

# Bondcare Shaftesbury Limited

## Hamilton House

### Inspection report

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### Ratings

#### Overall rating for this service

Requires Improvement



Is the service safe?

Requires Improvement



Is the service effective?

Requires Improvement



Is the service caring?

Good



Is the service responsive?

Requires Improvement



Is the service well-led?

Good



### Overall summary

This unannounced inspection took place on the 22 and 26 January 2015. Hamilton House is a Nursing home which offers personal and nursing care to 60 older people, some of whom live with dementia. The home has three floors, with a lift which gives access to all floors.

At a previous inspection on 28 March 2014 and 2 April 2014 we found continued non compliance with the regulations and issued warning notices regarding respecting people, care and welfare, staffing issues quality assurance, consent and records.

We inspected in June 2014 and found there had been an improvement with all the Regulations where warning notices had been served. However there was not sufficient improvement to have reached compliance and the breaches remained. Compliance regarding the issue of consent had not improved and a warning notice was served.

On 28 October 2014 we inspected and just looked at the issue of consent, with regards to the warning notice that had been served. We found the provider had improved and was compliant with this Regulation.

# Summary of findings

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are “registered persons”. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection, we found that staff had an understanding of abuse and what action they should take if they felt someone was not receiving safe care. Staff knew there were safeguarding policies and procedures but there was some confusion as to where these were located and what external agencies should be informed. Risk assessments relating to people were mainly well completed and had been updated as necessary. Staffing levels were planned and organised to meet the needs of people. The reliance on agency staff had greatly reduced from previous inspections. Staffing recruitment records were completed and detailed all the necessary checks had been undertaken to ensure people were safe. The administration of medicines practices in the home were not safe as the protocols for take as necessary (PRN) medicines did not include sufficient detail.

People felt staff had the knowledge to care for them effectively. Training was provided for staff to ensure they had the skills to meet people’s needs. Staff received formal supervision, but this was not planned and was delivered on an ad hoc basis. Staff had an awareness of

and understood the Mental Capacity Act 2005 and the principles of this had been applied. People had their nutritional needs taken into account and there was a choice at all meal times. Health needs were assessed and the relevant professionals were involved in people’s care provision.

Staff were kind, respectful and caring. People were not formally involved in discussions about their care but felt they were asked about decisions regarding their care. Most care plans were personalised and provided detailed information to guide staff about the support a person needed but some care plans and applicable risk assessments were omitted or lacked sufficient detail to guide staff on how to support people. People had no concerns or complaints about the home and felt able to speak to the manager if they did.

The manager operated an open door policy and welcomed feedback on any aspect of the service. Staff confirmed management were open and approachable.

Quality assurance in the form of auditing took place on a regular basis. Any learning from audits took place and this was reviewed to ensure it brought about effective change.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

The management of medicines was not safe as protocols for as required medicines needed to be clearer to ensure people's safety.

Staff were aware of their responsibility to keep people safe and raise any concerns if they felt people were not safe.

The majority of people had risk assessments to ensure their independence was promoted.

Staffing levels were organised to meet the needs of people. The home had a good recruitment procedure.

**Requires Improvement**



### Is the service effective?

The service was not always effective.

Supervision of staff was not well organised and happened on an ad hoc basis. Staff had the skills and knowledge to meet people's needs.

Staff understood the principles of the Mental Capacity Act 2005 and ensured consent was given when supporting people.

People's nutritional needs were assessed and planned for. People's likes and dislikes were catered for at meal times.

Health needs were reviewed regularly.

**Requires Improvement**



### Is the service caring?

The service was caring.

Staff demonstrated a good understanding of ensuring people's privacy, dignity and independence were maintained. Care plans were personalised to reflect individual needs and wishes.

There was no formal way of recording people's involvement with their care plans, but people felt this was not important and felt involved in choices around their care.

**Good**



### Is the service responsive?

The service was not always responsive.

Some care plans and applicable risk assessments lacked sufficient detail to ensure people's safety, whilst some care plans did reflect people's individual needs and were updated as people's needs changed.

There was a complaints policy and procedure available. Complaints were logged and dealt with effectively

**Requires Improvement**



# Summary of findings

## Is the service well-led?

The service was well led. The registered manager promoted an open door policy and was approachable and communicated well with people.

The registered manager monitored incidents and risks to make sure the care provided was safe and effective. Staff were supported by the home's management team.

There were systems in place to monitor the service offered and ensure there was learning from incidents and accidents.

