Krinvest Limited

The Hamiltons Care Home

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 caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This comprehensive inspection took place on 28 April 2016 and was unannounced.

The Hamiltons Care Home is registered to provide personal care and support for a maximum of 18 people. At the time of the inspection, there were 17 people living at the home and one person was in hospital. The home is situated close to Atherton town centre and other local amenities. All rooms at the home were for one person but there were two adjoining rooms that could be made into a double room if this was required. Six rooms had en-suite facilities and all rooms had a hand wash basin. Toilets and bathrooms were in close proximity to bedrooms and communal areas. There is a small car park at the front of the home.

At the last inspection on 12 January 2016 the service was given an overall rating of requires improvement. At that time we found the provider had not made the required improvements in relation to three of the regulations that were outstanding breaches which were identified at the previous inspection on 23 February 2015 relating to pre-employment checks for staff; care planning; training and supervision. At the inspection on 12 January 2016, we also found additional breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to systems and process in place to ensure the service was not inappropriately restricting people of their liberty; display of performance ratings; having adequate systems in place to monitor and assess the quality of service provision.

At this inspection on 28 April 2016 we found the provider had not made the required improvements in relation to the breaches identified at the inspection on 12 January 2016 regarding safeguarding, training and mitigating risk. We found 11 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of dignity and respect, safe care and treatment, safeguarding, staffing, person-centred care, good governance and fit and proper persons employed. You can see what action we have asked the provider to take at the back of the full version of this report. We also found one breach of the Care Quality Commission (Registration) Regulations 2009 in relation to the notification of other incidents. You can see what action we told the provider to make at the back of the full version of this report.

People we spoke with who lived at the Hamiltons told us they felt safe living at the home, but one relative said that they felt there were insufficient numbers of staff on duty and they were looking for an alternative home for [their relative].

Appropriate safeguarding procedures were not in place to safeguard people from abuse and the home had failed report five safeguarding incidents to both CQC and the local authority.

There was no formal dependency tool to establish how many staff were needed to support people safely and staff told us they felt that staffing levels were too low. We also observed there were insufficient staff to care for people safely.

People who lived at the Hamiltons sat unstimulated in the lounge area throughout the inspection and with

the last recorded activities taking place on 19 April.

During the inspection we observed these people weren't closely monitored by staff, in accordance with their needs, which could place these people at risk.

Medicines were not managed in a safe way, including four separate instances where medication had been signed as being administered, when they hadn't; an unlocked medicines room door; gaps in the recording of medicines fridge temperatures; two controlled drugs which could not be accounted for in the controlled book; some 'over-stock' controlled drugs were being stored in an unsuitable cabinet.

Bathing and showering records had not been completed since early April 2016. This had also been raised as a concern in the whistleblowing information we received prior to the date of the inspection.

Whilst looking at the accident and incident records, we noted four falls which had occurred in the month of April 2016. As a result of these falls, the recommended action was for there to be a staff presence at all times in order to ensure the safety of these people. However during the inspection we observed these people weren't closely monitored by staff which could place these people at risk.

At our previous two inspections in February 2015 and January 2016, we had concerns with how the home recruited new staff. During this inspection we still had concerns about how the home recruited staff. In one of the staff personnel files we looked at, we couldn't see any evidence of references being sought from previous employers. In two other files we could not see evidence of interviews being conducted and what the responses from applicants had been to the questions asked.

We found the service did not always mitigate risks presented to people living at home. We noted people had environmental risk assessments in their care plans. These risk assessments contained control measures such as all staff being trained in fire safety and the use of an extinguisher; however we found staff had not received this training when looking at training records.

All fire exits in the home also needed to be clear from obstacles, however we observed one exit to be blocked with arm chairs and walking frames in the conservatory.

We noted one person had fallen from their bed during the night. The control measures to be implemented included regular checks during the night. We asked to see evidence that these checks had been undertaken, however the service as unable to produce these.

The décor throughout the home was in need of refurbishment and we saw that a handyman was employed by the service and was undertaking a program of redecoration.

There was no menu displayed in the dining room and everybody had the same meal. We witnessed several poor interactions between staff and people who required support during the lunch time meal, as staff got up from the table on several occasions without explaining where they were going. One of the people affected by this was registered blind.

We saw there were some adaptions to the environment, which included pictorial signs on some doors, such as bathrooms, which would assist people living with a dementia to orientate around the home.

At our last inspection on 12 January 2016 we were concerned about how the service worked within the principles of the MCA and DoLS. We saw there had been eight applications for DoLS made to the supervisory

body prior to the date of the inspection. The manager said seven of these had not yet been authorized. However there was no evidence of capacity assessments being undertaken, where appropriate.

