Parkcare Homes (No.2) Limited

# Hamilton House

**Inspection report**

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## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Good** |
| Is the service safe? | **Requires improvement** |
| Is the service effective? | **Good** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Good** |
| Is the service well-led? | **Good** |

## Overall summary

Hamilton House provides accommodation and personal care for up to six people with learning disability and mental health needs. This inspection took place on 22 and 29 October 2015. The inspection on the 22 October 2015 was unannounced, however, on our arrival there were two sets of external contractors on site. Due to the nature of the people who lived at Hamilton house, it was agreed that having so many unfamiliar people at the home could have a negative impact on people. We made the decision to continue our inspection on the 29 October 2015, where we provided short notice to the provider.

There were five people who were living at Hamilton House on the day of our visit.

At the time of our inspection there was no registered manager in post. The provider was in the process of recruiting a new manager, during this time a manager from the providers organisation had been managing the home for five weeks. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

# Summary of findings

'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.

People did not always live in a safe environment as staff did not always know how to protect people from the risk harm. Staff did not always take actions to minimise risks to people who lived in Hamilton House. We found that people's medicines were not always managed in a way that protected people from risk of potential harm. The provider had identified medicines management as areas for improvement.

Staff recognised signs of abuse and knew how to report this. Relatives and staff told us there were enough staff to provide care and support to people.

Staff were supported by the deputy manager to use their knowledge and learning from past incidents to carry out their roles effectively so that people received care in the right way. Care and support was provided to people with their consent and agreement. Where it had been deemed that the person did not have the capacity to make decisions on their own behalf the provider had taken steps to ensure the Mental Capacity Act (MCA) had been followed. We found people were supported to eat a healthy balanced diet. We found that people had access to healthcare professionals, such as their doctor or the dentist.

People and their relatives were involved in planning their care. People's views and decisions they had made about their care were listened and acted upon. We found that staff treated people kindly, with dignity and their privacy was respected.

People were supported to continue their hobbies and interests that was individual to them. The provider actively sought information from people's family members to gain greater knowledge around people's personal likes and dislikes.

Information was provided to people in how they could raise a complaint should this be required. Relatives told us that they would know how to make a complaint and felt comfortable to do this should they feel they needed to. Where the provider had received complaints, these had been responded to. While there were no patterns to the complaints, learning had been taken from complaints received and actions were put into place to address these.

People, relatives and staff felt supported by people in management and the provider. They felt that they were listened to. The provider had identified and had begun address shortfalls that they had identified through their checks.

# Summary of findings

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

We always ask the following five questions of services.

**Is the service safe?**
The service was not always safe.

People were not always protected from harm and risks to people had not always been identified. People were supported by sufficient numbers of staff to keep them safe and meet their needs.

**Requires improvement**

**Is the service effective?**
The service was effective.

People were supported by staff who had the knowledge to provide care and support to people. People received care they had consented to and staff understood the importance of this.

**Good**

**Is the service caring?**
The service was caring.

People's decisions about their care were listened to and followed. People were treated respectfully. People's privacy and dignity were maintained.

**Good**

**Is the service responsive?**
The service was responsive.

People received care that was responsive to their individual needs. People's concerns and complaints were listened and responded to.

**Good**

**Is the service well-led?**
The service was well-led.

The provider had identified areas for improvement and had put plans in place, which were being addressed. People, relatives and staff felt supported and listened to by those in management.

**Good**

# Hamilton House

**Detailed findings**

## Background to this inspection

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

This inspection took place on 22 and 29 October 2015. The inspection on the 22 October 2015 was unannounced, however, on our arrival there were two sets of external contractors on site. Due to the nature of the people who lived at Hamilton house, it was agreed that having so many unfamiliar people at the home could have a negative impact on people. We made the decision to continue our inspection on the 29 October 2015, where we provided 24 hours' notice to the provider.

The inspection team consisted of one inspector and one specialist advisor who specialises in mental health.

As part of the inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also spoke with the local authority about information they held about the provider. The local authority informed us that they had undertaken a number of visits to the service and were working with the provider to complete outstanding actions to improve the quality of the service.

