Elizabeth Finn Homes Limited

Hampden House

Inspection report

120 Duchy Road
Harrogate
North Yorkshire
HG1 2HE

Tel: 01423566964
Website: www.efhl.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place over two days on 30 August and 14 September 2016. The first day of the inspection was unannounced. We gave notice of our visit on the second day of the inspection so that the manager and other key personnel would be available to speak with us.

At our last inspection on 25 and 30 September 2014 the provider was meeting all the regulations that were assessed.

Hampden House is registered to provide nursing care to a maximum of 66 older people. Accommodation in the main part of the building is provided in three nursing and two residential wings set out over two floors. A link corridor on the first floor provides access to further residential accommodation for another nine people located in the adjacent building. On the first day of our inspection 61 people were living at Hampden House.

When we visited there was a new manager in post. The manager was registered as a 'registered manager' by the Care Quality Commission on 12 October 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found management systems and processes were not effective. We identified a breach of Regulation 18 of the Care Quality Commission Regulations 2009 because incidents and events had not always been notified as required to the Care Quality Commission.

Where risks had been identified staff had not always followed the agreed action, to reduce the identified risk. Medicines management was inconsistent increasing the likelihood of errors. Protocols for the use of medicines used on as 'as required' basis were not in place and people had not always received their prescribed medicines in a timely way. People's care records did not always reflect people's health and care needs accurately. All of these matters placed people at potential risk of receiving inconsistent or unsafe care.

We found that there were not always enough care staff to respond quickly to people who needed assistance. Some people living in the residential part of the service required two people to attend to their personal care needs. This impacted the time staff had available to provide appropriate supervision and support for other people in a timely way.

Staff told us they felt they received the training they required. However training records showed significant gaps in training. Systems were in place to ensure staff received regular supervision and appraisals and staff told us this aspect was improving under the new management.

Good recruitment procedures were followed which made sure checks including checks for the nursing staff

with the Nursing and Midwifery Council (NMC) had been completed before new staff started work.

Appropriate arrangements were in place to respond to safeguarding incidents.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and acting within the legal framework of the Mental Capacity Act (MCA). However, records on MCA and DoLS were not well maintained. Information we received from staff suggested that they were not routinely using capacity assessments in their day to day decision making. We have made a recommendation to improve staff learning and understanding of the MCA.

People spoke positively about staff kindness and patience. We saw people had access to healthcare professionals such as GPs and district nurses. People told us they were treated with respect and this was confirmed in our observations. There was a relaxed and friendly atmosphere and we saw staff were attentive at the mealtime we observed. We saw mealtimes were a pleasant and sociable occasion with people being offered a choice of meals and drinks.

People could follow their own interests and pursuits. A range of activities were available and we were told of plans to increase the provision of these after consultation with people living there.

People were aware of how to make a complaint and we saw complaints dealt with by the service had been responded to appropriately. Two complaints were being investigated by head office and these were on-going when we visited. Not all of the issues people spoke to us about had been examined through the complaints procedure and these were referred back to the manager for investigation and resolution.

We found there was a willing and committed staff team. The new manager was enthusiastic and keen to make improvements. However, the effectiveness of some of the quality assurance systems required improvement, which is evident from the breaches we found at this inspection.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014: Regulation 12 (Safe care and treatment), Regulation 18 (Staffing), and Regulation 17 (Good governance). You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Systems and processes in place to manage and reduce risks were not effective. Medicine handling was not consistently safe.

Staff were busy and under pressure to complete essential tasks and to respond to people in a timely way.

Good recruitment processes were followed, to minimise the chance of unsuitable staff being employed.

The manager knew how to respond to safeguarding concerns, to keep people safe.

Systems were in place to maintain the premises and the equipment and address any repairs required.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff had received the up to date training they required to fulfil their roles. We have recommended staff understanding is improved in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were met.

People's healthcare needs were assessed and people had access to a range of health professionals.

Is the service caring?

Good

The service was caring.