Good



# 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 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 22 and 26 January 2015 and was unannounced. The inspection team consisted of; two inspectors, a specialist advisor in the care of frail older people, especially people with dementia and those with end of life care needs, 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. The expert had experience of caring for people who have dementia.

Before the inspection, we examined previous inspection reports, action plans from the provider, and other information we had received, including notifications. A notification is information about important events which the provider is required to tell us about by law.

Following the inspection we requested information from health and social care professionals. One social care professional told us they felt the home had greatly improved over the last twelve months.

During the inspection we spent time talking to ten people, four nurses, eleven members of care staff, the deputy manager and the registered manager. We looked at the staffing records of ten members of staff. We looked at the policies and procedures file, monthly reports by the provider's regional manager, the accident and incidents folder and the complaints log. We checked records of service quality audits, three residents' meetings and three staff meetings.

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

# Is the service safe?

## Our findings

People felt safe. One person told us, “Oh yes it is absolutely lovely here”. We were told by another person, “The staff make you feel safe”.

Staff knew about safeguarding procedures and could detail differing types of abuse. They had received training on safeguarding and keeping people safe and this was discussed on a regular basis. One staff member said, “We are reminded regularly it is our responsibility to keep people safe”. There was some confusion from staff as to where the safeguarding policy was kept and who the external agencies were if they needed to notify them. For example, one staff member said, “x”. However staff were aware of the need to raise any concerns with the registered manager where they felt people were not safe. Each floor had a designated staff member who was a ‘dignity champion’, whose responsibility it was to ensure people’s dignity was promoted at all times.

People had risk assessments in their care plans to ensure they were supported to be as independent as possible whilst keeping safe. One person who was new to the home had not had a risk assessment completed for the area of ‘falls’ although the risk had been identified in the assessment. This was brought to the nurse’s attention as we saw the person being supported by an agency staff member in a manner which did not best support them, with their mobility needs.

The registered manager was aware all policies in relation to emergencies such as flooding were not a little out of date, but was working on this with staff. All fire records were up to date with the home having a staff member who had been deemed competent to carry out fire checks and give staff training. Procedures were in place to ensure all safeguarding, incidents and accidents were learnt from.

Managers and staff used a dependency tool called ‘I-ON S’ which asks 11 questions for each person and then gives a

total score which relates to a level of dependency. This was completed on a monthly basis and staffing levels were organised in line with this. Staff and people felt there was enough staff on duty to ensure people were safe. Agency staff were still being used which had been a concern at previous inspections, but the need for agency staff had greatly reduced. Agency staff worked with more experienced staff and staff now worked their main duties on one floor, so they could get to know people’s needs. Recruitment records showed thorough checks were undertaken before staff worked in the home.

Medicines were dispensed into a 28 day monitored dosage system and staff administered medicines in a safe manner. Medicines were stored and disposed of safely. The medicines rooms on all floors were well organised and tidy. A refrigerator was available on three floors and the temperature checked and recorded daily to ensure medicines were stored according to the manufacturer’s instructions. We looked at all the Medicines Administration Charts (MARs) and found the MARs were fully completed and up to date. As required (PRN) protocols for medicines were used but these did not state the conditions under which a particular medicine should be given. For example, PRN protocols were in place for people who had been prescribed medicine to help them manage distressing symptoms such as anxiety or agitation. They did not include information about the individual’s signs that they required this medicine. There was a risk that they may not have received the medicine when necessary or that they could have received it when they did not need it.

The lack of clear protocols for as required (PRN) medicines was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to a breach of regulation 12 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

# Is the service effective?

## Our findings

People felt staff had the knowledge and skills to support their choices. One person told us, “They ask me every morning and I choose a shower. I like to do things for myself like washing my face”

Training was offered to staff on a regular basis in a wide range of areas. Many staff were being supported to undertake National Vocational Qualifications in care. National Vocational Qualifications (NVQs) are work based awards that are achieved through assessment and training. To achieve an NVQ, candidates must prove that they have the ability (competence) to carry out their job to the required standard. Staff were being given learning and development opportunities which were relevant to their role and required to support people effectively. Nurses told us they received annual competency assessments in medicines. The manager had recruited many new staff who had received an induction relevant to their workplace and role. This had included provisional training, written work and shadowing experienced members of staff. Staff felt supported by other staff and were receiving supervision sessions on an ad hoc basis. Formal supervision was taking place but this had not been organised well. Staff did not always know when they were going to receive supervision and did not know how often they had received supervision. We were shown a new timetable which had been created demonstrating when staff were going to receive supervision and who would be leading the supervision session. Staff received an annual appraisal.