We spoke with two people who used the service and two relatives. We also spoke with three staff, the deputy manager, the manager and the provider. We looked at three people's care records and two people's medication records and the staff daily handover log. We also looked at, the providers action plan to improve the service provision, environment and maintenance checks, complaints and compliments, incident and accident audit, three staff recruitment records and all staff training records.

Requires improvement

# Is the service safe?

## Our findings

Prior to our inspection we had received information of concern from members of the public regarding people who lived at Hamilton House. For example, people leaving the home without staff to support them. On arrival to the home we found one person outside of the grounds without a staff member with them.. We observed one person run across the road, without a staff member supporting them to safely cross the road. This put the person at risk of injury as staff told us that the person was unaware of potential dangers, such as cars. It was written in their care records that constant supervision was required to maintain their safety while outside of the home. The manager advised us that all people who lived in Hamilton House required supervision by a staff member when outside of the grounds.

We found that the garden gate was not always securely locked and saw people leave the grounds when they wanted, without the staff supervision that had been assessed as the most appropriate method to keep people safe. We raised our initial concerns about people's safety outside of the home and that the garden gate was not locked as per the services protocol. Upon raising these concerns the manager secured the garden gate immediately.

Risks to people were not always managed to protect people from harm. For example, on the first day of our visit, the fire alarm sounded, people and staff vacated the home, however, not all people were accounted for. Staff were not supervising the people they were assigned too and one person's behaviour began to escalate. This resulted in the person becoming agitated and going back into the home before it had been deemed safe. While this fire alarm was a false alarm, staffs lack of prompt actions during this time demonstrated that they were unclear of the correct procedures to keep people safe in the event of a fire.

Following the incident we spoke with the manager about how the situation was managed, where they agreed that this was not a safe evacuation. On our return to the home, we spoke with staff about the incident and what they had learnt from this. Staff, the deputy manager and the manager gave a consistent message and had clear understanding of what should happen in the event of a fire alarm sounding. We found that measures had been put into place, such as clear evacuation guidelines for staff to follow for each person living in the home.

We escalated our concerns found on the first day with the provider of the service who visited the home immediately. They provided us with re-assurances that action with immediate effect had been put into place to keep people safe.

All of above evidence supported this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

On the second day of our inspection we spoke with staff about how they kept people safe. Staff told us that since our first visit they had been given clear guidelines as to what it meant for people who were under constant supervision while outside of the home. A staff member told us that the previous manager had scheduled staff to supervise a person for two hours, before changing with another staff member. They told us, "We didn't know who was supervising who; it's a lot clearer now as we support one person for six hours". We found on our second day that staff supported people to be safe and remained in control of situations that put people at potential risk. For example, the garden gate was locked at all times, when a person wanted to go out, a staff member was with them to unlock the gate and support them outside on a one to one basis.

Relatives raised no concerns about the management of people's medicines. We spoke with one staff members about medicines. They confirmed that they had received training and their competency was regularly checked. We spoke with the manager who confirmed that only staff who were trained to do so administered people's medication. They told us that during a spot check of people's medication a shortfall had been identified in relation to a member of staff practice. The manager told us and we found that the person had been provided further training and supervision before being signed off as safe to administer medication to people.

The manager told us that the record keeping of medication was an area identified by the provider as an area that required improvement. We found that records had not been maintained in a way that was clear and easy to understand. For example, we found conflicting information in one person's care and medication records about what they were allergic to. In one record it said they were allergic to a particular type of medication and in their medication

Requires improvement

# Is the service safe?

record they had been prescribed the medication. While this medication was an, 'as required medication' and had not been used, it put the person at an unknown potential risk of harm.

Three staff who we spoke with showed a good awareness of how they would protect people from harm of abuse. They shared examples of what they would report to management or other external agencies if required. One staff member told us about the safeguarding training they had received and how it had made them more aware about the different types of abuse. We found that safeguarding information was on display at the home. We found that the manager had a good awareness of the safeguarding procedures and worked with the local authority.

