not ask the person questions in a way they could understand or give the person time to respond to the questions they were asked.

Staff did not always speak to people respectfully. We observed one staff member talking to a person encouraging them to eat. The staff member said to the person, "Show me how you eat it, like a big girl". This term was not respectful to the person. On other occasions staff treated people kindly and people appeared relaxed in the company of staff. One staff member who was new to the service spent time chatting to people, however, they did not know people well and were unable to talk to them about things that interested them.

People were not offered choices in ways that they understood. A staff member asked a person what they would like for lunch and offered them two choices. The staff member spoke very quickly to the person who appeared not to understand the information they were being given. The person did not reply to the question but pointed to one of the inspectors, who they had not seen before, and asked "Who is she?" The staff member did not respond to the person's question and asked them again what they would like for lunch. When the person did not answer, the staff member walked away.

Menus were not available and people did not know what the next meal was and the choice of food available to them. Photographs and symbols were not used to support people to make choices about their meals. Menu choices were not offered to people whose food was pureed. One person had their food pureed as they had lost weight. The person's assessments and care plan did not say why the person needed pureed food and if this was their choice. We observed that the person was able to make choices about their food and asked staff if they could have a riper banana as the one staff had provided was not ripe.

A staff member asked a person if they would like a biscuit. The person did not respond to the question and appeared to be trying to understand what was being said to them. The staff member told us that the person liked biscuits. The staff member then moved very close to the person's face and repeated the question in a louder voice. The staff member did not offer the person the choice of a biscuit in a way that they could understand, such as by offering them the tin of biscuits so they could help them self. The person did not have a biscuit.

We observed staff telling people how they were going to move them before they moved them using a hoist. However, we could not be sure that the information was given in the way the person understood, as staff did not wait for a response from the person.

People's privacy was not maintained at all times in their rooms or communal areas. The registered manager took us to see the room of a person with poor sight and hearing. The person was in their room. The registered manager did not knock on the door before they entered and did not speak to the person on entering the room. They spoke to us about the person's equipment and care needs in front of the person. Another person was being moved in the lounge, a screen was not used to protect the person's privacy whilst they were moved.

Limited information was provided to staff about people's personal history and preferences. When information was available; this was not used to plan people's daily routines and how they spent their time. Plans were in place to provide support to people to do things they enjoyed but these were not provided by staff. One person sat with us whilst we were reading documents, their plan said that they liked to read books, however staff could not find a book for them when they wanted it.

There were no advocacy services for people who were unable to advocate for themselves. The registered manager and staff had not recognised the need to obtain advocacy services for one person who had no family or friends to support them.

The registered provider and registered manager had not taken action to make sure that people were treated with respect and are involved at Hamilton's Residential Home. People were not given privacy and were not helped to remain independent. People were not supported to make

Inadequate

Is the service caring?

or participate in making decisions about their care and treatment. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not involved in planning their end of life care. End of life care plans were in place in all the care plan files we viewed. The plans recorded if people's families or the registered manager thought that the person would like to remain at the service at their end of their life, when families would like to be contacted about a person's death and that an undertaker was not to be contacted until the morning if someone died at night. The plans were not personalised to people's individual needs and wishes and all contained the same basic information. The registered manager told us it was not possible to involve people in their end of life care planning as they had dementia. The registered manager had not attempted to use other methods of involving people with dementia. Information about how to make people comfortable and reduce any anxiety and any religious, spiritual and cultural needs was not included. One person followed the Catholic faith but their religious needs and wishes for their end of life had not been considered or recorded.

The provider had failed to assess people's needs and plan their care to protect them from the risks of receiving care which was inappropriate or unsafe. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service responsive?

Our findings

People were at risk of receiving care which was unsafe or inappropriate care because assessments of their needs had not been carried out before they moved in to the service. People's needs had not been assessed by the staff and information had not always been obtained from other service providers or commissioners before people were offered a care service.

People's care was not planned when they began to receive care at the service. Three people who had recently moved into the service did not have plans of care in place. Staff had not been given information about these people's needs and how to provide safe and appropriate care in the way the people wanted. One new person was given a cup of tea by the cook. The person asked the cook for another cup of tea and told her that the one they had been given was too sweet as they did not take sugar. The person's preferences in relation to their care and support had not been recorded.