People told us staff were thoughtful and attentive. We observed staff were kind and patient.

People's privacy and dignity was respected by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff knew about people's individual needs. However, care records did not always clearly reflect people's current needs or detail the support they had received.

Activities were provided and future improvements included proposed plans to involve people's ideas.

A system was in place to record, investigate and respond to complaints. Not all of the issues raised with us had been recorded and investigated using the complaints process.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Management systems were in place to assess, monitor and improve the quality of the service. However, these were not being used effectively to ensure people's safety and wellbeing was safeguarded and promoted.

There was a new manager in post. The manager took quick action to address the areas of concern raised during the inspection.

There was a willing and committed staff team and the management team were committed to making the needed improvements.

Hampden House

Detailed findings

Background to this inspection

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

This inspection took place over two days on 30 August and 14 September 2016. Three adult social care inspectors carried out an unannounced inspection visit on the first day of the inspection. Two adult social care inspectors visited on the second day of the inspection. We gave the manager notice of this visit so that they would be available in the service to speak with us.

Before the inspection the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted local commissioners of the service and Healthwatch to gain their views. Healthwatch ensures the voices of people who use services are listened to and responded to and provides an insight into people's experiences of health and social care issues across the country. We used this information to plan the inspection.

We spoke with the manager, clinical care manager, admissions manager and trainer, the administrator, four nurses and six care staff. We reviewed care records, including support planning documentation and medicine records for seven people. We spoke with 12 people who used the service and with three relatives. Because some of the people living in the service could not speak to us directly about their care we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed records relating to the management of the service such as staff recruitment and training for six staff; policies and procedures developed and implemented by the provider; quality assurance systems; survey responses and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

We found that systems and processes in place to manage risks were not always effective and did not always highlight possible hazards. For example, some doors had signs which stipulated they needed to be kept locked at all times. This included doors to sluice areas and to store cupboards where hazardous substances may be stored. During our visit we saw a number of these were unlocked potentially placing people at risk of harm. On our arrival we witnessed staff had started to run a bath, which was then left unattended with the door wide open. When asked about the reason for this staff told us baths were fitted with sensors which would prevent the water overflowing. However, this practice did not take account of whether people were liable to enter the room and get into the bath unsupervised.

We observed one person had visible facial bruising from an incident that had occurred a month previously. Staff told us this was as a consequence of an un-witnessed fall on 28 July 2016. Records showed the person had been found on the floor in their room, and it was surmised the person had fallen from bed. Staff reported protective measures had been put in place. They told us this included the use of a mattress (or 'crash mat') next to the person's bed, to prevent further injury. However, when we visited we saw the crash mat was propped against the wardrobe even though the person was in bed at the time. In addition, we saw that the brakes on the person's bed were not engaged thus making the person at further risk of falls. We drew this matter to the attention of a care worker at the time, to make sure the person was safeguarded.

We discussed this with the manager who took appropriate action when we brought these matters to their attention. However, we were concerned that these risk factors had not been identified prior to our intervention.

We checked on the arrangements for the safe storage and administration of medicines. We looked at a sample of medicine administration records (MARs) and observed how medicines were administered. We saw staff were kind and patient; they made sure they gave people time to take their medicines and took time to explain what the medicine was for. However, we observed staff signed the MAR before people took their medicine. This is poor practice and increases the likelihood of errors.

Protocols were not in place or not completed fully for the administration of prescribed creams or medicines that were given 'as required'. Examples included medicines used to reduce anxiety and distress, laxatives and pain relief. For one person we saw that the solution, which they used to soak their legs, had been out of stock for one month. This meant the person had not received their treatment and we asked the nurse in charge to investigate. These issues had not been identified or resolved through the provider's internal audit processes. We discussed this with the manager who told us they would investigate.

We saw in one person's care records that they had sustained a scald on 5 May 2016. Emergency treatment had been followed up and supervised by a specialist outreach nurse from the regional burns unit. On discharge from their care the specialist nurse had given staff advice regarding the use of cream, to keep the scar tissue as soft and supple as possible. We checked the person's records including their medicine administration record (MAR), but could not ascertain whether the cream had been applied as directed

because a record had not been made.