We asked one person if they felt there were enough staff on duty and they replied that there were. We spoke with two relatives who did not have any concerns with the staffing levels. One relative told us that their family member had one to one support as it was required. Staff did not hurry people and allowed people to do things at their own pace. There were staff within the communal areas and they responded promptly to people's requests for assistance while maintaining people's independence.

We spoke with two staff members who felt there were enough staff on duty in the day and night to keep people safe. One staff member said, "We have enough staff, staffing levels are good and the deputy manager has got staffing sorted'. Another staff member said that, while they have never needed to, if they needed extra assistance in the night, there was always a manager on-call who would be able to provide them with the support. A staff member told us that the team worked together and went onto tell us that the deputy manager was visible within the home should they require further support.

The manager told us that staffing levels were determined by people's individual needs. They told us that all people required constant supervision during the day, and they planned their staff schedule around this. They told is that they used their own staff where possible to cover absences that were unplanned. They went onto say that when agency staff were used, they would use the same agency staff. The manager showed us how they used a one page profile of the people who lived in the home, so that any agency staff could easily read and gain a good understanding of the person's needs. They added that the agency staff would work alongside a permanent member of staff who knew people well. The manager told us that they were recruiting new staff to fill the staff vacancies and had received a good response.

We saw records of checks completed by the provider to ensure staff were suitable to deliver care and support before they started work for the provider. Staff we spoke with told us that they had completed application forms and were interviewed to assess their abilities. The provider had made reference checks with staff previous employers and with the Disclosure and Barring Service (DBS). The DBS is a national service that keeps records of criminal convictions. The provider used this information to ensure that suitable people were employed, so people using the service were not placed at risk through recruitment practices.

Good

# Is the service effective?

## Our findings

One person gave the thumbs up, when we asked if staffed cared for them in the right way. Two relatives who we spoke with told us that staff were good at what they do. One relative said, "(The person) is very contented here". All relatives we spoke with agreed that the staff met the needs of their family member and that it was done so in the right way.

We spoke with staff about their training and support that they receive in order to provide effective care. Staff told us they had received training that was appropriate to the people they cared for, however had not always been supported by previous management. For example, two staff members told us how they had received training in how to manage challenging behaviour but had not always had the support and confidence from those in a leadership role to utilise their knowledge. The deputy manager, who had been in post for four weeks, told us that they were continuing to build staffs confidence so they were able to use their skills they had learnt. The deputy manager told us that they worked closely with staff in making decisions about how best to support and carry out their role effectively. They went onto say that they had been booked onto training courses in areas for behaviors that challenge so they could further support and share their knowledge with staff.

We spoke with a staff member who had recently begun working for the service. They explained to us that initially they had felt they had been, "Thrown in the deep end". However, they went onto say that since the arrival of the new deputy manager they had felt more supported in their role and their knowledge had developed. They told us that the manager and deputy manager were supportive and that they would only work alone when they felt ready. They told us that they had not provided care tasks until they had received the training and had been assessed to be competent to undertake that role. We spoke with the manager who showed us how they ensured the staff member was utilised within the team, so that they were not put in the position of undertaking tasks that they had not been trained to do.

Staff told us that they worked together and had good communication on all levels. They said they would spend time talking with people to get to know them. One staff member said, "I have read the care files, but you get to know the people by talking and asking them questions". The manager showed us a record which staff were to read before each shift, which updated them on the most current information, so that information and messages were shared with all staff.

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.

We saw that staff sought people's agreement before carrying out any personal care and staff respected their wishes. Staff we spoke with understood their roles and responsibilities in regards to gaining consent and what this meant or how it affected the way the person was to be cared for. Staff told us they always ensured that people consented to their care where they had the capacity to do so. One staff member said if a person refused they would ask them later.

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. The application 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.

