Prime Life Limited

Hamilton House & Mews

Inspection report

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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 inspection took place on 31 July and 21 August 2015 and was unannounced.

Hamilton House is a nursing home that provides care, support and accommodation for up to 39 people with mental health needs. At the time of our inspection there were 28 people living in the home.

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

The registered manager had been absent from the service since the beginning of July 2015 and the deputy manager ceased their role with the organisation on 31 July 2015. The provider informed us that a named nurse would be responsible for managing the service with effect from 6 July 2015.

Summary of findings

Our previous inspection of November 2014 identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (which corresponds with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). We identified concerns that people's medicines were not managed safely.

During our inspection on 31 July we acknowledged that, although improvements had been made, there were some areas that still required improvement. This meant that there was a continuing breach of Regulation 12 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were still some record-keeping discrepancies that had not been identified by the internal audit and there was a lack of records showing further attempts to administer people their medicines, where they had been refused or not administered at the times prescribed.

Our previous inspection of November 2014 identified a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (which corresponds with Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). We identified concerns that the registered person did not operate an effective recruitment procedure to ensure that only suitable people were employed at the service.

During our inspection on 31 July and 21 August we found that improvements were still required in this area. This meant that there was a continuing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No recruitment records or personnel files were available on the premises for three new members of staff.

Our previous inspection of November 2014 identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (which corresponds with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). We identified concerns that proper steps were not being taken to ensure the dignity and respect of people in the home.

During this inspection we found that there were some areas that still required improvement. This meant that there was a continuing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that most of the staff were caring and generally treated them with kindness and respect. Interactions between some staff and people living in the home were particularly warm, reassuring and considerate. However, People were not always treated with respect and people weren't always able enhance or maintain their independence because there were not always enough staff to provide people with the individual support they required.

Our previous inspection of November 2014 identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). We identified concerns that 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.

During this inspection we found that improvements were still required. This meant that there was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's systems for monitoring, assessing and improving the service were ineffective and appropriate measures were not being taken to consistently identify and mitigate risks for people living and working in the home.

People told us that they felt safe living at the home and that they would talk with staff or the nurse if they had any concerns. Staff told us they understood what constituted abuse and were confident in reporting any concerns. However, low staffing levels and the poor quality of staff training compromised staff's ability to consistently ensure people were kept safe from avoidable harm.

Risks to people's safety were assessed but records were not all up to date or fully completed. The management of

Summary of findings

some of the risks identified was not always effective because actions to reduce, remove or improve the risks to people were not always taken or recorded appropriately.

There were not enough staff to ensure people were consistently kept safe and have their needs fully met. The shortfalls included housekeeping staff as well as care staff. This meant that some people did not receive the specific one-to-one support that they were funded for and other people were not being supported sufficiently in line with their identified needs.

Staff did not consistently receive effective support and were not enabled to access appropriate training that would ensure they had the relevant skills and knowledge to be able to meet people's needs and provide care and support safely and effectively.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

The service was not meeting the requirements of MCA and DoLS because the provider had not acted on the requirements of the safeguards to ensure that people were protected. Staff members did not understand the MCA well and best interests decisions were not always documented appropriately. The service was also not following correct procedures when medicines need to be given to people without their knowing (covertly).

People told us that they had enough to eat and drink, although we were concerned about people's quality and choice regarding some of the food. There were a number of gaps in the records for people who needed their food and drink intake and weights to be monitored, to ensure they remained healthy.

People had access to various healthcare professionals, according to their needs and regular visits to the home were also made by external practitioners, such as the chiropodist and a diabetes advisor.

Due to the lack of sufficient numbers of staff and effective deployment, people were not consistently able to access the local community as they wished. This was sometimes because there were no drivers on duty for the home's mini-bus or because staffing levels were not sufficient to enable a driver to take people out. Allocated one-to-one time for people and organised activities that were advertised within the home, were also not consistently being provided because there were regularly not enough staff on duty.

People told us that they spoke to staff or told the nurse or the deputy manager if they had any problems or wanted to make a complaint. However, staff were not completely sure how complaints were handled.

There was a lack of oversight from the provider with regard to the overall running of the service. The provider also did not demonstrate accountability or effective leadership because they did not ensure that appropriate action was being taken to improve shortfalls, where issues had been identified.

Our findings during our inspection of 31 July and 21 August 2015 showed that the provider had failed to "…meet every regulation for each regulated activity they provide…", as required under the HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3).

We found that the provider was in breach of eight regulations. You can see the action we have told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

Summary of findings

inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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?