The above issues placed people at risk of receiving unsafe or inappropriate care and treatment. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Medicines were stored safely and securely. Temperatures of the medicines fridge were monitored daily and were within the recommended safety range. We asked people if they received their medicines on time. Although one person told us there was sometimes a delay in getting pain relief in the afternoon and evening, most people reported they did get their medicines on time.

When we asked people about the staffing levels in the home we received conflicting views. While some people felt there were enough staff, others expressed concerns about staffing levels. One person told us, "Sometimes staff do take a while to answer call bells." Other comments we received included, "There are times when it feels like there aren't enough staff," and, "You have to wait for everything doing. I suppose it is the same everywhere." One person said, "Staff are sometimes slower at coming to me in the mornings, but that's because they are busy getting people up. I don't mind."

At the daily heads of department meeting we attended the manager reported they had monitored staff response times over a 24 hour period. They stated 77 calls (20%) were not responded to within agreed response times. When we visited a fault had developed on part of the call bell system making it difficult for us to check if calls were answered promptly in some parts of the service. The manager has since confirmed that this fault has been rectified and that they were keeping response times under review.

Agency care staff were being used and people felt that this had an impact on the care they received. A care worker said, "We have too many agency." Another senior care worker told us, "Some days are a rush. We have agency [staff] and some are good some are not. We are trying to recruit because people have left." They went on to say, "People do have to wait, residents expect to have what they want when they want and we can't always do it."

Records showed that one registered nurse had raised concerns about the safety of the nurses who worked at the service and the people who used the service. They reported having to stay behind after work for a long time to ensure all essential work was completed. One of the nurses told us, "We do the best we can, but people do have to wait." Another nurse said, "We have some good carers, but I agree people have to wait."

We were shown a document titled 'Normal staffing hours' that set out staffing levels for the service. We identified that staff deployment did not always follow these levels. For example, it was stipulated that when 61 people were accommodated one care worker should be allocated to supervise people in the lounge area. When we visited this was not happening and we found that people who were assessed as at risk of falls were not supervised in line with their assessed care needs.

We saw that some of the people living in the residential part of the home were physically and mentally frail and had complex care needs. Staff told us that some people living in this part of the service required two members of staff to support them with their personal care. This included one person who was waiting to be transferred to a nursing bed because of their increased health care needs. This impacted on their ability to provide support to other people in a timely way. Inspectors were informed that people had undergone a care review and were awaiting beds to become available in the nursing wing in preparation for transfer. However staffing levels had not been increased during this period.

The above shortcomings around staffing amounted to a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

The manager told us they were actively recruiting to staff vacancies and they explained the way staff were deployed was under review. For example, they said increased domestic cover was planned to assist with the evening and night time routines. The manager informed us that they aimed to ensure staff worked both day and night shifts in future, to aid team work and good practice. The described changes were due to take place at the end of September 2016.

Safe recruitment procedures were followed. Staff files were well maintained and easy to navigate. They contained evidence that checks had been completed including written references and a criminal record check through the Disclosure and Barring Service (DBS). This helped the provider make safer recruiting decisions and also minimised the risk of unsuitable people working with adults made vulnerable by their circumstances. We saw that where necessary further advice was sought at a senior level to confirm the suitability of a candidate and to undertake further checks if required. Interview notes were recorded and when all documentation had been reviewed a decision was made about employment.

Before their employment a check on the registration of nursing staff was completed with the Nursing and Midwifery Council (NMC). The NMC is the professional regulatory body for nurses and maintains a register of nurses and midwives allowed to practise in the UK. This includes any restrictions that have been placed on the individual's practice. The clinical manager told us they kept a list of the registration renewal dates for nursing staff and prompted staff when these were due. We were told that nursing staff were asked to bring in a copy of these into the administrator. The record for one nurse was not up to date. We discussed this with the manager who carried out the check with the NMC while we were present. They said they would keep a record of regular monitoring checks in future.