The lack of a planned and organised programme of supervision meant staff were not supported in their responsibilities to deliver care and treatment to people safely. This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They knew if a person lacked capacity,

relevant people needed to be involved and meetings held to help ensure decisions were made in the person's best interests. Staff asked people for their consent before carrying out any activity with them. Each section of people's care plans contained a mental capacity assessment, to ensure the person could consent to that part of the care plan. We did see in one person's records where the manager had not checked a document to ensure a relative had the legal right to make a decision for a person. This did not have a detrimental impact on the person and all decisions had been made in the best interests of the person. The manager had made Deprivation of Liberty safeguarding applications appropriately where people were being restrained in some way for their safety. These were being reviewed and applications were being made when they needed to be reviewed. Members of staff confirmed they had received training and this helped them to ensure they acted in accordance with the legal requirements.

People's care plans detailed people's specific nutritional needs. For example 'diabetic diets' and a 'high protein diet' were noted and detailed for some people. Staff responded to requests for different meals for people that were not on the usual menu, so that nutrition was appropriate to people's individual needs and choices. Staff were friendly and actively encouraged people to eat and drink independently where appropriate. People were offered adapted beakers to drink from. Staff made sure people were able to reach their food and drink, and people who couldn't were offered assistance.

People's healthcare needs were met. People were registered with a GP of their choice and the home arranged regular health checks with GP's, specialist healthcare professionals, dentists and opticians. People's specific health needs were recognised in relation to swallowing difficulties and referrals were made promptly to the local Speech and Language Therapy Service (SALT). People received attention from medical experts who provided clear and exact care plans that staff could follow to contribute to a person's safety and comfort.

# Is the service caring?

## Our findings

People told us the staff were caring and they were happy with the care they received. One person told us, “The staff never refuses me anything. In the night they will bring me a cup of tea. Sometimes I just ring for a chat”. People told us they were well looked after and said all the staff were kind and caring. Relatives said they were happy with the care and support provided to people and were complimentary about how the staff cared for their family member. Comments included, “The staff are wonderful, they are so kind and know exactly what people need. I can honestly say I have not a bad word to say about this home, in my view it is simply the best.”

Staff respected people’s privacy and dignity. They knocked on people’s doors and waited for a response before entering and closed the door when any kind of care was being provided. Staff provided care and support to people in a friendly and responsive manner. When people asked for assistance staff provided this promptly and with good humour. We saw some sensitive encounters when staff demonstrated skills delivered in a kindly manner. For example a staff member took their time and sat with a person who wanted to talk about bereavement. Staff sat with people speaking with them about their lives in ways that demonstrated a good knowledge of them.

Staff smiled often and when it was necessary to discuss a person’s needs they did so discreetly in ways that were inclusive and respected the person’s privacy. For example, when a senior member of staff enquired about what a person had eaten, the care staff involved the person in the discussion. When a person became upset, the care staff responded warmly towards them in spoken terms, ensuring their dignity was promoted and held their hand providing reassurance. Staff stayed with the person until they had recovered providing them with tea and biscuits. Once the person appeared to feel better the staff returned to them shortly afterwards and read the newspaper with them. This demonstrated an in-depth knowledge of how best to support the person through an uncomfortable situation.

Staff understood the need to respect people’s confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was passed verbally in private or put in each individual’s care notes. People’s care plans were kept in locked cabinets, with only staff having access to the cabinets. This helped to ensure only people who had a need to know were aware of people’s personal information.



# Is the service responsive?

## Our findings

People had little formal involvement with their care plans, but expressed this was not a concern to them. People felt involved in decisions around their care. One person told us, "I was asked if I wanted to move rooms, but I didn't as I wouldn't have felt safe". People knew to ask for the manager by name if they wanted to complain.

People had their needs assessed before they moved in, checking whether the service was able to meet their needs. Some people had information provided in a personalised "This is me" format, a recognised tool for those living with dementia. This records personal information about the person to tell staff about the person's needs, preferences, likes, dislikes and interests. This was not in all records which meant some people's records contained more personalised information than others.

People's care files were presented in a format where information was relatively straight forward to find. Some care plans included old records at the front which could cause confusion for staff about which plan to follow. Staff told us they tended to use a mini care plan which was kept in people's rooms. There was a handover at each shift from nurse to nurse and this information was handed onto the care staff. One staff member told us, "We rely mostly on handover and looking at the daily records to keep us up to date, as we do not always have time to look in the care plans but we can always ask the nurses who use them several times a day".