Inadequate

The service was not safe.

Risks to people's safety were assessed but records were not all up to date or fully completed. Risk management was not always effective because actions to reduce, remove or improve the risks to people were not always taken or recorded appropriately.

There were not enough staff to ensure people were consistently kept safe and have their needs fully met.

The registered person did not operate an effective recruitment procedure to ensure that only suitable people were employed at the service.

Record-keeping discrepancies and a lack of some records meant that people's medicines were not always managed safely.

Is the service effective?

Inadequate

The service was not effective.

Staff did not consistently receive effective support and were not enabled to access appropriate training that would ensure they had the relevant skills and knowledge to be able to meet people's needs and provide care and support safely and effectively.

The service was not meeting the requirements of MCA and DoLS because the provider had not acted on the requirements of the safeguards to ensure that people were protected.

People told us that they had enough to eat and drink, although we were concerned about people's quality and choice regarding some of the food provided.

People's health and wellbeing wasn't being monitored as consistently as it was meant to because there were gaps in a number of the monitoring records.

People had access to various healthcare professionals, according to their needs.

Is the service caring?

Inadequate

The service was not caring.

People were not always treated with respect and people were not always able enhance or maintain their independence because there were not always enough staff to provide people with the individual support they required.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive care and support that was individual to their needs. Staff were not able to consistently respond to people's needs in a timely fashion because there were not always sufficient numbers of staff on duty.

Summary of findings

People told us that they spoke to staff or told the nurse or the deputy manager if they had any problems or wanted to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of oversight from the provider with regard to the overall running of the service.

The provider's systems for monitoring, assessing and improving the service were ineffective and appropriate measures were not being taken to consistently identify and mitigate risks for people living and working in the home.

The provider did not demonstrate accountability or effective leadership because they did not ensure that appropriate action was being taken to improve shortfalls, where issues had been identified.

Hamilton House & Mews

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 was unannounced and was carried out by four inspectors on 31 July 2015 and two inspectors on 21 August 2015.

Before our inspection we looked at information we held about the service including statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also reviewed information recently given to us by social services, the local fire department and the local authority's quality monitoring team.

During this inspection we met and spoke with 14 people living in the home, the deputy manager, the nurse in charge and eight staff, including care and domestic staff. We also met and heard comments from a district nurse and two community police support officers.

We looked at six people's care plans and a number of other health and wellbeing records, including medication records, for people living in the home. We also looked at the records for staff in respect of training, supervision, appraisals and recruitment and a selection of records that related to the management and day to day running of the service.

Inadequate

Is the service safe?

Our findings

Our previous inspection of November 2014 identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (which corresponds with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). We identified concerns that people's medicines were not managed safely.

During our inspection on 31 July we acknowledged that, although improvements had been made, there were some areas that still required improvement. This meant that there was a continuing breach of Regulation 12 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Medicines were being stored safely for the protection of people who used the service and at the correct temperatures. Audits were in place to enable staff to monitor and account for medicines. The audits showed people living at the service received their oral medicines as prescribed. However, we found record-keeping discrepancies that had not been identified by the internal audit and which did not confirm the medicines were being administered as intended by prescribers.

Supporting information was available to assist staff when administering medicines to individual people. There was information about known allergies or medicine sensitivities for people living at the home. When people were prescribed medicines on an as required basis, there was information to show nurses how to administer these medicines to people prescribed them in a consistent way to meet their needs.

However, there were some people who were regularly refusing to take their prescribed medicines and others who were not administered their medicines during the day because they were sleeping. There was a lack of records showing further attempts to administer people their medicines as scheduled. In addition, where people were regularly refusing their medicines there were no records of recent and on-going actions taken by staff to consult with other healthcare professionals about this.

We also noted that when people refused some of their required medicines or clinical appointments, there were no action plans to show what should happen next. There was also no clear information to explain the implications if people refused to take their medicines such as the increase in risk to the person themselves or that they could pose to others. For example, staff told us that if one person refused to take their required medicine for any length of time, they became withdrawn and would sometimes walk down the middle of the road. Another person would become irritable and less tolerant of others around them, sometimes resulting in 'aggressive' outbursts.

Our previous inspection of November 2014 identified a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (which corresponds with Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). We identified concerns that the registered person did not operate an effective recruitment procedure to ensure that only suitable people were employed at the service.