The manager told us they had not received any safeguarding concerns. They had a good understanding of safeguarding and how to identify and act on allegations of abuse. This provided us with assurance that action would be taken to keep people safe

There was a health and safety policy in place and the premises and equipment were regularly checked, to ensure they were safe for people to use. When we visited two out of the three passenger lifts and parts of the call system were awaiting repairs. The manager has since confirmed that remedial action had been completed and the lifts and call system were back in working order. Maintenance and safety certificates were in place in areas including electrical equipment, water and gas safety. Regular checks were carried out in areas including fire doors, emergency lights, fire equipment, and fire alarms, to ensure they were safe to use.

There were no specific personal emergency evacuation plans (PEEPs) within the 'fire file' kept at the front desk. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. We discussed this with the manager, who agreed on the benefit of keeping this information centrally and we confirmed on the second day of the inspection that this had been introduced.

Requires Improvement

Is the service effective?

Our findings

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 take 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met. In their PIR the provider told us that 14 people had their liberty, rights and choices restricted by their care plans and were subject to a DoLS authorisation. However, when we visited the manager reported only five people had a DoLS authorisation in place. They told us that people's capacity was being assessed more appropriately as staff understanding about MCA and DoLS had improved. They said this accounted for the drop in notifications.

During our visit we noted that DoLS information was not well organised. When we spoke with staff it was evident that they did not fully understood the principles of the MCA and had not fully understood the importance of using capacity assessments routinely to help with their decision making. For example, one person had conditions for a medicines review and referral to the dietitian. Staff confirmed this had been done however had not linked these to the recommendations from the independent mental capacity advocate (IMCA).

We recommend that staff use current best practice guidance in relation to the Mental Capacity Act.

Staff told us they felt they received the training they needed to meet people's needs. The training manager told us that the annual training considered to be essential by the organisation was MCA, safeguarding, manual handling, medicines training, infection control, cardio pulmonary resuscitation and fire safety awareness, together with three yearly updates on first aid. However, training records sent to us after the inspection showed there were significant gaps in the training staff received including dementia awareness training. During our inspection we identified some people were living with dementia however only 50% of nursing staff had received dementia awareness training. Eight nurses (72%) required training on MCA and manual handling. Six nurses (54%) required medicines training. We spoke with one nurse who told us they had received end of life and infection control training in the past year, which was confirmed on the training records. However, they had not completed DoLS, MCA, medicines handling, and dementia awareness training.

The admissions and training manager said they were addressing training shortfalls with the individual members of staff. Staff confirmed that training sessions had recently been cancelled owing to staff sickness and urgent admissions of people ready for discharge from hospital. After our inspection the provider told us that the training year runs from April to April and at the time of the inspection was four to five months into

the training year. The outstanding training was planned over the remaining seven to eight months which would ensure all staff had undergone appropriate training.

The above shortfalls in training meant that there was a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

Staff told us that they had an annual appraisal and the frequency of supervision had recently improved. They said the manager had encouraged them to undertake supervisions monthly, to support staff development and learning.

During our visit we observed the lunchtime experience. We saw that the dining tables were set with wine glasses and condiments. The menu was on display at the main door. Alternative options were listed for people to choose. People were spoken with respectfully and conversation around the table with one member of staff was jovial. They were discussing the storm that had occurred the previous night. We saw that staff sat with people and gave people discreet assistance with their food as required. All interactions were positive and people were alert and engaging.

One person was reluctant to eat their meal. We saw staff patiently offered other alternatives such as milky drinks or a yogurt to tempt their appetite. This showed us that staff had an understanding of the need to encourage the person to eat. The staff who served drinks knew people's preferences well and they knew people's names. We saw that they gave people a choice and waited for an answer.

