# Hamilton Care Limited

# St Helens

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
St Helens is a residential care home providing personal and nursing care for up to 28 older people, some of whom have mental health conditions or dementia. At the time of this inspection 18 people were using the service.

People's experience of using this service and what we found
Robust quality assurance systems were not established or operated to monitor the quality and safety of the service provided. There was ineffective provider oversight and where concerns had been found, timely action had not been taken to address them.

The provider failed to follow their own improvement plan to ensure they were meeting regulations and providing safe care.

People were not always safe. The provider had not taken action to address maintenance, safety and infection prevention and control issues around the service. Risks to people were not always recognised or appropriately assessed. Medicines storage was inappropriate, and prescriber instructions had not always been followed.

Safe recruitment processes were not always operated. Staff had not received consistent support or had their competencies assessed to ensure they had the appropriate skills and knowledge to carry out their role.

Appropriate support had not always been provided to ensure people's nutritional needs were being met. Monitoring documents had not been completed sufficiently.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Signed consent was not always in place. Where people lacked capacity appropriate capacity assessments had not been completed.

For more details, please see the full report which is on the Care Quality Commission website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 12 November 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the safety of the building, risk assessing and nutrition management as

well as the governance of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Helens on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safety of the service and risk assessing, nutrition, consent, safe recruitment and governance systems at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Since the last inspection we recognised that the provider had failed to ensure a manager registered with the Care Quality Commission was in post. This was a breach of regulation and we are dealing with this outside of the inspection process.

Follow up
We will continue to monitor information we receive about the service and we will continue to work with partner agencies. We will work alongside the provider and the local authority to closely monitor the service. We will return to visit in line with our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six  months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions 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.

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

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not safe.<br>Details are in our safe findings below. | **Inadequate** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our effective findings below. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not well-led.<br>Details are in our well-led findings below. | **Inadequate** |

# St Helens

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The first day on inspection was conducted by two inspectors. One inspector returned for the second day of inspection.

Service and service type
St Helens is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission and we are dealing with this outside of the inspection process. A manager was in post, but they were not registered. We have referred to them as 'the manager' throughout this report.

Notice of inspection
This first day of inspection was unannounced. The second day was announced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and other professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to

send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with five members of staff including the manager, provider, nurses and care staff. We also spent time observing staff interactions with people and conducted a tour of the service.

We reviewed a range of records. This included ten people's care records in part and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records and policies.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people were not consistently assessed and recorded. For example, the risks posed by open staircases and single pane glass windows had not been considered.
- Where risks to people had been identified, appropriate action was not taken to mitigate risks. For example, people who were at risk of choking were left unsupervised at lunch time.
- Checks to ensure the service and equipment remained safe were not sufficient. A number of significant issues were found which placed people at increased risk of harm. For example, exposed wiring and blocked fire exits. We asked the provider to take immediate action to address this.

Failure to assess the risk to the health and safety of people and do all that is reasonably practicable to mitigate such risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- Lessons had not been learnt when things went wrong. Concern with regards to single pane windows, open staircases and the use of portable heaters had been highlighted to the provider at previous inspections, but they had failed to take appropriate action.

Failure to assess the risk to the health and safety of people and do all that is reasonably practicable to mitigate such risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were not assured that the provider was meeting shielding and social distancing rules. Chairs were not positioned to promote social distancing and staff did not follow social distancing guidance.
- We were not assured that the provider was using PPE effectively and safely. PPE was not stored appropriately, and staff did not change their PPE as and when required.
- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were somewhat assured that the provider was accessing testing for people using the service and staff. However, appropriate consent was not in place.

Failure to ensure guidance was implemented in relation to the prevention and controlling of the spread of infections was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were assured that the provider was admitting people safely to the service.

Staffing and recruitment
● Safe recruitment processes were not followed.
● Staff did not have full pre-employment checks completed prior to working at the service. Full employment history and sufficient references had not been obtained before employment commenced.

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

● Observations showed there was a sufficient number of staff on duty.

Using medicines safely
● Medicines were not always stored, recorded and administered safely.
● The medicine storage room contained clutter and was unkempt; some items were inappropriately stored.
● Medicine records did not always provide clear guidance with regards to administration instructions.

Failure to maintain complete, accurate and contemporaneous records is a breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes were in place to safeguarding people from the risk of abuse; these had not always been followed.
● Staff had completed safeguarding training, but their knowledge was lacking with regards to when to raise concerns.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The principles of the MCA had not been followed.
- Appropriate signed consent was not always in place. Where people lacked capacity, decisions made in a person's best interest were not recorded in accordance with the provider's own policy.
- DoLS authorisations had not been requested in a timely manner resulting in people being unlawfully deprive of their liberty. Where DoLS contained conditions, these conditions had not been complied with.

Failure to act in accordance with the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
- Appropriate support had not always been provided to ensure people were able to maintain a balanced diet.
- Care records did not provide staff with clear guidance as to the level of fluid people required.
- People did not have fluids readily available to them. There were large gaps in fluid monitoring records so we could not be certain people were provided with fluids on a regular basis.
- Where people were at risk of choking, appropriate supervision with meals was not provided.