At our last inspection on 12 January 2016, we had concerns regarding staff training and competencies. At this inspection, there was no staff supervision schedule in place. Two staff members told us they had not received any form of regular supervision which they found demoralizing and one staff member told us they had never seen the manager since they commenced in post several months prior to the date of the inspection.

There was no evidence in staff files that the training needs of new staff had been considered. It was not clear that there was any programme of training or support in place to ensure that the requirements of the care certificate were being met.

The people we spoke with told us they liked living at the home and staff we spoke with demonstrated a good understanding of the needs of people living at The Hamiltons. We saw that staff knocked on people's bedroom doors and waited for a reply before entering and they were able to tell us about how they helped people to maintain their independence.

People said they felt treated with dignity and respect. However, we observed one instance where a staff member placed a medicine into a persons' mouth without first asking their permission or explaining what was happening, and another instance where a staff member placed a tabard on one person without asking them first.

People's care files contained information about how staff could effectively communicate with people, for example through non-verbal communication. Care files also contained end of life care plans, which documented people's wishes at this stage of life where they had been open to discussing this.

We looked at the bathing and showering records for all the other people who lived at the home and found extensive gaps in all the records. Although most people's records indicated they had had a 'wash' it was not clear how thorough this was and records indicated that baths and showers were not being carried out frequently for all people who used the service.

Staff told us they struggled to interact and socialise with people due to poor staffing levels at the home and this was evident through our observations.

At our last inspection we raised concerns about pre-admission assessments either not being completed, or lacking in detail. We looked at any pre-admission assessments undertaken since the last inspection. We saw these were completed with good detail.

During the inspection we looked at four care plans and found they were not always reviewed at regular intervals and this was a concern we had raised out our previous inspection.

The manager told us that the service had not received any recent complaints. We could not find a copy of the complaints policy on display but people who used the service and their relatives told us they knew how to complain.

At the time of our inspection, there was a manager in post, but they weren't yet registered with CQC. 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 our previous inspections in both February 2015 and January 2016, we identified several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, some of which were identified as continuing breaches during this inspection. These were in relation to staff recruitment, mitigating risk, safeguarding and seeking consent. We also issued warning notices following our inspection in January 2016, in relation to staffing and good governance. Although there had been different managers working at the home, at each inspection, we found appropriate action had not been taken by the provider to ensure standards were improved at the home. At our last inspection, we raised concerns about a lack of provider oversight at the home. The manager told us the provider had visited the home recently and conducted an audit, but that the findings hadn't been shared.

We looked at what quality assurance systems had been implemented since our inspection in January 2016 and found these to be limited. The manager showed us various blank templates they intended to use going forward, but none were filled in. Additionally, we saw no documented evidence of any observations within the home done by the manager, or checks to ensure staff were competent to give people their medication safely.

The manager provided evidence of some other audits which were stored on a computer in the office. These covered accidents and incidents, bed rails, complaints, pressure sores, infection control, recruitment and weights. However, we had concerns that these audits weren't effective given that any recommended action to reduce falls wasn't followed through and where people required weighing each week, this hadn't been identified as being done.

We were also unable to clearly see what training staff had done, with two members of staff in particular telling us they hadn't been provided with any training since working at the home.

At our previous inspection we also highlighted that things such as residents and relatives meetings hadn't been taking place. During this inspection we saw no evidence that this concern had been acted upon.

During this inspection we had concerns about how the service maintained accurate records of people living at the home. These were mainly in relation to people's food and fluid intake, baths and showers and records of activities in place. We also had concerns with how confidential information was stored. This was because we saw staff personnel files stored in plastic wallets, on the floor in the manager's office. There was also confidential 'return to work' information left on the desk, which could be viewed by anybody in the room and contained private information about people.

During the inspection we brought to the attention of the manager the fact that appropriate alerts and notifications had not been submitted to both the local safeguarding authority and CQC when safeguarding incidents had occurred and we saw five instances during the inspection. The manager told us they would submit these immediately; however as of 9 May 2016, these still hadn't been submitted.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and

work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration. We will report further when any enforcement action is concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Appropriate safeguarding procedures were not in place to safeguard people from abuse. We identified a failure to report five safeguarding incidents to the local authority in line with the service's safeguarding procedures.

Medicines were not managed in a safe way. We identified four separate instances where medication had been signed on the MAR sheet as being administered. We also found two controlled drugs could not be accounted for in the controlled drugs book.

Safe recruitment practices had not always been followed. There was a lack of evidence of references being sought from previous employers for one staff member and in two other files we could not see evidence of interviews being conducted and what the responses from applicants had been to the questions asked.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was no evidence of a formalised staff supervision schedule or supervisions and annuals appraisals having been carried out for some staff members.

The meal time experience was poor for some people who did not receive the identified support required from staff.

Is the service caring?

