Prime Life Limited

Hamilton House & Mews

Inspection Report

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Summary of findings

Overall summary

Hamilton House and Mews is registered with the Care Quality Commission (CQC) as a care home. Hamilton House and Mews are two separate buildings in the same grounds and managed by the same registered manager. They provide residential care for up to 24 adults in the House and 14 in the Mews, all with mental health needs. On the day of inspection there were 19 people in the house and six in the Mews.

The home had a registered manager. A registered manager is a person who has registered with CQC to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The DoLS are a code of practice to supplement the main Mental Capacity Act 2005 Code of Practice.

We looked at whether the home was applying the DoLS appropriately. These safeguards protect the rights of adults using services by ensuring that if there were restrictions on their freedom and liberty these would be assessed by professionals who were trained to check whether the restriction was needed. Whilst no one at the home required these safeguards at the time of our inspection, we found there were proper policies and procedures in place to protect people who could not make decisions for themselves. There was evidence that staff had received training but two out of six staff were unclear about how the principles of the MCA should be taken into consideration within their day to day work. Four of the staff spoken with could not demonstrate a good understanding of the Deprivation of Liberty Safeguards (DoLS) but the provider has stated staff would be supported by the management team to ensure people were not deprived of their liberty.

The service did not always follow current and relevant professional guidance about the management of medicines, which meant people were at risk.

There were enough staff on duty to provide the care and support needs for people in the home. Five out of seven people told us that staff lacked compassion and did not treat them with respect.

People's welfare and safety was at risk because the individualised risk assessments had not been updated.

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.

Are services safe?

The administration and management of medication was not always undertaken correctly, which meant people were not protected.

One person told us that staff had shouted at people using the service. This was confirmed by a staff member. This had not been reported as a safeguarding concern by the staff member. Most staff we spoke with understood how to report safeguarding concerns to the relevant authority.

Risk assessments had not been updated when there had been changes in people's mental health and wellbeing to ensure they were kept safe.

Staff had received training about the Mental Capacity Act and Mental Health Act, but some did not understand the Deprivation of Liberty Safeguards. However the provider said that staff would be supported by the management team to make sure people were not deprived of their liberty.

Are services effective?

People told us they were not always consulted in the planning and reviewing of their care.

Staff had received training in a variety of subjects but there was no evidence that their on going knowledge and competency had been tested as part of good practice. However most had the skills and knowledge for their role.

Hamilton House was in a poor state of repair, although the manager said a major refurbishment would be completed once the new fire sprinkler system was in place.

Are services caring?

People told us that staff were not kind or compassionate. They also said most staff did not listen to them. One person stated: "Staff could listen more." However, we observed and heard how one member of staff positively supported and helped one person in the home in dealing with some concerns.

People told us the food was not always good, although the cook told us the choice of food was regularly discussed with people who lived in the home.

Summary of findings

Are services responsive to people's needs?

Most people told us they were aware of the provider's complaints procedure. People told us that concerns they had raised were not recorded as complaints.

People were supported to undertake meaningful activities and told us about the different activities they were involved in, including attending day centres, shopping trips and activities within the home such as playing football or knitting.

People told us they were helped by staff in maintaining contact with their families and friends.

Are services well-led?

The provider had undertaken a number of audits to check on the quality of the service provided to people. However, these had been ineffective in improving the service as many of the shortfalls they had identified were the same as the ones we found during our inspection.

A copy of the quality assurance discussion, (which was a method the registered manager used to check the quality of the service for those who lived there), in January 2014 could not be found by the registered manager, so we were not able to check whether any action had been taken as a result.

Summary of findings

What people who use the service and those that matter to them say

People told us they did not feel staff treated them well. One person said: "Staff can be sarcastic sometimes" and another commented: "I have heard staff being disrespectful behind service users' backs."

When asked about care plans people told us: "I think I signed something but I can't remember what," and: "My family has been involved in the planning of my care."

People told us that there were not always enough staff working in the home. Comments included, "Sometimes there's a shortage of staff at the weekends", and, "Being short staffed means that we can't go out."

People gave us mixed feedback about the meals in the home. One person told us: "The food sometimes comes out under or over cooked", another commented "The food's good, it's hot and fresh most of the time."

One person gave an example about the activities in the home and said: "We can do painting and knitting."

Hamilton House & Mews

Detailed findings

Background to this inspection

We visited Hamilton House and Mews on 8 May 2014. This was an unannounced inspection, which meant the provider was not informed about our visit beforehand. Our inspection team was made up of two inspectors, a pharmacist inspector and an expert by experience who had experience of mental health services.