During our inspection on 31 July and 21 August we found that improvements were still required in this area. This meant that there was a continuing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One new member of staff had begun working at Hamilton House and was in the process of completing their induction at the time of our inspection on 31 July. This person had been interviewed at another of the provider's locations and had initially commenced work there. We asked to see this person's personnel records but the deputy manager told us that there was no documentation on the premises for this person and that it was probably still at the other location. During our inspection on 21 August, we asked again to see this person's personnel records but there was still no documentation on the premises, other than the staff member's personal induction folder.

On 21 August, the second day of our inspection, we noted that two more people had recently begun working in the home. One person told us that they had been interviewed by the manager and deputy manager approximately 12 weeks previously. We asked the nurse in charge to show us these people's personnel records but the nurse was unable

to locate any documentation relating to their recruitment. The filing cabinet where other staff files were stored did not contain any information relating to any of the three newest members of staff.

This meant that the registered person was still unable to demonstrate that they operated an effective recruitment procedure, to ensure that only suitable people were employed at the service.

We looked at how the risks to people's safety were being managed.

We found that risks to people's safety had been assessed but records of these assessments were not all up to date or fully completed. We also had concerns with regard to the effective management of some of the risks identified.

For example, one person's care records showed that they had been assessed as being at risk of pressure ulcers and reviews of this risk had been completed in March and June 2015. However, there was no associated care plan in place to explain what action staff needed to take in order to minimise the risk.

Two people's care records showed that they had been assessed as being at risk of falls and the latest reviews of these risks were dated February 2015. However, there were no specific care plans in place and there was no information regarding falls in their care plans about mobility. This meant that staff did not have any guidance about how to support those people who were at risk of falls.

Another person's care records contained detailed information regarding behaviour that may challenge. However, we noted that this information focused on what to do when the person became 'aggressive' or agitated, rather than describing how to recognise and avoid triggers. The care records did state that frustration could be a trigger but did not clearly explain what could lead to the person becoming frustrated.

We saw that risks for one person, in respect of smoking in their room and starting fires, had been assessed and the actions to be taken were clearly documented. We saw that evaluations had been completed monthly and staff confirmed that they continued to follow the action plans as required. We also noted that fire retardant bed linen and curtains were being used.

A falls, incidents and accidents audit was carried out by the registered manager for the month of May 2015. The registered manager had recorded that there had been an increase in incidents requiring referrals to safeguarding and CQC notifications since the organisation's reduction in staffing numbers and stated that their concerns had been discussed with an associate director. The registered manager had also recorded that this area would continue to be audited but no further audits had been completed. The nurse in charge told us that, although they continued to complete notifications and referrals as needed, they did not have time to complete the audits. No further action was recorded as having been taken by the provider and there was no evident response to the registered manager's concerns. Staffing levels had remained at the reduced levels with regular additional shortages due to leave or sickness or unfilled gaps on the rota.

We saw that an action plan had been recorded by the registered manager to help address the increase in incidents, which included reviewing and updating care plans if needed, further training for all staff in managing challenging behaviour and a note stating that staff were to 'be in the communal areas and remain vigilant – especially when service users were smoking'. However, at the time of our inspection on 31 July and 21 August we saw that not all staff had completed this training and that staff were not always visible in the communal areas.

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

There were not enough staff to ensure people were consistently kept safe and have their needs fully met.

One person living in the home said, "There's never enough staff around." Another person told us that they agreed with this comment.

Staff told us that they tried really hard to keep up to date with everything but they were always short staffed so it was a struggle to keep on top of everything.

At the time of our inspection there were 20 people living at Hamilton House and eight people living in Hamilton Mews.

The deputy manager gave us a copy of the provider's confirmation of the required staffing levels, which had been agreed for the current occupancy levels.

We saw that the service should be staffed with one nurse and six support workers between 8am and 2pm, reducing

Inadequate

Is the service safe?

to five support workers between 2pm and 8pm and one nurse and two support workers between 8pm and 8am. In addition, there needed to be one cleaner for 35 hours per week, one cook for 35 hours per week and supernumerary management hours of 42 hours per week.

However, over a fourteen day period (Monday 20 July 2015 to Sunday 2 August 2015), the rotas showed Hamilton House & Mews were short staffed (from the above levels) with a reduced number of support workers on ten of these days. On three of these ten days, some shifts were short by two support workers. The rotas for this period also showed the premises did not have a cleaner for four days out of fourteen. Due to long term sickness, there was no registered manager present and no replacement supernumerary management hours had been provided.

The staffing levels above were including core staffing levels for the service as a whole, as well as one-to-one hours for eight named people, totalling 116 hours per week. Two of these people were stated as requiring 35 one to one hours each per week but we could not see evidence of those hours being provided.