Failure to meet the nutritional and hydration needs of people who use the service is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Pre-admissions assessments had been completed prior to admission; the information within these assessments had not always been used to develop appropriate care plans.
● Poor record keeping meant that people's needs, and choices were not always recorded or being met.

Failure to maintain accurate, complete and contemporaneous records is a breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● New staff received an induction to the service. This had not always been completed when employment commenced. For example, one staff member's induction had not been completed until three weeks after employment commenced.
● Staff told us they felt supported. Records in relation to staff support were not sufficient. One staff member commenced employment in February 2020 and no formal supervisions were recorded.
● Observations and assessments to ensure staff had the appropriate skills and knowledge had not been recorded for areas such as wound care and moving and handling.

Failure to maintain complete, accurate and contemporaneous records is a breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff communicated with other professionals when concerns were identified.
● Due to poor records, it was not always clear if the advice and guidance provided was followed.

Adapting service, design, decoration to meet people's needs
● Risks to people in relation to some areas of the service had not been considered. People had access to high risk areas such as staircases and storage rooms.
● Areas of the service needed addressing as they were old and worn and presented a health and safety and infection control risk.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last two consecutive inspections the provider failed to operate an effective quality assurance system and maintain accurate, complete and contemporaneous records. This was a breach of regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Following the last inspection in September 2020 the provider was requested to submit an improvement plan to say what they would do, and by when, to improve the quality and safety of the service. During this inspection we found they had not followed their improvement plan and risks remained.
- Effective quality assurance processes were still not in place. Significant risks to people's safety were identified at this inspection that the provider was unaware of and therefore, had not taken action to address.
- Where checks to monitor the quality and safety of the service had been completed, timely action had not been taken to address shortfalls. For example, windows reported as cracked in January 2021 remained cracked at the time of this inspection.
- There was no registered manager in post. We are dealing with this outside of the inspection process.

Failure to operate an effective quality assurance system, assess, monitor and mitigate risks to people and maintain accurate, complete and contemporaneous records. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- The provider had not taken action to ensure lessons were learnt. They failed to take action to address shortfalls that has been identified to them at previous inspections.
- Action had not been taken to ensure the service was meeting regulations and providing people with the expected standard of care. The service had further deteriorated since the last inspection.

Failure to implement systems or processes that are establish and operate effectively to ensure compliance with regulations is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had not been open and honest. Following the last inspection, they submitted an improvement plan to CQC. This plan had not been followed.
● The provider had not communicated with people to inform them of action they were taking to improve the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others
● Staff were observed providing kind and caring support to meet people's needs. People spoke highly of the staff team.
● Staff told us there was an open culture at the service and they were confident in raising any concerns with the manager. However, they were not confident these concerns would be addressed.
● Guidance from other professionals in relation to COVID-19 had not been followed, which put people at increased risk of harm

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People told us they had been able to maintain contact with their relatives during COVID-19 restrictions and visiting was now taking place.
● The manager had maintained regular contact with relatives via emails and telephone to ensure they were kept up to date.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Section 33 HSCA Failure to comply with a condition<br><br>The provider failed to ensure a registered manager was in post |

**The enforcement action we took:**

Fixed penalty notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider failed to implement and follow the principles of the Mental Capacity Act 2005<br><br>11(1)(3) |

**The enforcement action we took:**

Notice of decision to vary a condition of registration for the regulated activity(s) accommodation for persons who require nursing or personal care and Treatment of disease, disorder or injury

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider failed to assess the risk to the health & safety of people and do all that is reasonably practicable to mitigate such risks including ensuring the premises were safe to use.<br>The provider failed to ensure guidance was implemented in relation to the prevention and controlling of the spread of infections.<br><br>12(1)(2)(a)(b)(d)(h) |

**The enforcement action we took:**

Notice of decision to vary a condition of registration for the regulated activity(s) accommodation for persons who require nursing or personal care and Treatment of disease, disorder or injury

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 14 HSCA RA Regulations 2014 Meeting |

| | |
|---|---|
| personal care | nutritional and hydration needs |
| Treatment of disease, disorder or injury | The provider failed to meet the nutritional and hydration needs of people who use the service.<br><br>14(1)(2)(4)(a) |

**The enforcement action we took:**

Notice of decision to vary a condition of registration for the regulated activity(s) accommodation for persons who require nursing or personal care and Treatment of disease, disorder or injury

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The provider failed to operate effective quality assurance system, assess, monitor and mitigate risks to people and maintain accurate, complete and contemporaneous records.<br>The provider failed to implement effective systems or processes that are establish and operate effectively to ensure compliance with regulations.<br><br>17(1)((2)(a)(b)(c)(d) |

**The enforcement action we took:**

Notice of decision to vary a condition of registration for the regulated activity(s) accommodation for persons who require nursing or personal care and Treatment of disease, disorder or injury

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed |
| Treatment of disease, disorder or injury | The provider failed to operate effective recruitment procedures.<br><br>19(2) |

**The enforcement action we took:**

Notice of decision to vary a condition of registration for the regulated activity(s) accommodation for persons who require nursing or personal care and Treatment of disease, disorder or injury