The manager, deputy manager and staff had an understanding of the MCA process and regular reviews for people where it had been identified that they lacked capacity or that this fluctuated. They had taken steps to determine who had legal responsibility to make decisions for people where they lacked capacity. We found that the manager had sought advice from the local authority when they had considered a person may be deprived of their liberty. Where people were being deprived of the liberty, applications were submitted to enable staff to restrict people of their liberty in a way which was legal. For example, we found that staff encouraged people to maintain a healthy and balanced diet. Staff had identified that one person would consume large quantities of fizzy pop and chocolate. We saw that a MCA had been completed and a best interest decision was made to

Good

# Is the service effective?

ensure the person maintained a healthy balanced diet to maintain the person's weight and keep them healthy. Staff we spoke with knew that this restriction was in place and how this was maintained.

We found that people were supported to maintain their independence and would plan, prepare and cook their own food. Staff spoke of how people were given the choice of cooking in the home or going out for a meal if they wished. We saw that when one person requested a particular type of food they were supported by a staff member to go shopping for this item. We saw people were encouraged to make their own drinks throughout the day and staff ensured people had drinks to hand. Staff we spoke with explained that people were independent in maintaining their fluid levels, but went onto say that should this change they would contact the person's doctor.

At the time of our inspection the provider was making changes to the kitchen and dining area within the home, which provided people more options about where they could eat their food. Staff spoke of the support they offered people to eat out as part of their planned activities outside of the home.

The manager and staff told us about the close working relationships that they had with external healthcare professionals. All staff we spoke with spoke about how this knowledge was individual to the people they cared for, so they were able to provide the most tailored personalised care and support for the person's needs. Staff were aware of people's healthcare appointments and ensured that people made these appointments where they had been arranged. People had regular appointments with the doctors, optician and dentist and staff followed the guidance given at these appointments.

Good

# Is the service caring?

## Our findings

We asked one person if staff were kind and caring towards them, they told us that they were. One relative told us how their family member had, "Settled well into the home, but two staff members who were 'special carers' had left". They went onto say that they now have a new key worker who had planned to visit the family home. This was so they could gain a greater insight into the person's individual needs and understand what their hobbies and interests were to enable them to support them.

Throughout the inspection we saw that staff were kind and caring towards the people they cared for. Staff we spoke with knew people well. They spoke about people as individuals and told us about how people's independence was promoted, for example, making their own drinks, to tidying bedrooms, to going places where they wanted to go.

Staff told us how they worked with people to ensure their views about their care and support were listened to. Staff provided an example of a person whose temperament would fluctuate. They told us of the initial signs they would look for to indicate the person was not enjoying a particular activity that they were doing. Staff knew the person well and knew what activities the person enjoyed so they would offer the choice of the person's favourite activity. They told us that when this happened the person would be calm and settled.

We saw that people were supported to make their own decisions about their care, where possible, and that their wishes were respected. For example, people had planned a day trip out; however, some people had changed their mind before they had left. This was respected by staff, who helped them think of alternative places they may like to visit instead. Relatives told us that they felt involved and listened to. One relative said, "I have been involved from the beginning in talking about what care (the person) needs". Another relative we spoke with told us that the person was well looked after and supported the person well.

People were supported and encouraged to maintain relationships with their friends and family. Relatives we spoke with told us they could visit as often as they liked and were able to take the person out for the day or where able to make plans for the person to visit the family home over a weekend or holiday period.

We saw people were treated in a dignified manner and people were spoken to in a respectful way. While people received supervision within the home and garden, it was done so in a way that was unobtrusive while still maintaining their safety within the home. People had the choice to stay in their room or use the communal areas if they wanted to. Where staff were required to discuss people's needs or requests of personal care, these were not openly discussed with others. Staff spoke respectfully about people when they were talking to us or having discussions with other staff members about any care needs.

Good

# Is the service responsive?

## Our findings

People and their relatives were involved in the development and review of their care. A relative told us how they could talk to staff at any time. They told us they felt staff understood their family member's needs and provided appropriate support in response to them. One relative said, "(The person) is fully supported with their independence and choice of activities". Relatives told us that they felt involved with their family members care and could speak with the deputy manager should they need to.