One of the nurses told us that there were currently not enough staff to provide people with their required one-to-one time. They said that 'if they provided all the one-to-one they were supposed to, there wouldn't be any staff left on the floor for the remaining people'.

On the first day of our inspection, the home was short of one support worker between 8am and 2pm and two staff were attending appointments away from the building. In addition, although another member of staff was on the duty rota as a support worker for Hamilton Mews, we noted that this member of staff was busy with other areas of responsibility, such as the grocery order and administration and was therefore in the main house during most of our inspection, with no replacement cover for The Mews. This left the home very short of staff and meant that people were at risk of not having their needs met as they required.

We noted that the rota for Saturday 1 August showed there was no cook and no cleaner and that support staff were short by two staff between 8am and 2pm and one staff between 2pm and 8pm. Comments from staff and people living in the home told us that this was not unusual, especially on a Saturday.

This meant that additional pressures were being placed on support staff, which prevented them from being able to fully support people with their individual health, care and welfare needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that they felt safe living at the home and that they would talk with staff or the nurse if they had any concerns. One person told us, "They [staff] do a good job; they do look out for me when I'm not well. Yes, I feel quite safe here."

Staff we spoke with told us they understood what constituted abuse and were confident in reporting any concerns. One member of staff told us that they were currently responsible for making sure any safeguarding issues or concerns were followed up and that the appropriate action had been taken.

From the notifications we had received, plus a discussion with the deputy manager on 31 July and another nurse on 21 August 2015, we saw that incidents in respect of safeguarding people were reported appropriately and additional input was sought from relevant professionals where appropriate. However, we were concerned that staffing levels and the quality of staff training compromised staff's ability to consistently ensure people were kept safe from avoidable harm.

Inadequate

Is the service effective?

Our findings

One member of staff we spoke with told us that they were currently completing their first week of induction at Hamilton House and Mews and would be starting on their own soon after the first day of our inspection. This person told us that they had received a good induction by the member of staff they had been shadowing but had not received any company training to date. On 21 August we noted that this member of staff had been providing one-to-one supervision for a person who had been identified as being at high risk of instigating, and being subject to, aggressive incidents. However, this member of staff had not completed any company training in respect of understanding and managing behaviours that may challenge. They told us that their colleagues had been very good at 'showing them the ropes and teaching them what to do'.

The home did offer training, which we saw was recorded on a training 'matrix'. However, the quality of staff training in many cases was very poor, with no reliable method in place to be able to assess staff competency or understanding of the subject. Staff we spoke with agreed that this was often the case and said that a lot of their training was with multiple choice answers, which they usually checked with each other and went with the majority.

There had been some specific training provided in the past, when required, such as for PEG (Percutaneous Endoscopic Gastrostomy) feeding and 'behaviour management'. Three members of staff told us that they had received the 'behaviour management' training in July 2015 and said this training had been so much better, as they had received a trainer who had made the topic interesting and easier to learn from.

However, four staff said that although they were reminded of training they could not always attend if they were on a day off or on leave, as they did not get paid to attend if they weren't on duty. Attendance or completion of training was also an issue when there was a shortage of staff on duty.

We were given a copy of the organisation's staff training matrix that was dated 10 July 2015. We saw that there were a number of gaps in these records, indicating where staff had not received training that was relevant to their role. We also saw instances where training was not up to date and refresher training had not been provided or undertaken.

For example, three people's moving and handling refresher training was overdue and one person, who started working in the home in 2013, was not recorded as having received this at all. Of 20 support workers, eight had not undertaken emergency first aid training and two staff were recorded as having completed theirs in 2010 and 2011, which meant they were out of date. 13 staff (including four nurses and the deputy) had not completed training for challenging behaviour.

With regard to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), only nine members of staff were recorded as having completed this training in 2014 or 2015. Four support workers and two nurses were not recorded as having completed this training at all and 13 staff had completed this in 2012. As there were a number of people living in the home who lacked capacity to make some decisions, this meant that not all staff would have the current knowledge to be able to support people appropriately.

Hamilton House & Mews is registered to provide the regulatory activity of Accommodation for persons who require treatment for substance misuse. However, although training in alcohol awareness, drug abuse and drug/alcohol was listed on the training matrix, only seven staff were recorded as having completed any of this training, including one nurse and the deputy manager. The registered manager was not recorded as having completed any of this training at all.

Four members of staff spoken with told us they had only received one supervision session so far this year and couldn't remember having had an appraisal. In the absence of both the manager and deputy manager, and with staffing levels being so low, none of the staff we spoke with thought that this would change for the foreseeable future. However, staff said they were able to discuss any concerns with the nurses, manager or deputy and felt they were acted upon. They said that they had been happy with the support provided up until now.