The manager explained a new servery had been bought for upstairs. This followed feedback that meals were cold when they reached people if carried from the kitchen downstairs. When we visited this equipment was not being used because the allocated member of staff was in a caring role that day. However, we were told that this equipment would be used once training had been provided to staff.

A visitor had raised concerns about whether their relative sometimes missed out on the mid-morning and mid-afternoon drinks because staff did not always have the time to sit with and help them with their drink. During our visit we observed staff had not offered one person a mid-afternoon drink. When we asked staff about this they explained they did not like to disturb people if they appeared to be resting. We discussed hydration risk assessments with staff, which could be used where people were at potential risk of poor fluid and food intake.

People's care records showed that people's healthcare needs and any medical conditions had been assessed. They provided evidence that people had access to a range of health professionals including district nurses, opticians, chiropodists and GPs. Their advice was recorded within care records to help staff provide appropriate care. A senior care worker said, "The GP visits every week and we send a list of appointments the day before to say who we want the doctor to see when they visit." Staff confirmed this arrangement worked well and meant that people received consistency of care from the same doctor.

Good

Is the service caring?

Our findings

People told us staff were staff were thoughtful and attentive. One person commented, "Staff are wonderful, very attentive to my needs." Another person said, "They [staff] are very concerned and are very helpful in every way." People spoke positively about the care they received. One person told us, "Staff are lovely, very kind and friendly." Another person said, "Staff are lovely, I have a good relationship with them."

We found that staff took an interest in people and knew about their life histories, their likes, dislikes and personal preferences. This helped staff understand the people they were caring for and provide personalised care. One care worker told us, "The best thing about the service is the staff they are all lovely, we try our best and make people feel welcome and it is their home." Another care worker said, "As a senior I watch to see how staff interact with people. I like to work alongside staff and see how they speak to people. I know someone is well cared for when their appearance is clean, dressed well and look tidy, well hydrated and enough food. As a general rule this always happens here."

People told us that staff treated them with dignity and respect. One visitor whose relative was on a short stay at the home told us they had been very impressed with the respectful way staff treated people. Our observations confirmed people respected people's privacy. For example, we saw staff knocked on doors and waited for an answer before entering. For other people we saw they had notices on their doors asking not to be disturbed and we saw that staff respected these.

We observed staff were kind and patient when interacting with people. For example, we saw a member of staff had escorted a person to a hospital appointment. On their return staff made sure they were comfortable had everything they needed, including a hot drink, before leaving them. We saw that staff allowed people to take their time to respond to questions and did not rush them.

We saw written feedback was equally positive. For example, one relative commented on the, "Cheerful, thoughtful and heartfelt kindness and care not only to [Name] but also to us as family." One visitor told us about the special efforts made to celebrate their relative's birthday, which they had very much appreciated. Another person told us, "The lady [staff] who comes in to clean my room knows I love my plants so they take care of them for me."

Care records showed people were consulted about their care and support. People were encouraged to maintain their independence and a number of people told us that they largely followed their own interests and pursuits although they very much appreciated the help offered when they needed it. People could spend time in their own rooms, in the communal areas or outside in the attractive gardens. One person told us, "We have new furniture outside and it is lovely. I like to sit out there or in the conservatory for a change."

No one was currently using advocacy services. However, Care Aware advocacy service leaflet was available on the communal notice board for anyone who would benefit from this service.

Requires Improvement

Is the service responsive?

Our findings

We found that care and support was planned to meet people's individual needs before they were admitted. A preadmission assessment was completed for new admissions including people admitted for short term care. This information was used to devise an initial care plan and information regarding any special requirements was passed to the relevant department before admission. We were told that any individual staff training needs were also identified and met to meet people's individual care needs. For example, for one person staff had received training on the management of a suprapubic catheter. This is a type of indwelling catheter that is inserted into the bladder through the abdomen.

When we spoke with staff we found they were knowledgeable about people and knew their choices and care preferences. However, not all of this information was included in people's care plans and in some cases people had placed notes in their rooms or on their bedroom doors to remind staff about their preferences. Examples included people who did not wish to be disturbed at night and instructions about not placing heavy items on a piece of treasured furniture. We discussed this with staff who agreed more personalised information could be included in people's care plans. For example, staff said they knew one person liked to stay in their room with their door closed and this information could be included.