Care plans described how people's needs should be met. They detailed conditions which affected the individual such as when a person was affected by osteoarthritis which could be painful and how analgesics should be given prior to movement. People's records were reviewed each month. Where necessary there were clear care plans regarding people's behaviour which could be considered challenging. These explained the person's behaviour was their way of communicating. Where a deprivation of liberty safeguard was in place, which legally placed some restrictions on the person's free movement, this had been incorporated into the person's care plan and it explained how it affected the person. Staff demonstrated a good knowledge of people's needs and preferences.

Two people had been recently admitted. One person had a full set of risk assessments and care plans, which contained a considerable amount of specific detail about any risks to the person and their care and support needs. The second person's records were not so well completed and included basic information such as the person's weight and Malnutrition Score (MUST) but there was no moving and handling risk assessment. The person had a history of falls. This meant there may have been some degree of falls risk to the person that had not been detailed to reflect their support needs. There were some small gaps in other care records, for example, when one person had an infection such as a urinary tract infection, or another had a chest infection their records did not contain a short term care plans which would have provided instructions for staff about how to support them to assist their recovery and increase their comfort.

Care plans did not consistently or sufficiently detail all a person's needs to ensure their welfare and safety at all times. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a well-equipped activities room and on the day of our visit there were ten people joining in the activity of singing. For people who remained in bed for their care, records made infrequent reference to individual activities. The service had an activities co-ordinator who told us they did have a programme of provision for people in their rooms but there had been a lot of staff sickness and new staff starters during the past month which meant there had not been the time they would have wanted since the middle of December 2014.

There was an effective complaints system and any complaints were recorded in a complaints log. We were able to see these were responded to within reasonable time scales. People, relatives and staff all felt able to raise any concerns or complaints with the registered manager demonstrated this during our inspection when concerns were raised about staff and immediate action was taken.

# Is the service well-led?

## Our findings

We saw there was lots of contact between people and staff. Staff would regularly try and involve people in day to day decisions. There were regular residents meetings, which were held on each floor between staff and people. People were asked before the meetings if they wanted to raise any issues to be put on the agenda. We could see people's views were recorded and there were actions to improve areas which had been detailed. These included the garden and the handling of post. Relatives and residents meetings were also arranged to ensure they were kept up to date with how the home was progressing and the chance to raise any concerns.

There were regular staff meetings, which were held at various times to ensure all staff, could attend. The minutes reflected that staff could raise any issues of concern and the action taken to resolve an issue was recorded. Staff could recall the key values of dignity, respect and privacy, but were uncertain if these were their own values or the values of the organisation. Two staff told us "The manager is always saying we want to provide outstanding care not for the star above the door but so that people have the best care in the world and we all sign up to that vision and we are all working hard doing our best towards it".

The home has had a registered manager who was registered in May 2015. The manager was a visible presence

within the home and the culture they promoted was one of an open door policy. The registered manager made contact with all staff on a daily basis. Visitors were aware who the registered manager was and felt comfortable discussing their concerns with them. "Flash" (quick) meetings were held daily, which were attended by all leads in the home and all issues relating to people were discussed. Staff found the registered manager approachable and reported they were always around the home. One staff member said, "They are a really good manager, they really care about us but they are no push-over and can be firm when needed just like any good boss should be".

There was a policy and procedure for quality assurance and these service quality audits were taking place regularly. The provider's regional manager carried out a monthly audit which looked at eight areas of overall performance. These identified areas which were working well but also areas which needed to be improved. It was clear the areas which needed to be improved were addressed at the following monthly audit to ensure there had been progress. The manager had introduced an 'Employee of the month scheme' which recognised staff who were working towards excellence. Accidents and incidents were being logged and these were being analysed to look to see if there could be any learning from these events. People's records were audited on a regular basis and the manager was aware of the issues we had identified with the care plans and had a plan to address these.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
Diagnostic and screening procedures	<b>Care plans did not consistently or sufficiently detail all a person's needs to ensure their welfare and safety at all times.</b>
Treatment of disease, disorder or injury	

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines
Diagnostic and screening procedures	<b>There was a lack of clear protocols for as required (PRN) medicines, which meant service users were at risk of not always receiving this medication safely.</b>
Treatment of disease, disorder or injury	

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff
Diagnostic and screening procedures	<b>The lack of a planned and organised programme of supervision meant staff were not supported in their responsibilities to deliver care and treatment to people safely.</b>
Treatment of disease, disorder or injury	