Staff did not consistently receive effective support and were not enabled to access appropriate training that would ensure they had the relevant skills and knowledge to be able to meet people's needs and provide care and support safely and effectively.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

The Care Quality Commission (CQC) is required by law to monitor the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS). The MCA aims to protect the human rights of people who may lack the mental capacity to make decisions for themselves. The DoLS are part of the MCA and aim to protect people who may need to be deprived of their liberty, in their best interests, to deliver essential care and treatment, when there is no less restrictive way of doing so. Any deprivation of liberty must be authorised by the local authority for it to be lawful.

The service did not follow correct procedures when medicines need to be given to people without their knowing (covertly).

There were some people who regularly refused their prescribed medicines and records showed that the service had consulted with their GP about administering some of their tablets crushed and concealed in food (covertly) to enable them to take them. However, the deputy manager confirmed to us that there had been no assessment or recording of people's mental capacity or records showing that best interests decisions had been made by staff on their behalf. Therefore, people may not have been administered their medicines in a way that was appropriate and in their best interests.

The staff spoken with were quick to answer the question about training on MCA and DoLS, stating they had received training. However, when questioned about how it affected them in their day to day work, they said the nurse would sort out any concerns and that the training had been via a questionnaire; therefore the nurses would deal with any queries on the subject. The deputy manager told us that the registered manager was the only person who had received full training on the subject and was able to complete the MCA assessments. This meant that staff may not always provide people with care and support that was appropriate for their needs and in their best interests.

Following this inspection, we also spoke with the nurse who was in charge in the absence of the registered manager and deputy. This person demonstrated a clear understanding of MCA and DoLS and explained to us how they were in the process of ensuring people's capacity was assessed appropriately, particularly where there was doubt in areas such as medicines. They also told us that, having completed a capacity assessment, a DoLS application had been submitted to restrict a person from being able to have sources of ignition, such as their own lighter or matches, due to the person posing such a high risk of starting fires within the home.

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

People told us that they had enough to eat and drink. One person said, "We get drinks at 11am – if you ask you can have one anytime." They also said that drinks were served at other times in the day as well.

We heard the vegetable order being placed on both days of our inspection. We were concerned about the quality and choice of food for people when we heard the member of staff opting for cheaper products and negotiating over prices. For example, we heard them say that the price of an iceberg lettuce was too expensive and that they couldn't have red grapes because they were more expensive than green. Recent feedback from a person's social worker stated that the manager was overheard near Christmas saying to order a smaller turkey because the bigger one was too expensive.

Staff told us that they had a specific budget, per person per day, to work to, which we acknowledged should be sufficient. However, we identified that staff were also having meals and eating food that was being purchased from within this budget.

For example, on 31 July we observed a member of staff going to the kitchen to 'get a sandwich' and asking other staff if they wanted anything. We were also told that, "The chef cooks well" and that there was usually enough food left over for staff to have something if they wanted. We were told that this was not officially supposed to happen but that it had always been the case.

We looked at the Malnutrition Universal Screening Tool (MUST) in four people's care records. Three people's MUST information was well documented with weights and reviews completed regularly and in good detail. However one person's records stated that monthly weights were required but these hadn't been completed since May 2015.

One person did not like to eat food provided by the home and we saw that this person had received a lot of support and input from the dietician to help boost and maintain their weight and keep healthy. A high calorie drink was being provided that the person liked and we saw that this

Inadequate

Is the service effective?

person was being supported to purchase their own choice of food from the local shops or take-away outlets, for which they were given a personal food budget. This person's weights were being checked monthly and their records were up to date.

Some people needed to have their intake of food and drink monitored to ensure they were eating and drinking enough. Food and fluid monitoring charts were written clearly and contained good detail when they were completed. However, there were a number of gaps, which meant that people's intake of food and drink couldn't be monitored consistently, to ensure they remained healthy.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Discussions with staff and the deputy manager, together with care records seen, showed that people had access to various healthcare professionals, according to their needs. For example, regular visits to the home were made by external practitioners to help people manage their diabetes, as well as visits from the chiropodist. Records showed that people also attended appointments with the GP, dentist and optician.

One person's communication care plan reflected an appropriate referral and professional advice received from a speech and language therapist in 2010 and this information had been updated each month this year.

Inadequate

Is the service caring?

Our findings

Our previous inspection of November 2014 identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (which corresponds with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). We identified concerns that proper steps were not being taken to ensure the dignity and respect of people in the home.