Care plans did not offer staff clear guidance on how to provide people's care safely. Staff used a hoist to move one person from their bed to a chair. The person's care plan dated November 2014 stated, 'a lift aid is to be used when assisting with standing' and 'a hoist is used to put them back on their feet'. Information was not available to staff about the equipment and techniques to be used to protect the person from the risks of inappropriate or unsafe moving and handling.

Some people had difficulty seeing or hearing. Care had not been planned to support these people to remain as independent as possible and to help them understand what was happening around them. Staff did not know what people were able to hear or see. The risks of people becoming anxious or isolated as a result of their sensory disabilities had not been identified and care had not been planned to meet the people's needs.

People were not always supported to be as independent as possible. We observed a staff member help a person sit at the dining room table for their lunch. The staff member said to the person "Let me go and get your bottom set of teeth". The staff member left the room but did not return with person's denture and the person struggled to eat their meal without their bottom set of dentures.

Care plans were not up to date and so not accurate. One person's care plan and risk assessment stated, they 'enjoyed the company of others, often sits in the communal lounge/dining room with other people'. The person now spent most of their time in their bedroom and often accused staff of trying to harm them and called out 'help'. The person's behaviour management plan did not identify the risk that the person may be anxious or scared. The person's behaviour records showed that they did not respond when staff spoke to them and their behaviour continued. Guidance had not been given to staff about how to support the person in a positive way and reassure them when they presented with behaviours which caused them distress.

The provider had failed to assess people's needs and plan their care to protect them from the risks of receiving care which was inappropriate or unsafe. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not supported to continue with interests and hobbies they enjoyed before moving into the service. There was no programme of activities for people and people did not participate in day to day household activities. The registered manager told us that activities were provided every day at 3pm. We observed one person taking part in a craft activity provided by staff in the dining area in the afternoon, other people were sat at the other end of the room and were not participating in any activities.

The registered manager had purchased two toy dolls and gave them to people as an activity. This was described as 'doll therapy' in people's records. The activity was not planned and guidance was not given to staff on how to support people to benefit from the activity. One person walked around with dolls and did not interact with them. The registered manager had not made sure the activity was provided in a way that benefitted people and so it was not in line with recognised guidance.

People were at risk of isolation. Some people stayed in their rooms and had limited interaction with staff. Other people were isolated because of their sensory impairments. One person sitting at the dining room table when we arrived at 9:30am, was sat in the same place when we left 5:30pm. Staff only spoke to the person as they walked past to check if they were OK and then walked away.

Inadequate

Is the service responsive?

The provider had not taken action to support people to make complaints or raise concerns they had about the service. People's relatives told us that they did not have any concerns about the standards of care, and said they would speak to the registered manager if they had any worries.

They said that they were confident that any concerns or complaints would be addressed. The registered manager had not received any written complaints during the past year. Informal complaints and the service's response to concerns and complaints had not been recorded.

Inadequate

Is the service well-led?

Our findings

The registered manager and staff were not meeting the aims and objectives contained in provider's statement of purpose. These included respecting people's privacy and dignity, making people feel safe, encouraging them to be independent , involving people in the running of the service, and making sure people received a good quality service. The registered manager and staff did not know what the aims and objectives of the service were when we asked them. The provider did not have a clear set of values and behaviours they required from their staff.

The registered manager and the provider were not aware of the shortfalls in the quality of the service found at the inspection. Systems were in place to assess the quality of the environment and health and safety procedures but checks on the quality of the care people received had not been completed. People's care was planned and reviewed by the registered manager without the involvement of staff, who provided people's care, and without involvement of people themselves. Reviews of care records had not identified the shortfalls in assessments, care planning and care delivery that we found. The registered manager told us that staff sickness levels were high, action had not been taken to monitor or manage staff sickness absence.

Systems were not in place to ask people and their representatives for their views or to reduce the risks of people receiving inappropriate or unsafe care. People had not been asked for their views on the care they received. Questionnaires had been sent to family members asking for their views of the care, one response had been received. The registered manager did not know what feedback had been provided from the questionnaire. Action had not been taken to follow up questionnaires not returned or to ask relatives for their views in other ways. Systems were not in place to obtain the views of staff and other professionals involved in people's care, such as people's nurses and doctors, on the quality of the care people received.