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 was meeting the regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process.

The last scheduled inspection for Hamilton House and Mews took place on 4 September 2013. The home was compliant in four of the five regulations inspected. In October 2013 a desk top review was undertaken and found the home was compliant with the outstanding breach in regulation 23 supporting workers.

Prior to the inspection we reviewed the information we held about the home. This included looking at safeguarding incidents and notifications sent to us by the provider.

During the inspection process we talked with seven people who lived in the home, spoke with nine members of staff and the registered manager. We looked at three people's care plans and supporting documents. We looked at other documentation such as accidents and incidents and daily notes. We observed staff when they interacted with and provided care to people. We looked at information about people's medicines and the way medicines were administered. We checked information about the mandatory and specialist training that staff had received. We checked eight staff member's recruitment files. We looked at the information in the provider information record and minutes of the last staff meeting. We spoke with four health and social care professionals.

Are services safe?

Our findings

During the inspection our pharmacist inspector looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines. We conducted an audit of medicines which considered medication records against quantities of medicines available for administration. We were unable to account for all medicines that we looked at and found numerical discrepancies and gaps in records of medicine administration so we could not be assured people were receiving their medicines as prescribed.

We found records that indicated some people prescribed inhaled medicines for regular administration were rarely being administered them and were not receiving them regularly as prescribed. We found a medicine that had been discontinued by the prescriber still remained in the medicine trolley and had since been administered to the person. We noted records that indicated that two medicines had not been administered as scheduled for periods of three and four days respectively because they had not been available to administer and had not been obtained in time. This meant we could not be assured people living at the service were being administered their medicines appropriately and as intended by prescribers. The manager showed us that an auditing system was in place for medicine management but we noted this was most recently conducted 17 February 2014 and identified some issues similar to those we identified during our inspection. Therefore the audit was ineffective at protecting people against the unsafe management of their medicines.

We looked at supporting information available alongside medication administration record charts to assist staff when administering medicines to individual people. We noted there was personal identification and information about known allergies/medicine sensitivities for most but not all people living at the home. We found that the information available to staff for the administration of 'when required' medicines was not robust enough to ensure that the medicines were administered appropriately. There was also a lack of records about when these medicines were used. This meant we could not be assured people living at the service were being administered these medicines appropriately and as intended by prescribers.

We found that medicines were stored safely for the protection of people who used the service. We found that medicines that required cold storage were being stored in a refrigerator but the temperatures of the refrigerator were not being monitored and recorded properly. The service was therefore not able to demonstrate that these medicines were being stored appropriately and that they would be effective when used. This meant there had been a breach of the relevant regulation (Regulation 13) and the action we have asked the provider to take can be found at the back of the report.

We asked people about the level of staff and they told us: "Sometimes there's a shortage of staff at the weekends", and, "Being short staffed means that we can't go out." The provider had a system in place to determine how many staff were required to support the people who lived at the service. We checked 32 days of the staffing rotas from the 7 April 2014 to the 8 May 2014 to make sure that the numbers of staff on duty equalled the number required. We found that the staffing hours allocated to support people in the home were sufficient to meet people's needs.

Information in the PIR showed that people's risk assessments were reviewed regularly to monitor their effectiveness. We looked at three people's care files and noted, that although some risk assessments had been written, they did not reflect changes or reviews of people's behaviours. One file showed that the person's care plan and risk assessment in relation to their 'aggression and violent behaviour' was last updated in August 2012, even though we were told they had made some improvements. There was further information on file that showed the incidents of aggressive and violent behaviour had recurred and the most recent were in January 2014. There was information regarding issues with another person, who required a second staff member if being transported by car. The registered manager said the person distracted staff when they were driving, but no separate risk assessment had been completed to manage this. This showed that staff and people in the home were not protected or kept safe and meant there had been a breach of the relevant legal regulation (Regulation 20). The action we have asked the provider to take can be found at the back of this report.

We spoke with one community health professional who informed us that staff from the home had been involved in a mental health assessment for one person who lived in the home. Four out of six members of staff were able to tell us

Are services safe?

about the Mental Capacity Act 2005 (MCA) or Mental Health Act 1983 (MHA). They said they understood the principles of the Act and how to care for people in their best interests. However, two staff were unclear about how the principles of the MCA should be taken into consideration within their day to day work. Four of the staff spoken with could not demonstrate a good understanding of the Deprivation of Liberty Safeguards (DoLS). However we received assurances from the provider that staff would be supported by the management team to make sure people were not deprived of their liberty.