Good

The service was caring.

Staff we spoke with demonstrated a good understanding of the needs of people living at the home and were able to tell us about their family histories and current preferences.

The people we spoke with told us they liked living at the home and said they felt treated with dignity and respect.

People's care files contained end of life care plans, which documented people's wishes at this stage of life.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not always reviewed at regular intervals. The manager acknowledged reviews had fallen behind and said they aimed to prioritise the completion of these following our inspection.

Pre-admission assessments undertaken since the last inspection were completed with good detail.

Most people were largely unengaged in any meaningful activity throughout the day and there was no activities coordinator in post. Staff told us they struggled to carry out activities in addition to other care and support tasks.

Is the service well-led?

Inadequate

The service was not consistently well-led

Appropriate action had not been taken by the provider to ensure standards were improved at the home since our last inspection.

Quality assurance systems were limited and there were no audits in place to cover areas such as care plans, medication, staff recruitment, staff training, the environment, record keeping, and storage of confidential information.

There was a manager in post, but they were not yet registered with CQC and Statutory notifications had not been sent to CQC as required.

We saw no evidence that concerns previously raised about residents and relatives meetings and the lack of surveys had been acted upon.

The Hamiltons Care Home

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

We carried out this inspection on Thursday 28 April 2016, which was unannounced. This meant the provider did not know we would be visiting the home on this day. The inspection team consisted of two adult social care inspectors from Care Quality Commission (CQC).

In advance of our inspection we liaised with Wigan Council Quality Assurance Team, to establish if they had any recent involvement with the home and to seek their feedback.

We also looked at information such as any notifications we had received either from or about the service. These came in the form of any deaths, safeguarding incidents or any serious injuries. We also viewed previous inspection reports and action plans sent by the service, since our last inspection.

During the day we spoke with five people who used the service, three visiting relatives and one visiting friend. As part of the inspection, we looked around the building and viewed records relating to the running of the home and the care of people who lived there. This included four care plans, three staff personnel files and seven medication administration records (MAR's). We also spoke with the manager, three staff members, a visiting local authority professional and a visiting nurse.

We spoke with people in communal areas and in their personal rooms. Throughout the day we observed how staff cared for and supported people living at the home. We also observed the lunch time meal being served in order to ascertain how people were supported to maintain good nutritional intake.

Inadequate

Is the service safe?

Our findings

The people we spoke with told us they felt safe living at the home. One person said to us: "I feel safe. The building is safe as far as I am concerned and it seems secure." Another person said: "I have never had concerns about my safety and I like living here." However, one visiting family we spoke with did raise concerns about the safety of their relative. They told us: "We are looking to move our relative and have already enquired about it. There simply isn't enough staff, and [our relative] has been hit before by another resident recently and nothing seems to have been done."

We asked staff about their understanding of safeguarding adults. One member of staff said: "It's about making sure all the residents are safe and well and looked after properly. Physical and sexual abuse are some of the types which can occur. I would report anything straight to the manager who would report it."

During the inspection we identified a failure to report five safeguarding incidents to the local authority in line with the service's safeguarding procedures. These included four incidents of physical abuse between people who used the service and another where a person had been verbally abused. Two of these incidents occurred in early April 2016, but the manager said they had only become aware of these on 26 April 2016. These incidents still hadn't been reported appropriately at the time of our inspection on 28 April 2016.The manager told us senior care staff were able to make safeguarding alerts but hadn't done so.

This meant there had been a breach of regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safeguarding. This was because systems and processes had not been operated effectively to prevent the abuse of people using the service. You can see what action we have asked the provider to take at the back of the full version of this report.

Prior to our inspection, we received information of concern about staffing levels at the home, from various different sources. This was also echoed by three staff members and four relatives we spoke with during the inspection. One relative told us: "Once when I visited on Saturday [my relative] asked me to get them a drink as [they] had not had one. I asked a staff member for a cup of coffee and was told there was none in the home and there were only 11 tea bags left and so I had to go and buy some myself. At tea times it's bedlam because there are only two staff members on duty. Once [my relative] didn't have a bath for two weeks and staff said they hadn't had the time. I'm now worried about [my relative's] safety and am looking for another home." Another relative said: "The staff are lovely but there simply aren't enough of them."

We checked to see if there were enough staff working at the home, to meet people's needs safely and looked at the staff rota. On the day of the inspection, we arrived at the home at approximately 6.45am and found the home to be staffed by one care assistant and one senior carer. This was to provide support to 17 people during the previous night from 10.30pm to 7.30am. The day shift commenced at approximately 7.30am to 3.30pm, with staff consisting of the home manager, a deputy manager and two care assistants. These were supported by domestic staff from 8.30am to 1.30pm and kitchen staff from 8.00am to 5.00pm. The home manager told us there was no formal dependency tool to establish how many staff were needed to support

people. Staffing levels were consistent with what was identified on the rota.