Care records included an assessment of people's needs in a range of areas such as communication, mobilisation, nutrition and privacy and dignity. All care plans were electronic and in paper form in people's rooms. We found people's care records did not always contain accurate information about their changing care and support needs. This meant there was a risk that inappropriate or inconsistent care would be provided. In addition, we saw that paper records were not well maintained making information confusing and difficult to find. For example in two rooms we saw hospital discharge letters were stored separately in plastic pockets behind the bedroom door. This meant that information could potentially be lost and that people were at risk of not receiving care and treatment as advised by hospital staff. After our inspection we were told these documents are usually stored at the back of individual care plans but are often read and re read by people using the service and their relatives as well as staff. They can become "worse for wear" through continued use.

In their PIR the provider told us they had received 13 formal complaints and 304 compliments in the past year. During our inspection we reviewed the complaints file. The file included a copy of the complaints procedure and a flowchart, which staff handling complaints followed. There was a monthly return of compliments / complaints and this included a category under which they were to be viewed such as catering, staff attitude and laundry. The manager told us that two complaints were being dealt with by head office and the findings from these were not available.

People we spoke with said they were aware of the formal complaints procedure, and said would have no difficulty in raising any concerns. One person told us they had raised an issue and they said it had been dealt with straightaway and felt it had been handled very well. Another person said, "No complaints here."

We found that complaints examined under the formal complaints procedure within the service had been

responded to appropriately and in a prompt manner by staff. However, we identified that some issues we were told about had not always been addressed using the complaint procedure. One visitor told us about a number of concerns they had raised concerning the lack of care their relative received. None of these were in the complaints log when we checked. The manager told us that they had responded to each concern. They said they had written to the family and had met with them. We asked the manager to deal with this as a complaint.

We received mixed views about the social activities in the service. In their PIR the provider told us that the social engagement leaders ensured wherever possible that no one missed out on activities. They stated that individuals were invited to build relationships and networks with the local community including visits by children from nearby schools, local performers, and from a vicar and priest. Some people told us they were able to take part in a range of activities and social events both inside and outside in the local community. However, other relatives felt more could be done for those people who were unable to leave their rooms. The manager told us that they had planned a meeting with people who lived at the service and their relatives, to include their views about planned activities. People had a leaflet which gave a summary of the weekly activities. The manager told us that hanging baskets had been purchased, planted and hung around the home and they planned to purchase a greenhouse so that flowers and some vegetables could be grown and utilised. They told us this was to enhance the social opportunities provided.

Requires Improvement

Is the service well-led?

Our findings

Audits were undertaken and these covered areas such as care records, staff, premises and health and safety. However, we found the auditing process was not always being used effectively, to identify areas for improvement. For example, a medicines check was completed daily and then a monthly sample was undertaken. There was a clear process for staff to follow if they found an error, including the completion of an incident form. However, we found that incident forms were not always completed when a medicine's error was made. Audits were not being used effectively, to ensure action was taken to address identified shortfalls. For example, we found medicine audits had not been completed or were not fully completed. Where issues had been identified action had not been taken to address the shortfalls, which we found when we visited. The provider's audits had not picked up on the issues that we identified and we found that the lack of adequate record keeping was adversely affecting the safe and smooth operation of the service.

An annual quality assurance audit was completed in November 2015. This stated that the Mental Capacity Assessment tool needed to be completed to show who was involved in decision making for people who lacked capacity. It stated, "If residents are deemed to lack capacity after a capacity assessment has been carried out then the appointed representative / advocate should be giving consent to care plans." We saw examples of where this had not happened for people who lacked capacity. It also stated that people had voiced concerns about call time response, which was on-going when we visited. An action plan to address the above actions was not present in the quality assurance file.