During this inspection we found that there were some areas that still required improvement. This meant that there was a continuing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always treated with respect and people weren't always able enhance or maintain their independence.

For example, one person told us, "If I can't get out, I have to get staff to buy stuff for me. I'd like to do more food for myself but it gets too expensive using taxis and I daren't use the busses."

Another person told us, "I haven't got my own fridge so if I buy anything I have to store it in the fridge in the kitchen but then stuff goes missing. Staff were using my peppers that were in the fridge in the kitchen the other day. They said they needed to be used up before they went off but they were still okay and they didn't ask me and they didn't replace them!"

During a discussion with people about the meals, one person told us, "It's sandwiches for tea every night and supper at 9pm is usually leftover food from tea time. Staff don't give people plates at supper, they just put the sandwiches straight on the table – it's mainly because some people need to have something to eat with their meds." Another person also told us this was the case and said, "They could even get paper plates if they want to save washing up." Staff we spoke with regarding this said that they hadn't actually seen this but 'wouldn't be surprised' if it was the case.

When we looked at people's individual requirements and funded additional one-to-one hours, we identified that some people were not receiving the one-to-one time they were being funded for. For example, one person was being funded for 35 hours per week of one-to-one time, in order to receive support and encouragement to work towards more independent living, such as cooking, cleaning and managing their flat. However, we saw this person walking around the house and gardens during both days of our inspection chatting with other people along the way but no specific one-to-one time with staff was being provided. Staff told us that because this person did not pose a risk to themselves or others without their one-to-one time, they needed to focus their attention where it was needed more. This meant that the person's potential for developing and enhancing their independent living skills was being compromised.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that most of the staff were caring and generally treated them with kindness and respect. One person said, "Staff are good – even the new ones."

Another person told us, "There's been a big improvement since they've had that new door on the office, with the glass in it. At least you can see if anyone's in there now and they answer it quicker. Before, you could knock on the door and nobody would answer but you didn't know if there was anyone in there or not. Sometimes there was and sometimes there wasn't."

On both days of our inspection we noted that people regularly knocked on the office door for support, cigarettes or reassurance. On each occasion staff listened and supported that person in a polite and respectful manner. We noted that interactions between some staff and people living in the home were particularly warm, reassuring and considerate.

We took note of when and how many staff were in the office at any one time and for what purpose and there were no concerns. Staff entered the office for reasons associated with supporting people, such as writing records or getting cigarettes or money for people, and only remained in the office for the necessary amount of time. This meant that staff were more visible for people in the home when needed.

However, Staff were not always aware of their actions regarding triggers for people's agitation. For example, one person used a wheelchair but could move themselves around in it when they chose. This person's care plan stated that they did sometimes exhibit 'aggressive

Is the service caring?

behaviour' and that 'frustration' could be a trigger. The guidance for staff said that they should speak clearly to the person and wait for a response from them before taking any action.

We spent some time chatting with this person while they were in the dining room and they were relaxed and calm. As we left, the person began to move themselves away from the table, at which point a member of staff went to the person and asked, "Do you want to go to…?" and immediately started pushing their wheelchair towards the conservatory. When the person started vocalising angrily, the member of staff stopped, then said, "Oh sorry, did you want to go to…?" They then proceeded to push the person in their chair towards the hallway instead. Once again the person began angrily expressing their dissatisfaction. When the member of staff stopped moving the person, we noted that they became calm again.

This told us that, where guidance was in place for staff to know how to support people, it wasn't always followed. This also demonstrated that, although there was guidance regarding what action to take when a person exhibited 'aggressive behaviour', staff did not always avoid action that could cause a person's mood to change or cause them to become agitated.

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

We noted that one person had recently had a visit from an independent advocate. The deputy manager also told us how they had been trying to source an advocate for another person, as they currently didn't have a social worker and this person needed to have some independent advice and support with regard to some of their dealings in the home.

We saw a record of a conversation between one person and a member of staff, regarding whether the person wished to have visitors to their flat when they were unwell. The person had stated that they didn't and agreed a course of action for staff to take to keep them safe and ensure unwanted visitors did not disturb them. We saw examples to confirm that staff appropriately followed the guidance and action plan that had been agreed and implemented.

Inadequate

Is the service responsive?

Our findings

Due to the lack of sufficient numbers of staff and effective deployment, people were not consistently able to access the local community as they wished. This was sometimes because there were no drivers on duty for the home's mini-bus or because staffing levels were not sufficient to enable a driver to take people out.