Our observations during the day were that staff appeared rushed and were unable to spend time with people in the lounge area throughout the day. One member of staff said: "It is a real struggle at the minute. All I hear is that we are going to get more staff but it never happens. We really struggle to give people baths, showers, do activities and spend quality time with people. Some people would love a few baths a week but we just can't do it."

The issues of bathing/showering had also been raised as a concern in the whistleblowing information we received, with a relative also commenting during the inspection that their family member 'smelled a bit' in recent weeks. The bathing record for this person showed that the last bath taken was 10 April 2016. We looked at bath/showers records that had been completed for April 2016 for all 17 people who lived at The Hamiltons. Two people had no recorded entries for the entire month; two people had only one shower recorded, with the remainder having, on average, two or three baths/showers recorded for the month.

We saw two people needed two members of staff to take them to the toilet and when this happened, the rest of the people were left unsupervised in the lounge area. On two separate occasions we also heard a person shouting out that they were cold, however there were no staff in the room to hear these requests.

One person who lived at the home, who had been involved in several safeguarding incidents, was walking about the home throughout the day of the inspection and despite the best efforts of staff, they struggled to monitor this person throughout the day. This person's care plan stated staff needed to monitor this person closely and 'be vigilant' about their whereabouts. We observed this person, on several occasions, approaching other people who lived at the home and either prodding or poking them and if things had escalated, staff would have been unable to respond due to not being in the room. The manager told us that the service intended to discuss this person with the local authority with a view to finding an alternative home as they felt the service was unable to meet the person's needs.

These issues meant there had been a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Staffing. You can see what action we have asked the provider to take at the back of the full version of this report.

At the last inspection on 12 January 2016 we recommended that the service reviewed guidance in relation to the safe administration of medicines in care homes. At this inspection we looked at how medication was handled to ensure this was done safely. We found medication was stored in a trolley in the staff room, however we noted that it was not securely fixed and had become detached from the wall. This was in contradiction to The Misuse of Drugs (Safe Custody) Regulations 1973. When we arrived at the home in the morning, the keys were also left on top of the trolley. The door to this room was also left unlocked on several occasions meaning people could potentially gain access to medicines, placing themselves at risk. We spoke with the manager about this and shortly after the date of the inspection they contacted us to confirm that the medicines trolley had now been secured to the wall.

We identified four separate instances where medication had been signed on the MAR sheet as being administered, but when we checked the stock we found it was still in the medicines blister pack. One of these medicines could cause a person's blood pressure and heart rate to rise if it is not given. The following day's medication had been given but the manager told us this error had not been brought to her attention. If people do not receive their medication as prescribed then they could be placed at risk. Due to our concerns, we made an alert to the local safeguarding team about these issues.

We saw there was a medication fridge used, which enabled certain medicines to be kept at the correct temperature, however we found daily checks weren't always clearly recorded. This meant staff would be unaware if the fridge dropped to a temperature that wasn't safe.

We also found two controlled drugs could not be accounted for in the controlled book. We saw that the stock check had gone from 84 to 80, with only two being recorded as administered, which meant that two tablets were unaccounted for.

We also found that some 'over-stock' controlled drugs were being stored in a wooden kitchen type cabinet. Although this cupboard had a lock attached this could have easily been forced open which meant people could gain unauthorised access due to it not being secure. This was in contradiction to the requirements of The Misuse of Drugs (Safe Custody) Regulations 1973. The manager was unaware of these concerns and hadn't done any recent audits of medication, or competency checks of staff.

These issues meant there had been a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment. You can see what action we have asked the provider to take at the back of the full version of this report.

At our previous two inspections in February 2015 and January 2016, we had concerns with how the home recruited new staff. This included references from previous employers not always being sought and not always checking why staff had left their previous employment. During this inspection we still had concerns about how the home recruited staff.

During the inspection we looked at three staff personnel files, who had been recruited since our last inspection in January 2016. Each file we looked at contained evidence of a DBS check (Disclosure Barring Service) being undertaken before staff commenced in employment. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people.

In one of the files we looked at, we couldn't see any evidence of references being sought from previous employers. In the other two files we could not see evidence of interviews being conducted and what the responses from applicants had been to the questions asked. The manager told us these people had been recruited before they started working at the home. The manager also told us she had spoken to other staff who had told her they weren't interviewed before commencing employment.

These issues meant there had been an on-going breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Fit and Proper Persons Required. You can see what action we have asked the provider to take at the back of the full version of this report.