The registered manager had not identified the concerns about staff practice we found. Staff meetings and one to one meetings with staff were held regularly but staff practice and how to improve the quality of the care had not been discussed. Staff told us they felt supported by the registered manager.

The registered manager did not have the skills and knowledge to lead the staff effectively. Staff had not received information and guidance about how to provide safe care to meet people's individual needs. A deputy manager worked at the service, they were not clear about their management role and responsibilities, and told us, "I am more of a glorified carer".

The provider had failed to take action to protect people, and others who may be at risk, against the risks of inappropriate or unsafe care, by means of the effective operation of systems designed to regularly assess and monitor the quality of the services provided. This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records were kept about the care people received and about the day to day running of the service. Some records could not be found easily and the registered manager was not always clear where important information and documents, such as a DoLS authorisation, were.

Important events that affected people's welfare, health and safety had not been reported to the Care Quality Commission without delay, so that, where needed, we could take action. The provider had failed to notify the Commission without delay of the death of service users living at Hamilton's Residential Home. This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009

The service's statement of purpose had not been updated when rooms had been converted into bedrooms and double rooms had been changed to single rooms. The registered manager was planning to provide day care at the service, the impact of this on people living at the service had not been considered and people had not been informed or asked for their views.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Sufficient numbers of suitably qualified, skilled and experienced staff were not employed to safeguard the health, safety and welfare of service users. Regulation 22**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Staff had not completed appropriate training to enable them to deliver care to an appropriate standard. Regulation 23(1)(a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The provider had not taken action to protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care, by means of the effective operation of systems designed to regularly assess and monitor the quality of the services provided. Regulation 10(1)(a)(2)(e)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services **The provider and registered manager had not notified the Commission without delay of the death of service users living at Hamilton's Residential Home.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People who use services were not safeguard against the risks of the possibility of abuse as the provider did not have systems in place to protect service users from the risk of excessive control, restraint, neglect, isolation and psychological abuse. Regulation 11(1)(a)(2)(a)(b)(3).

The enforcement action we took:
CQC has issued a formal warning to Lett's Care Ltd and Lisa Gotts, Registered Manager telling them that they must take reasonable steps to identify and prevent the possibility of abuse by 31 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The provider had failed to operate an effective recruitment procedure in order to ensure that no person was employed to provide the service unless they were of good character. The provider had failed to ensure that information specified in Schedule 3 of the Act was available in respect of each person employed to provide the service.

The enforcement action we took:
CQC has issued a formal warning to Lett's Care Ltd and Lisa Gotts, Registered Manager telling them that they must take action to operate effective recruitment procedures by 31 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider had failed to take proper steps to obtain, and act in accordance with the consent of service users or others who are lawfully able to consent to care and

This section is primarily information for the provider

Enforcement actions

treatment on their behalf. The provider had failed to take proper steps to establish and act in accordance with the best interests of the service user where they are unable to consent.

The enforcement action we took:
CQC has issued a formal warning to Lett's Care Ltd and Lisa Gotts, Registered Manager telling them that they must take action to obtain and act in accordance with the consent of service user or their lawful representative or in the service user's best interests by 31 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider had failed to assess people's needs and plan their care to protect them from the risks of receiving care which was inappropriate or unsafe.

The enforcement action we took:
CQC has issued a formal warning to Lett's Care Ltd and Lisa Gotts, Registered Manager telling them that they must take action to assess service user's needs and plan and deliver safe and appropriate care by 31 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The provider had failed to make suitable arrangements to respect and involve service users at Hamilton's Residential Home. They had failed to ensure service user's privacy and independence and had not made suitable arrangements to ensure service users were enabled to make or participate in making decisions relating to their care and treatment.

The enforcement action we took:
CQC has issued a formal warning to Lett's Care Ltd and Lisa Gotts, Registered Manager telling them that they must have suitable arrangements in place to respect and involve service users at Hamilton's Residential Home. They must ensure service user's privacy and independence and have suitable arrangements in place to ensure service users are enabled to make or participate in making decisions relating to their care and treatment by 31 January 2015.