The registered manager stated that the home had a 'no restraint' policy, however we found evidence in one of the three files that one person had been restrained by staff. There was no appropriate record about the incident or what had been done about it. The registered manager had not been informed of the restraint and was unaware of the event. The use of restraint is governed by the requirements of section 6 of The Mental Capacity Act 2005. Section 6 allows a person who lacks capacity to make a particular decision to be physically restrained in order to prevent them from being harmed. The restraint must be proportionate to the likelihood of the person suffering harm and must not amount to a deprivation of liberty. It was not clear if the restraint had been carried out lawfully and in accordance with the requirements of the 2005 Act, as the records did not show any assessment as to the decision to use the restraint and if it had been proportionate to the risk of harm. The service user was therefore not being protected from the risk of the restraint being inappropriate or unlawful. This meant there had been a breach of the relevant legal regulation (Regulation 11) and the action we have asked the provider to take can be found at the back of this report.

We checked eight staff member's recruitment files to ensure that the required checks had been carried out to ensure that these staff were suitable to work with vulnerable adults. One staff member's file who had recommenced working for the service full time having previously completed some bank work, could not be found. The registered manager advised that they thought the file was with their HR department. This meant that we could not check this file.

Of the other seven staff files we checked, two did not contain any proof of identification for the staff member. Six files did not contain photographic identification of the person. Two did not contain details of references from previous employers. One did not have information relating to the staff member's employment history or a record to show that they did not have any health issues that would impact on their ability to provide care to the people who used the service. This meant there had been a breach of the relevant legal regulation (Regulation 21) and the action we have asked the provider to take can be found at the back of this report.

The service had a policy that told staff how to safeguard adults. This policy was dated August 2011 and did not contain any information on how to report concerns outside of the service, although four out of nine staff knew that the local authority investigated safeguarding concerns and told us they would report directly to them if they felt they needed to alert an authority outside of the service. The local authority safeguarding team told us that staff in the home raised any safeguarding issues with them (the team) in an appropriate and timely way.

We checked staff training on this subject. Of the seven training records we looked at, six staff were shown as having received training. No evidence could be produced to show that one staff member had received training. We could not be assured that all staff would report safeguarding concerns to the relevant agency to investigate.

We spoke with five people who all said they felt safe. One person said: "The staff make me feel safe." Another person said: "Oh yes I feel very safe here", and the staff we spoke with were able to demonstrate a good knowledge about safeguarding adults from abuse. They said that any concerns would be reported directly to the registered manager or the nurse in charge or would be escalated to the provider if they felt this was necessary. However one person in the home said: "I've heard two staff members shout at other service users" and a member of staff confirmed this and said: "I have heard staff shouting at residents occasionally." There was no evidence that the staff member had raised the issue as a safeguarding. This meant people were not safeguarded against abuse and there was a breach of the relevant regulation (Regulation 11) and the action we have asked the provider to take can be found at the back of this report.

Are services effective?

(for example, treatment is effective)

Our findings

All of the staff we spoke with were able to demonstrate that they had a good understanding of what care people who lived in the home required. We spoke with five people in the home who told us they were not always consulted as part of the planning or review of their care. One person said: "Sometimes I feel involved but I've never had my care explained to me." Another said: "I don't know what a care plan is." We looked at three people's care plans and noted they had not been signed by the person or their representative.

The registered manager told us that staff had to complete training in the following areas: moving and handling; infection control; safeguarding and fire safety. We checked seven staff members training records and saw that they had all received training within these subjects except for one member who did not have any evidence to show that they had completed the safeguarding of vulnerable adults training. They had also all received training about the Mental Capacity Act (2005) (MCA) and the Deprivation of Liberty safeguards (DoLS) and mental health awareness.

Although training within these subjects had been completed, we did not see evidence to show that staff's on going knowledge and competency surrounding them had been tested. For example, although staff had received training in the MCA and DoLS, two were unable to tell us how these affected their day to day work when questioned. However the provider stated that where a mental capacity issue was identified by staff, it would be addressed by the home's management team in conjunction with the staff team and other appropriate agencies. Two of the staff spoken with said they would like further training in specific mental health conditions to help them support the people they cared for more effectively. Another said: "I think we would benefit from more specialised mental health training. I am worried that one of the residents is not getting the right support with their mood swings."

Training in other subjects had been completed by some staff to help them support people who used the service. These included areas such as food hygiene, diabetes, nutrition, dignity and medication management. Staff had the necessary techniques for managing behaviour that challenged because it was included as part of other specific mental health related training. Staff had the skills to support and protect people who lived in the home.