Allocated one-to-one time for people and organised activities that were advertised within the home, were also not consistently being provided because there were regularly not enough staff on duty. One-to-one records for one person showed no specific involvement with staff or activities since 17 April 2015 where the activity was recorded as 'chats throughout the day'.

One person told us, "I need to go out this afternoon but I don't know if I'll be able to – I don't know if there's a driver on. They haven't had any drivers for a couple of days this week." "There's no chance of going out on the [house] bus on Saturday's cos they're always so short staffed."

Another person said, "People need to get to the shops and the bank. Sometimes there's three drivers on and sometimes there's none." "The [public] busses are so unreliable and taxis are really expensive; you can't afford to use taxis very often."

This was confirmed by the rota, which stated 'No Driver' on Wednesday 29 and Thursday 30 July. Staff also told us that sometimes the nurse was the only driver, which was "useless", as they couldn't leave the premises without a nurse anyway. Staff also told us that Saturdays were always very short staffed and being short staffed often meant that they couldn't take people out, unless it was for scheduled appointments.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff generally knew the people well that they were supporting and recognised signs that indicated if someone was becoming unwell. One person's care plan showed that eating and drinking had become a concern since they had suffered an accident and so a food and drink monitoring chart had been introduced. However, their chart was not always completed fully and we noted gaps on a number of days, which meant that the person's intake of food and drink could not be monitored properly. The deputy manager and staff acknowledged that there were gaps in these records but said that nothing had been done about it. We could not establish who was auditing this risk or see any action taken on the poor recording.

Another care plan we looked at was organised and detailed regarding the person's needs. Monthly evaluations had been completed in detail including MUST and risk assessments. Daily notes were comprehensive but notes written regarding professional visits did not give details. This meant that not all staff could know the outcome or whether any action was required to follow on from the person's appointment. Staff said this information was usually communicated at handover but there were no records of this information.

On 21 August, the district nurse arrived to carry out a pressure care assessment for a person who had needed to remain in bed for a number of weeks, following an accident. There had been a recent occasion where the signs of a pressure ulcer developing had been noticed by staff and the district nurse had provided staff with guidance on managing this. During our inspection we heard the nurse complimenting the staff and saying how well they had managed this person's health care, whilst they remained in bed. Particularly the pressure area, which had virtually cleared up completely. This showed that, although there were sometimes limited records for people, staff reacted well to individual needs and followed professional advice given.

There was a lack of follow up details in some people's care records, so that staff would understand why people had been for medical appointments or what the outcome was. For example, one person had been to the GP and their records stated, 'prescribed amoxicillin' but there was no reason given as to why or what this was for. Other records stated that people had a 'review' but it was not clear what the review was for or the outcome.

The deputy manager told us that some people attended GP appointments on their own and didn't want to share the information with staff, so it was sometimes very difficult to keep that information up to date. However, we noted a number of occasions when staff had accompanied the person to an appointment but the records were still not being maintained and kept up to date.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

People told us that they spoke to staff or told the nurse or the deputy manager if they had any problems or wanted to make a complaint. However, staff we spoke with were not completely sure how complaints were handled officially but did say that they would inform the nurse in charge or management if they had any concerns themselves or needed to pass information on from people using the service.

Inadequate

Is the service well-led?

Our findings

Our previous inspection of November 2014 identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). We identified concerns that 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.

During this inspection we found that improvements were still required. This meant that there was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's systems for monitoring, assessing and improving the service were ineffective and appropriate measures were not being taken to consistently identify and mitigate risks for people living and working in the home.

Policies were out of date and were limited in number. Upon request, the deputy manager gave us a file, which contained policies and procedures for the following only: Safeguarding, Whistleblowing, Managing Behaviours that Challenge Others, Moving and Handling, Infection Prevention and Control, and a draft policy on MCA and DOLs.

We discussed the fact the policies were out of date with the deputy manager and they showed us an email from head office, dated 17 July 2015, that contained copies of reviewed policies that needed to replace the out of date ones in the policies file. This hadn't happened and therefore staff did not have access to up to date policies and procedures to help ensure they carried out their duties correctly.

The environmental risk assessment for the service was generic for the organisation and not specific to Hamilton House and Mews. This meant that possible risks in relation to the premises and grounds had not been appropriately assessed or recorded specifically for Hamilton House and Mews.

Although staff acknowledged that there were gaps in people's care and medical records, at the time of our inspection there was no effective system in place to audit these records and ensure improvements were made and maintained.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was still on sick leave, with an unknown return date at the time of our inspection on 31 July and 21 August. The deputy manager finished their last shift in their management capacity on Friday 31 July.