At the inspection on 12 January 2016, we found the provider was not adequately assessing or doing all that is reasonably practicable to mitigate risks to people who used the service. At this inspection on 28 April 2016, we found the service did not always appropriately mitigate risks to people who used the service. We observed one radiator and a portable radiator to be turned on and to be very hot. These did not have appropriate guards on them and with several people walking about the home during the day and un-supervised, this posed the risk of them burning themselves. Shortly after the date of the inspection the manager contacted us to confirm they had raised this issue within their organisation with a view to purchasing radiator covers.

We noted people had environmental risk assessments in their care plans. This identified risks such as emergencies, electrical equipment, floors, furnishings and external exits. These risk assessments contained

control measures such as all staff being trained in fire safety and the use of an extinguisher; however we found staff had not received this training when looking at training records. All fire exits in the home also needed to be clear from obstacles. However, we observed one exit to be blocked with arm chairs and walking frames in the conservatory, which a member of staff told us was one of the fire exits in use. The home's policies and procedures also needed to be reviewed regularly, however we saw this hadn't been done since 2014.

At the last inspection on 12 January 2016 we made the fire service aware of our concerns regarding the lack of fire drills and the absence of personal emergency evacuation plans (PEEPS) for people living at The Hamiltons. At the time of this inspection we had not received any return information from the fire service. At this inspection we found the home had an emergency evacuation folder in place which included details of each person living at the home in addition to an emergency evacuation procedure, a building plan and staff emergency contact details. A senior care staff member told us that this was being reviewed to include more detailed information about all people living at the home so that staff would better understand the support requirements for each person in the event of the need to evacuate the building.

We noted one person had fallen from their bed during the night. The control measures to be implemented included regular checks during the night. We asked to see evidence that these checks had been undertaken, however the service was unable to produce these. The daily records only referred to this person having a 'settled night' as opposed to checking this person every few hours.

Whilst looking at the accident and incident records, we noted four falls which had occurred in the month of April 2016. As a result of these falls, the recommended action was for there to be a staff presence at all times in order to ensure the safety of these people. However during the inspection we observed these people weren't closely monitored by staff which could place these people at risk.

These issues meant there had been a breach of regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation Safe Care and Treatment. You can see what action we have asked the provider to take at the back of the full version of this report.

We looked at how the service managed the control of infectious diseases. We saw evidence recorded for the servicing and maintenance of equipment used within the home to ensure it was safe to use. We undertook a tour of the building and found that it was secure. Daily cleaning schedules were in place and a 'room preparation' document was used to ensure a thorough clean was undertaken when a room became vacant. However the décor throughout the home was in need of refurbishment and we saw that a handyman was employed by the service and was undertaking a program of redecoration.

The handyman also used a maintenance audit tool to identify for example if all furniture was clean and in good working order. A recent infection control audit had been carried out by the supporting infection prevention control team on 10 March 2016 and this identified a number of outstanding items that required action, such as the need to introduce a carpet cleaning schedule and replace some missing tiles in the laundry room.

An action plan had been drawn up against these items with a timescale for completion and this was on-going at the time of the inspection. The service had also carried out an infection control audit on 21 March 2016 and this covered a variety of areas throughout the building. The home had an infection control policy but this was out of date and in need of updating to ensure it reflected the latest guidance.

Requires Improvement

Is the service effective?

Our findings

We asked people for their views of the food provided and received mixed responses. One person told us: "The food is alright and I enjoy eating mushrooms. I also like egg and bacon for breakfast and I get that." Another person commented; "The food is nice and is tasty and fresh." We asked a third person how their lunch was and were told: "It was rubbish. I didn't enjoy it and there wasn't a choice, there never is."

We observed the lunch time meal served at the home. We saw tables were set with cutlery and condiments. The meal consisted of chicken/broccoli pie, carrots and mash. There was no menu displayed in the dining room and everybody had the same meal. There were two people who needed support to eat at meal times and we observed staff sitting with one of these people who was registered blind. There were two members of staff in total to provide support to people. Although this member of staff supported this person to eat, we witnessed several poor interactions, as they got up from the table on several occasions and didn't tell this person where they were going or how long they would be gone for. This left this person sat at the table on their own.

We spoke with the manager about the food and shortly after the date of the inspection they sent us a new four week rolling menu that was nutritionally balanced and due to be introduced on Monday 9 May. The service had previously achieved a Food Hygiene Rating Score of three.

We saw there were some adaptions to the environment, which included pictorial signs on some doors, which would assist people living with a dementia. There were assisted bathrooms with equipment to aid people with mobility problems.

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 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).

At our last inspection on 12 January 2016 we were concerned about how the service worked within the principles of the MCA and DoLS. At this inspection 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. We saw there had been eight applications for DoLS made to the supervisory body prior to the date of the inspection. From these, seven were awaiting authorisation form the local authority and one had been granted and the manager showed us records of applications that were currently outstanding.