The registered manager told us that they assessed people's risk of malnutrition each month using the malnutrition universal screening tool (MUST). Seven of the 12 records we checked showed that people's risk of malnutrition had not been assessed since March 2014 although most of these people had not been identified as being at risk of malnutrition at this date. The registered manager told us this was because people had refused to be weighed although this was not documented within their records. (People's weight is required to identify their risk of malnutrition using the MUST). Where people had been assessed in March 2014 as being at risk, we saw that they had been weighed again in April 2014. Three of the people had been assessed as being at medium risk of malnutrition. These people's food and fluid intake was not being monitored by the staff. Therefore, staff were not able to determine whether people had received sufficient amounts to meet their needs. We saw that one person's MUST had been calculated incorrectly. This showed them as being at medium risk when in fact they were at high risk of malnutrition. We asked the registered manager what actions had been taken to protect this person from the risk of malnutrition. They told us that they were fortifying their food and drink on a regular basis. (Fortifying is where extra calories are added to food and drink). This was confirmed by a member of staff. We noted that the person had put on four pounds in weight between March and April 2014. However, no referral had been made to a dietician for specialist advice. The registered manager told us that this person was naturally slim. We saw from records that they had lost a stone in weight since February 2012 and that this weight loss had not been investigated to make sure it was not as the result of an underlying health problem. Improvements were needed because we were not assured that the service had done all that it could to protect this person from the risk of malnutrition.

We spoke with a health professional who told us the referrals from staff to the district nurses service were appropriate and timely. They said that one person in the home became distressed if their dressings were not changed, so a member of staff, who was a nurse, had been trained to dress the leg ulcers. They told us that the staff had supported one person in the home who was at risk of pressure sores and provided excellent care, which included encouraging the person to eat and drink to maintain their skin integrity.

Are services effective?

(for example, treatment is effective)

Hamilton House is a separate building from the Mews, which is a newer building. The internal décor of Hamilton House looked very tired and shabby and many of the doors and walls were marked and dented. The registered manager stated that a major refurbishment of the home was due once internal work on a sprinkler system had been finished, but a date for the work to be completed had not been agreed. Information in the PIR showed a refurbishment and maintenance programme was in place alongside risk assessments for the environment.

Are services caring?

Our findings

Information in the provider information return (PIR) showed that Hamilton House and Mews had identified staff as Dignity and Quality Champions. However, we received mixed feedback from people with most of the people we spoke with who lived in the home telling us that staff were not kind and compassionate. One person told us: "Staff have an attitude. They shout and slam doors in my face" and another person told us: "I don't think that I am treated with respect as the staff talk to me sarcastic and call me names." Another person said: "Staff treat me fine", and another: "Staff make sure the doors are shut and no one can see when they help with showering me."

We spoke with five people and some said they did not feel that staff listened to them. One person said: "We have residents' meetings but the staff never seem to listen to our issues we bring up." Another said: "The manager doesn't have time for me." Although one person said: "Staff listen to my concerns."

People were not always treated with dignity and respect by staff, which meant there had been a breach of the relevant legal regulation (Regulation 17) and the action we have asked the provider to take can be found at the back of this report.

People gave us mixed feedback about the meals in the home. One person told us: "The food sometimes comes out under or over cooked", another commented "There is always a choice of food," and another "The food's good, it's hot and fresh most of the time." One member of staff said: "We know the residents think the food is not good. The residents want plain food and we've told the cook but he won't listen and keeps putting herbs in." We spoke with the cook who said people did not like changes in the menu, but did discuss the menu regularly with people who lived in the home. The cook was aware that people did not like spicy food and told us they did not cook those types of meals.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

All of the staff we spoke with told us that the people who used the service could raise concerns with them at any time and were confident that any issues raised were resolved to the person's satisfaction. However this contradicted what people told us, as one person told us: "I used to listen to music but my stereo went missing when I went into hospital, I have asked the staff about it but they don't know what happened to it". Others told us that staff shouted at them and others were not happy with the meals served in the home. The registered manager told us that no formal written complaints had been received in the month since they had managed the service (April 2014) and that people's concerns were dealt straight away. There was no written evidence of the concerns raised nor the outcome for people.

Although the service had a policy that advised people who used the service how to make a complaint, one person said: "I have never seen a complaints procedure and I have never been told how to complain". However one person said: "If I wanted to complain I would speak to a member of staff or the manager." The policy clearly detailed the process people needed to follow to complain to the service directly and the provider told us that there were posters around the home which made reference to referring complaints on to CQC and/or the Local Government Ombudsman.