We found that people's needs were assessed and reviewed when these needs changed. The service worked with external healthcare professionals to ensure that individuals were receiving the care and treatment was planned and delivered in line with their individual care plan. For example, when one person's mental health needs had changed staff worked with the positive behaviour specialist nurse. This provided staff with techniques to ensure that the person was understood. For example, they introduced a card system, which the person could show to staff, so staff were clear what outcome the person wanted, rather than asking questions and making the person become frustrated. Staff told us that this technique had been working well for the person. One staff member said, "Things are much calmer, as (the person) feels more in control of the situation".

Staff knew people well and their likes and dislikes. This information was initially found from assessment of the person's care and then through continual communication, such as visiting family members to gain more insight. Staff gave examples of how one person enjoyed going out for drives and they took the person most days. Another staff member told us of a person who enjoyed swimming and told us that they would take the person swimming at least three times a week.

We spoke with staff about some people's care needs. All staff we spoke with knew about the person's health care needs and what support the person required. Staff told us that it was a small home and good communication and hand-over information between staff meant they were kept up to date with the most recent information. Staff told us that they would speak with the person to ensure they were providing care to them the way in which they preferred. Relatives we spoke with told us that staff always respected people's decisions about their care.

Relatives and staff felt confident that something would be done about their concerns if they raised a complaint. A relative said the deputy manager was, "Very approachable and always says come and speak if there is a problem". They told us that when they raised a concern once it was sorted immediately.

The provider had a complaints procedure for people, relatives and staff to follow should they need to raise a complaint. We found that the provider had provided information to people about how to raise a complaint. This information gave people who used the service details about expectations around how and when the complaint would be responded to, along with details for external agencies were they not satisfied with the outcome.

We looked at the provider's complaints over the last 12 months and saw that two complaints had been received. We found that these had been responded to with satisfactory outcomes for the people who had raised the complaint. There were no patterns or trends to the complaints raised however we did see systems were in place that showed lessons had been learnt. For example, developing a clearer more robust system for identifying when routine appointments, such as the dentist or opticians were in place, so that appointments are not missed.

Good

# Is the service well-led?

## Our findings

It was recognised that there had been a lack of consistency with the management of the home which staff told us had impacted on the service provision. Over a period of 12 months there had been three managers at the home. The previous registered manager had left their long-standing post and a new manager had been appointed who worked at the service for six months. At the time of our inspection the provider had appointed a manager from within their organisation to cover the post. The manager told us that they would remain in post until a permanent manager was recruited and had settled into their new role. They told us that the provider was in the process of interviewing for a permanent manager for the service.

We spoke with the deputy manager who had been in post for four weeks. They said, "You could see there wasn't the leadership the staff needed". And went onto say that, "Staff haven't had any direction". The deputy manager told us that all staff were having one to one conversations with them and individual action plans had been drawn up as a result of this. They said, "We want people to be confident, we are retraining people, rather than taking their role away".

Staff told us that there had been many changes with management, however felt confident that the manager and deputy manager would support them. One staff member said, "They are top notch". All staff we spoke with told us they felt supported by management and had seen an improvement over the last four weeks since the deputy manager and new manager had been in post.

Relatives we spoke with knew who the manager and deputy manager were and told us they felt that all people in management were open, approachable and responsive to their requests.

The provider had checks in place to continually assess and monitor the performance of the service. We found the checks undertaken looked at ways to involve people and their relatives to gain knowledge and understanding into people's personal preferences. Through conversations with relatives and staff this work had already begun.

The provider had identified areas that required improvement and had developed an action plan to address these. The manager, who had been in post for five weeks, told us that they were working alongside the provider to complete the action plan. We found that identified shortfalls were in the process of being addressed.

Following our inspection on day one, management had responded to our initial concerns about people's immediate safety and had drafted an action plan that had commenced immediately. On the second day of our inspection, it was acknowledged that management had put measures in place and prompt action to improve the quality of the service had taken place. Management acknowledged that further work was required to improve the quality of care in the home and expressed their passion for getting this right for people. While management has provided positive assurances to improve the service, it was recognised that time was needed to embed these changes and future tests to check the sustainment of this would be required.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>People who use services did not receive care that kept them safe from harm. Regulation 12 (2) (b) (c) (d). |