However there was no evidence of capacity assessments being undertaken, where appropriate. We spoke with the manager about this and shortly after the date of the inspection they sent us new documentation that they told us was going to be introduced including a 'best interests decision making – self audit questionnaire', the purpose of which was to reflect on the best interest's decision making process and demonstrate evidence/compliance with the MCA. Another document was being introduced that recorded the involvement of people who lived at The Hamiltons, their relatives and appropriate 'others.' Additionally an 'information sharing record' was to be introduced that would identify a person's consent, for example to share care planning information, or for a photograph.

We observed one instance where a staff member placed a medicine into a persons' mouth without first asking their permission or explaining what was happening, and another instance where a staff member placed a tabard on one person without asking them first

These issues meant there was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Dignity and Respect. You can see what action we have asked the provider to take at the back of the full version of this report.

At our last inspection on 12 January 2016, we had concerns regarding staff training and competencies. At this inspection we looked at staff training, staff supervision and appraisal information. There was no staff supervision schedule in place, which would identify meetings held or scheduled during the year and there was no evidence of annual appraisals taking place. We looked in staff personnel files for evidence of recent supervision or appraisal having been carried out. The manager told us there was no document to provide an overview of supervisions completed and that support had mainly been through team meetings. Supervisions are important to ensure the effective management and support of staff to ensure they are competent in their role.

Two staff members we spoke with told us they had not received any form of regular supervision, which they found demoralising and one staff member told us they had never seen the manager since they commenced in post several months prior to the date of the inspection and had never undertaken a process of formal induction. Another staff member told us they had 'shadowed' other staff for a one day period only before working independently.

We saw there were induction checklists in staff files, which would help ensure staff received some essential information when commencing their employment, such as fire escapes and use of equipment. However, there was no evidence in staff files that the training needs of new staff had been considered.

It was not clear that there was any programme of training or support in place to ensure that the requirements of the care certificate were being met. The care certificate sets out minimum standards of training that all new care workers should be supported to meet. The training policy made no reference to the care certificate or the training new or existing staff would be expected to carry out. There was no evidence of staff receiving training in care planning, which was a concern we identified at the last inspection.

These issues meant there was a breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Staffing. You can see what action we have asked the provider to take at the back of the full version of this report.

Good

Is the service caring?

Our findings

The people we spoke with told us they liked living at the home. One person told us: "I think it's alright here. I've been here a while and everything has been ok. The staff seem nice and if they weren't I would tell them." Another person said: "It's very nice and has grown on me. The staff are alright and seem friendly. They seem caring and will help you if they can. I'm quite happy here and people seem satisfied." A third person added: "I have nothing bad to say and would put this place top of the list."

Staff we spoke with demonstrated a good understanding of the needs of people living at The Hamiltons and were able to tell us about their family histories and current preferences. Staff interacted with people in a friendly manner before they provided any assistance, for example at the breakfast meal one staff member said: "Good morning, how are you today? Are you ready for your breakfast yet?" On another occasion we heard a staff member say to one person: "Are you alright? Are you cold? Let me get you a blanket." The person indicated that they wanted a blanket and we observed staff member then brought a warm blanket and gave this to the person who smiled positively.

We saw that staff knocked on people's bedroom doors and waited for a reply before entering. A visiting professional told us: "I think the staff are caring but they seem to be short staffed in the past few weeks." A visiting friend said: Staff are always friendly and listen to you."

Staff were able to tell us about how they helped people to maintain their independence. They told us that people were encouraged to contribute to tasks as much as was individually possible, for example laying the dining tables. During the inspection we saw that people were supported discreetly, for example if they required assistance with personal care.

People said they felt treated with dignity and respect. One person told us: "No problems with that, they have always treated me very well." We spoke with a visiting family and were told: "They provide good care and we have no qualms with the staff. The staff are pleasant and seem to be ok."

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights though person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed to lead fulfilling lives, which met their individual needs.

People's care files contained information about how staff could effectively communicate with people, for example through non-verbal communication. Care plans contained a document called 'This Is Me – my care passport'. The 'This Is Me' care passport has been developed to support anyone of any age with a long term condition, in order to ensure that their care needs are managed appropriately. The passport was in pictorial format.

People's care files contained end of life care plans, which documented people's wishes at this stage of life

where they had been open to discussing this. Staff told us they involved families when developing care plans or carrying out assessments. Visitors to the service who we spoke with confirmed this was the case. The service worked in partnership with the local hospice, and was supported by district nurses when supporting people in the latter stages of life. At the time of the inspection no person was in receipt of end of life care.

Requires Improvement

Is the service responsive?