The provider's health and safety audit completed in January 2016 identified that unauthorised areas were not kept secure. On the first day of our inspection we observed some doors were not kept locked meaning people could access unauthorised areas. This meant that the action taken had not reduced the risk posed to people using the service or visitors. The audit also highlighted fire drill records were not in place. We discussed this with the manager as training records still did not evidence all staff were undertaking fire safety training in line with the provider's own specific requirements.

We saw further improvement was needed to ensure staff received management support to fulfil their roles effectively. We saw that staff meetings were not being held on a regular basis. The last recorded care staff meeting was held in July 2015 and the last team briefing we saw was dated April 2015. One member of staff told us, "We haven't had a team meeting [recently], not on nights anyway which is where I usually work." We saw that a nurses meeting was held in February 2016 and a senior care staff meeting in January 2016 however notes were not available from these meetings. We discussed this with the manager who said that meetings should take place three monthly.

We looked at accident and incident reports and saw the number of accidents and incidents were reported monthly. It was not clear who was responsible for the analysis of these and the action needed to prevent further recurrences and reduce risks to people was not recorded. We identified incidents, including a scald and falls, which had not been reported to CQC as the law requires.

Failure to submit notification of notifiable incidents is a breach of Regulation 18 of the Care Quality

Commission Regulations 2009. We are pursuing this separately with the provider.

We also identified one of these incidents had not been included as part of the monthly internal reporting systems This meant that the provider would not be able to pick up on trends and themes and take action to reduce the risks to people.

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

There was a new manager in post. The manager was registered with the Care Quality Commission on 12 October 2016. We spoke with the manager and highlighted their duty to tell CQC of specific changes, incidents and events that occur in the service. For example, we identified a number of people living in the service had a diagnosis of dementia however this was not included in the provider's statement of purpose, which specified care provided was for older people only. After our inspection the provider confirmed that the service does not provide specialist dementia care.

The manager displayed an open attitude and told us they were beginning to make progress on the changes they wanted to introduce. One initiative was the daily staff meeting (or 'huddle) which involved all heads of department. This meeting discussed people's progress and information about the service was shared. We observed staff used the meeting to problem solve issues and each department discussed how they could help. At the huddle we attended staff discussed call time responses for the previous day and any which required further investigation.

We found there was a committed staff team and observed a pleasant atmosphere within the service with positive interactions between people who used the service and staff. One member of staff said, "There has been a lot of change with the new manager, which is to be expected. They seem professional and approachable." We received mixed feedback about the proposed changes however staff agreed the manager was making progress. One staff told us the manager had listened to them about the proposed rota changes and had taken their view into account.

Although we identified areas that required improvement people told us they felt safe and well cared for. People's views on the quality of the service were sought and the provider told us in their PIR that the results of these surveys would be shared more widely in future. The manager confirmed they were hoping to consult much more widely with people living at Hampden House and include them in decision making about the running of the service including decisions on staff recruitment. We saw that action had been taken in response to concerns voiced about food being cold when it was served upstairs and a new servery purchased. One relative said, "I have absolute confidence in the home, I can leave Mum here and not worry that she isn't safe and well cared for." Another relative told us, "I feel she is safe, I am reassured that they look after her well."

We reviewed the responses from a provider survey and found the responses were positive demonstrating people's satisfaction with the quality of the care they received. When we asked about the manager one person said to us, "The manager pops in to check everything is okay and I think [they] would take action if I wasn't happy about something." Another person said, "My friend told me the manager has been in at night to check up on staff. I think that's really good."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not provided with care and treatment in a safe way because risks, including risks relating to the proper and safe management of medicines, were not being assessed and managed properly. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The management systems in place to assess, monitor and improve the quality of the services were not effective. Records were not effectively maintained to ensure the health, safety and wellbeing of people. Regulation 17 (1) (2) (a) (b) (c) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Suitably trained staff were not provided in adequate numbers to make sure people could receive prompt, timely assistance when needed. Regulation 18 (1) (2) (a)