Information in the provider information return (PIR) stated that people attended services in the locality, such as day centres, farm group, MIND (a mental health charity), and Headway. People told us about the activities they were involved in. One person said: "I like football and the staff support this, we even had a kick about", and "Staff encourage me to do my knitting". One person told us how they enjoyed attending their day centre and had made friends from other places, and one health professional said staff encouraged and enabled people to attend and have links with people outside the home.

People told us how they kept up contact with their family. One person said: "My family is made to feel welcome when they come to visit", and another said, "Staff are wonderful with my family". During the inspection we saw one person who became upset because they missed their relative. We heard staff talk with the person and suggested they could contact them by letter. Another person was able to organise and visit family abroad with support from staff. The person was very enthusiastic and positive about the arrangements. We were informed by the registered manager and people who lived in the home that the payphone in the hall was often broken, but they could use the office phone so that they could still make personal calls.

Information in the PIR stated that people who were unable to make informed decisions were supported with advocacy services. The provider stated that many people had family or friends, health or social care staff advocate on their behalf. None of the five people we spoke with knew what an advocate was or how to access the services. We spoke with six staff and three were unaware of advocacy services and how to access them. Improvements needed to be made so that people who lived in the home had the information they needed to access advocates independently.

Are services well-led?

Our findings

Although the provider had written and sent in a provider information return (PIR), there were areas where we found the information to be inaccurate. For example the PIR stated that people's risk assessments were reviewed regularly and monitored. During the inspection we found risk assessments did not reflect changes or reviews of people's behaviours with one person's risk assessment last updated in August 2012. The PIR stated that people who were unable to make informed decisions were supported with advocacy services, although 5 people in the home and 3 staff we spoke with were unaware of advocates or how to access them. The PIR detailed that the HR Director supported the manager to ensure staffing levels in the home reflected people's level of need, although during the inspection people said they were unable to go out because there were not enough staff and one person was not receiving the individual support they were assessed as needing. The provider information return stated that audits of the service, which covered people's wellbeing and safety, including nutrition and dignity, were used to identify trends. We identified concerns in relation to these areas during our visit. This showed that the provider's assessment of the service did not identify the areas we found where improvements were needed.

The registered manager showed us that a monitoring system was in place for medicine management. We noted that although the most recently conducted audit dated 17 February 2014 identified some issues similar to those we identified during our inspection this had not led to improvements being made. Therefore the audit was ineffective at protecting people against the unsafe management of their medicines. This meant there had been a breach of the relevant legal regulation (Regulation 10) and the action we have asked the provider to take can be found at the back of this report.

We looked at the accident record book provided by the registered manager and saw they had been recorded. We saw that incidents were written in the daily notes in people's care records. This meant it would be difficult for the registered manager to audit the incidents to see if there were any trends in poor care or changes that were needed to prevent further incidents and to improve the quality of the service.

The registered manager told us that the provider monitored the training completed by staff. However, we found that some staff had training that was out of date. For example, the registered manager told us that moving and handling, infection control, the safeguarding of vulnerable adults and fire safety were mandatory training that had to be completed by staff each year to ensure that their knowledge was current. We checked seven staff members training records and found all seven staff had not refreshed their moving and handling, three their infection control and six their safeguarding of vulnerable adults training within the past year. We found that one staff member had not identified and reported a safeguarding concern. This showed that the providers system for monitoring staff training was ineffective and improvements were needed.

We found limited consultation with people living in the home on the running of the service. Although there was e mail evidence of a quality assurance discussion about meals and activities involving people living in the home in January 2014, the registered manager was unable to find the report with the details of this discussion. There was information that the action plan from the discussions was due to be reviewed in May this year but the review had not been completed at the time of the inspection. The registered manager said that another quality assurance questionnaire was about to be distributed but could not give definite dates.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

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 registered person did not have an effective system in place to monitor and assess the quality of service provided to people. Audits and quality assurance monitoring were not completed or addressed to identify, assess and manage risks relating to the health and welfare of people in the home.

Regulated activity	Regulation
	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding vulnerable people who use services The registered person did not have suitable arrangements to identify the possibility of abuse and prevent it before it occurs. The registered person did not have suitable arrangements in place to protect people against the risk of unlawful or otherwise excessive control or restraint.

Regulated activity	Regulation
	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services. The registered person did not take proper steps to ensure the dignity and respect of people in the home.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person did not maintain an accurate record of the care and treatment provided to each service user. The registered person did not ensure the welfare and safety of people who use the service as the individualised risk assessments had not been updated.
	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers. The registered person did not operate an effective recruitment procedure to ensure that only suitable people were employed at the service.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not have appropriate arrangements in place for the obtaining, recording, using, safe keeping and safe administration of people's medication.