Our findings

We asked people whether they thought the service was responsive to their needs. A visiting friend told us: [My friend] has told me that during the night time, if she gets anxious, staff come into her room to provide reassurance, which is important to her. I've never had a reason to complain but if I did I would tell the manager." However, a visiting relative told us that [their relative] had not had a bath for over two weeks due to staff shortages.

We checked the care records for this person and found that they not taken a bath for the entire month of April 2016, although two instances of taking a shower were recorded, and there was a gap in records for the four days immediately prior to the date of the inspection where nothing had been recorded. We looked at the bathing and showering records for all the other people who were living at The Hamiltons and found extensive gaps in all the records. Although most people's records indicated they had had a 'wash' it was not clear how thorough this was and records indicated that baths and showers were not being carried out frequently for all people who used the service.

Care plans contained a document called 'The life and story of [the person'] which gave a range of information about childhood, family history, hopes for the future, work history, food preferences, significant life events, preferred name, desired times for rising/going to bed, spiritual beliefs, hobbies and interests. This would ensure staff had relevant information available to them to provide person centred care.

An activities chart was displayed on the dining room wall that identified a range of activities for each day of the week such as bingo, dominoes, sing-along, arts and crafts. However, we observed most people to be largely unengaged in any meaningful activity throughout the day, other than watching television and we saw one person consistently walking around the home for the majority of the duration of the inspection. The two staff members on duty during the day appeared unable to interact with them due completing other tasks.

We spoke with staff about this and they told us the home did not employ an activities coordinator and staff were expected to provide activities for people in addition to carrying out care and support tasks, which they found difficult to do because of the staffing levels. Another person was accessing the hairdresser in the local community with the support of a visiting friend. We were told by the manager that all people living at the location had taken part in a 12 week programme in music/movement/exercises via the local authority.

The last recorded activities to take place were on 19 April and we saw none taking place during the inspection until we raised the concern with staff. At approximately 4pm, we asked the manager if any activities were planned and shortly afterwards a game involving throwing an inflatable ball commenced for a short period, however not all people were interested in taking part in this. This meant that although people's interests and hobbies had been recorded in their care plans, we did not find any evidence that these had been recognised and acted upon at the time of the inspection.

This meant there was a breach of regulation 9 (1)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Person Centred Care. You can see what action we have asked the

provider to take at the back of the full version of this report.

At our last inspection we raised concerns about pre-admission assessments either not being completed, or lacking in detail. We looked at a sample of pre-admission assessments undertaken since the last inspection. We saw these were completed with good detail and provided a focus on medication, communication, eating and drinking, sight, hearing and general things of importance. This enabled staff to understand the care and support people needed.

We saw people had care plans in place that covered hearing, vision, communication, mobility, toileting and drinking. This provided guidance for staff about how to deliver care to people. During the inspection we looked at four care plans and found they were not always reviewed at regular intervals and this was a concern we had raised out our previous inspection. One of these files was last reviewed in November 2015. We asked the manager about this who acknowledged reviews had fallen behind and said they aimed to prioritise the completion of these following our inspection.

The manager told us that the service had not received any recent complaints. We could not find a copy of the complaints policy on display but people who used the service and their relatives told us they knew how to complain. One person said: "I've no concerns but if I had I would tell staff." A visiting friend said: "I think staff are competent and always speak to me. I've no concerns or complaints."

Inadequate

Is the service well-led?

Our findings

At the time of our inspection, there was a manager in post, but they weren't yet registered with CQC. 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.

The home manager had commenced employment at the home in March 2016. The manager told us they had previously worked at another Krinvest home in the region, as had the deputy manager. We asked staff, people who lived at the home and relatives, for their views and opinions of the home's leadership. One member of staff said; "I work nights so I haven't yet met the manager. I've spoken to her on the phone though and she seems nice and approachable". Another member of staff said; "Management are approachable. I've no doubt I could go to them with concerns". A relative also commented; "The manager hasn't really been here long enough to answer that unfortunately. We've no concerns, but there seems to be a high turnover of staff".

At our previous inspections in both February 2015 and January 2016, we identified several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, some of which had been identified as continuing breaches during this inspection. These were in relation to staff recruitment, mitigating risk, safeguarding and seeking consent. We also issued warning notices following our inspection in January 2016, in relation to staffing and good governance. Although there had been different managers working at the home, at each inspection, we found appropriate action had not been taken by the provider to ensure standards were improved at the home. At our last inspection, we raised concerns about a lack of provider oversight at the home. The manager told us the provider had visited the home recently and conducted an audit, but that the findings hadn't been shared. If the findings aren't shared, then it would be difficult for the manager to implement changes and improve standards.

We looked at what quality assurance systems had been implemented since our inspection in January 2016 and found these to be limited. For example we saw there were no audits in place to cover areas such as care plans, medication, staff recruitment, staff training, the environment, record keeping, and storage of confidential information. These had all been areas where we had identified concerns during this inspection. The manager showed us various blank templates they intended to use going forward, but none were filled in. Additionally, we saw no documented evidence of any observations within the home done by the manager, or checks to ensure staff were competent to give people their medication safely.