The deputy manager told us that no one from head office would be coming to the home on 31 July, as both directors who covered the area were unavailable or on leave. There was no formal handover planned from the deputy manager to anyone and the deputy manager told us that they did not know what arrangements were in place for managing the home, after they finished on the day of this inspection.

We received an email from the provider's Nominated Individual on 4 August, stating that the interim management position would largely be covered by a specific nurse, who was also a former manager of the home. In addition we were told that the nurse would be supported by one of the directors who would visit twice weekly in the interim period. We received a notification from the provider on 5 August 2015, which also stated that the named nurse would "manage and be responsible for the home". This notification stated that the date that this person would begin to 'carry on/manage' the location would be 6 July 2015.

However, we spoke with this nurse on Friday 7 August and they told us that they had not been informed that they were to be responsible for the running of the home in the absence of the manager or the deputy manager. We spoke again with the nurse on 11 August, who told us that the director had been that day and said they would be visiting the home each week to provide support. On 21 August we noted that the director had only attended Hamilton House one day during that week.

The provider had provided CQC with inaccurate information, which meant they did not demonstrate or promote a culture of candour, openness and honesty.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

There was a lack of support to the home by the provider. Training was limited and there was limited recorded supervision. Staff meetings were not taking place and there was little or no information cascaded to the team from the provider company.

The staff we spoke with said they felt they worked well as a team but had limited support from the organisation. On 31 July, all but one had worked at the home for some time and told us they worked well together and sorted out issues between them as a team. However, we saw that this was an internal process with the team not benefiting from the background, support and development of a wider knowledge base.

The care plans we saw were organised and easy to follow. However, staff told us that they were in the process of updating the care plans to a new format because the organisation said they preferred an alternative layout. Staff were very despondent about this because, they said, it was "…a lot of work to do for no real reason." One staff member said, "We really haven't got the time to do that as well as keeping up to date with everything else. It's really annoying because we're just having to do it for the sake of it!" Three other staff present said they also agreed with these comments.

Our findings during our inspection on 31 July and 21 August 2015 showed that the provider had failed to "…meet every regulation for each regulated activity they provide…" as required under the HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3). In addition, the provider had consistently failed to sustain improvements where non-compliance and breaches of regulations had been identified during previous inspections.

This was a breach of Regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with unsafe and inadequate assessment of and action to reduce identified risks. People who use services were not protected against the risks associated with the administration of medicines that is not accurate or in accordance with prescriber instructions. Regulation 12 (1)(2)(a)(b)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed People who use services were not protected against the risks associated with unsafe recruitment practices because the provider could not demonstrate that they ensured that only suitable people were employed at the service. Regulation 19(2)(a)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services were not protected against the risks associated with the inadequate number of staff available to meet their care needs and to keep them safe.

This section is primarily information for the provider

Enforcement actions

People who use services were not protected against the risks associated with the inadequate provision of training and supervision for staff members to ensure their health and care needs were properly met.

Regulation 18(1)(2)(a)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People who use services were not protected against the risks associated with a lack of consent, application of the Mental Capacity Act 2005 and associated code of practice. Regulation 11(1)(2)(3)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People who use services were not protected against the risks associated with a lack of dignity and respect in relation to the way they were being regarded, having their individual needs and preferences met, being supported to enhance their independence and having access to their local community. Regulation 10(1)(2)(b)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	People who use services were not protected against the risks associated with ineffective systems resulting in unsafe and inadequate monitoring and assessment of the quality of the service provided. People who use services were not sufficiently protected because the provider did not take action to assess, monitor and mitigate identified risks. People who use services were not protected against the risks associated with inadequate record keeping because some records were inaccurate and some had not been completed. People who use services were not protected against the risks associated with a lack of recording in relation to care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. People employed in the service were not protected against the risks associated with the insecure storage of personnel records. People who use services were not protected against the risks associated with not being able to provide feedback regarding the quality of the service, in order to highlight shortfalls and help drive improvement. People who use services were not protected against the risks associated with the provider's failure to ensure that their audit and governance systems remain effective. Regulation 17(1)(2)(a)(b)(c)(d)(e)(f)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour People who use services were not protected against the risks associated with receiving care and support in an environment where the provider did not demonstrate or promote a culture of candour, openness and honesty. Regulation 20(1)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 8 HSCA (RA) Regulations 2014 General People who use services were not protected against the risks associated with the provider's failure to "…meet every regulation for each regulated activity they provide…", as required under the HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3). Regulation 8

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.