The manager did show us some other audits stored on a computer in the office. These covered accidents and incidents, bed rails, complaints, pressure sores, infection control and weights. However, we had concerns that these audits weren't effective given that any recommended action to reduce falls wasn't followed through and where people required weighing each week, this hadn't been identified as not being done. Due to these audits being stored on a computer that not all staff would have access to, it would be difficult for them to act on any suggested control measures, such as monitoring people more closely in the

lounge to reduce falls. We saw so other evidence of how this information was disseminated to staff to promote learning.

This meant there had been a breach of regulation 17 (2) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Good Governance. This was because the provider had failed to assess, monitor and improve the quality and safety of people using the service. You can see what action we have asked the provider to take at the back of the full version of this report.

We looked at the minutes from the most recent staff meeting which had taken place since our last inspection. However we there were no discussions about the previous CQC report, what the concerns had been and what staff needed to do differently to make a change. Staff had also voiced concerns about a lack of staff training, staff not always wearing uniforms and had also requested a new bath for people to use. We checked to see how these issues had been responded to. We were unable to see that a new bath had been provided and observed one member of staff working at the home on the day of the inspection without a uniform. We were also unable to clearly see what training staff had done, with two members of staff in particular telling us they hadn't been provided with any training since working at the home. One of these members of staff had certificates on their file, which they had carried over from a previous job, but when we checked; saw they were all out of date.

At our previous inspection we also highlighted that things such as residents and relatives' meetings hadn't been taking place and that surveys hadn't been sent to ascertain people's views. During this inspection we saw no evidence that this concern had been acted upon. The only recorded evidence was of one conversation with a family member who had voiced concerns. This meant people weren't always being given the opportunity to voice their opinion about the quality of service they received.

This meant there had been a breach of regulation 17 (2) (e) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Good Governance. This was because the provider had failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity. You can see what action we have asked the provider to take at the back of the full version of this report.

During this inspection we had concerns about the home maintained accurate records of people living at the home. These were mainly in relation to people's food and food and fluid intake, baths and showers and records of activities in place. For example, bath and shower records hadn't been completed for the month of April, with no documented activities since 19 April. The manager showed us new documentation they intended to use to ensure this information was captured.

We also had concerns with how confidential information was stored. This was because we saw staff personnel files stored in plastic wallets, on the floor in the manager's office. There was also confidential 'return to work' information left on the desk, which could be viewed by anybody in the room if they wanted to see it, containing private information about people.

This meant there had been a breach of regulation 17 (2) (d) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Good Governance. This was because the provider had failed to maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity. You can see what action we have asked the provider to take at the back of the full version of this report.

During the inspection we brought to the attention of the manager the fact that appropriate alerts and

notifications had not been submitted to both the local safeguarding authority and CQC when safeguarding incidents had occurred and we saw five instances during the inspection. The manager told us they would submit these immediately; however as of 9 May 2016, these still hadn't been submitted.

This meant there had been a breach of regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009 in relation to Notification of other incidents. This was because the manager had failed to send appropriate notifications of abuse, or allegations of abuse in relation to people living at the home to CQC, which will be considered outside the inspection process in this instance.

At our last inspection in January 2016 the home was rated as requires improvement overall and inadequate for the well-led key question. We also issued a fixed penalty notice. This was a fine the provider had to pay for not meeting the legal requirements of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with regards to displaying the rating of performance assessments. During this inspection we saw the previous inspection ratings were displayed on the notice board near the front door.

At the end of our inspection we shared our findings with the home manager. We also sent an email to the manager shortly after the inspection, requesting various information to be sent, that could not be produced on the day. Most of this information was subsequently sent to us.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service had failed to send appropriate notifications of abuse, or allegations of abuse in relation to people living at the home to CQC. Regulation 18(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service had not demonstrated that they had provided care and treatment which is appropriate, meets peoples' needs and reflects their preferences. Regulation 9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service did not always treat people with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had failed to ensure the proper and safe management of medicines.Regulation 12 (2) (g) The service had not done all that is reasonably practicable to mitigate risks to people using the service. Regulation 12(1)(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes had not been operated effectively to prevent the abuse of people using the service. Regulation 13(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to assess, monitor and improve the quality and safety of people using the service. Regulation 17 (2) (a) The service had failed to act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity. Regulation 17 (2) (e) The service had failed to maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity. Regulation 17 (2)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service had failed to establish and operate effective recruitment procedures.Regulation 19(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. Regulation 18(1) Staff had not received appropriate support, training, professional development, supervision

and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a)