E Dawson

Hamilton House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Hamilton House provides care and support to older people who have a diagnosis of dementia and/or mental health.

People's experience of using this service: People and their families told us they received good care and support, and were complimentary of the environment, staff and leadership of the service.

Overall, staff treated people with dignity, kindness and respect. However, we found some staff did not display such values, and there was, at times an institutionalised and task orientated culture, rather than a person-centred culture.
There were enough staff to meet people's physical needs. However, people's social needs were not always met. There were aspects of the providers recruitment processes which meant staff were not fully recruited safely.

Some staff told us they did not feel they had the skills and knowledge to provide care and support to people living with dementia and/or complex mental health. Whilst some staff received training in moving people safely, staff did not always put their training into practice. The provider's training records showed significant gaps in staff training relating to mental health, dementia care, and behaviour that could challenge. Some staff also told us they did not feel adequately skilled to meet people's individual needs.

Staff and the registered manager continued to have a limited understanding of the Mental Capacity Act 2005, which meant people's human rights were not always protected. Deprivation of liberty safeguards (DoLS) applications were not always being followed.

There were variable opportunities for social stimulation, and on the first day of our inspection people sat around the edges of the lounge with nothing to do. Those living with dementia were not always supported by best practice principles relating to dementia care.

People's risks associated with their health, social care and the environment had not always been assessed to help keep them safe. We reported one environmental concern to the local fire service.

The provider had limited oversight of the ongoing quality and safety of the service, and whilst there were some systems and processes in place to help monitor the service, these continued to not be effective.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014; we also made recommendations relating to staffing, the Accessible Information Standard (AIS), best practice principles relating to dementia care and for the provider to use the National Institute for Clinical Excellence (NICE) guidance.

More information is in Detailed Findings below.

Rating at last inspection: Requires improvement (Report published 12 December 2018).

Why we inspected: This was a planned inspection.

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

Follow up: We will continue to monitor this service and plan to inspect in line with our reinspection schedule for those services rated Requires improvement.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led

Details are in our Well-Led findings below.

Hamilton House

Detailed findings

Background to this inspection

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

Inspection team: The inspection team consisted of an inspector, an assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or cares for someone who lives with dementia.

Service and service type: Hamilton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide support to 36 people. At the time of the inspection there were 35 people living at the service.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of the last inspection in 2018 the service had been put up for sale due to the provider retiring after 35 years in the sector. At this inspection, we were told the service had been sold and the sale was due to complete in the coming weeks. The necessary applications had been submitted to the Commission

Notice of inspection: This inspection was unannounced.

What we did: We looked at notifications they had made to us about important events. In addition, we reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

During the inspection we contacted and spoke to:

12 people and/or their relatives

The registered manager
The registered provider
Nine members of staff
Plymouth City Council, Quality assurance and improvement team (QAIT) and commissioning team
Healthwatch Plymouth

We used our Short Observation Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the view of people who are not able to talk to us.

We looked at:

Policy and procedures
Five people's care records
Records of complaints
Training records for all staff
Three personnel records
Equipment and building servicing records
Fire records

Because of concerns identified at the inspection, we spoke with the local authority quality assurance and improvement team (QAIT) and commissioning team and raised four safeguarding alerts with the local authority adult safeguarding team.

Requires Improvement

Is the service safe?

Our findings

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

Requires improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations had not been met.

At our last inspection in 2018 we asked the provider to act to ensure behaviours that could cause risk to people and others were assessed. In addition, we recommended they sought advice and guidance on fire safety and the management of people's medicines. Whilst some action had been taken, further action was required, with additional improvements now needed. Therefore, the rating of this key question continued to be requires improvement.

Assessing risk, safety monitoring and management

● Risks associated with people's health and social care were not always detailed in risk assessments to help staff know how to support people consistently and safely. Risk assessments were not in place for those people living with diabetes, who had behaviour that could challenge, who had mental health needs or who were at risk of choking. When we spoke with staff about what action they would take in the event of a deterioration in a person's health because of these illnesses, staff gave inconsistent responses as to how they would respond.

●Some people used equipment to help them to mobilise, however despite staff receiving training in moving and handling, we observed two members of staff unsafely move one person with the use of equipment. The registered manager told us both staff would be spoken to and shown the correct way to move people.

●People lived in an environment which was not always assessed for its safety, and activities carried out by people, had not always been risk assessed to ensure they were fully safe.

●Some people were at risk of consuming liquids, which were not suitable for drinking. However, on two occasions we found cleaning products left unattended and in reach of people as well as a pot of open gloss paint.

The lack of assessment and mitigation of risk was a breach of Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) 2014.

● Equipment in the service, including the fire system was regularly serviced in line with manufactures guidelines. People had personal emergency evacuation plans (PEEPs) in place, which helped advice emergency services what support people needed in an event, such as a fire.

Staffing and recruitment

● Staff were not always recruited safely. Whilst checks had been carried out to ensure staff were suitable to work with vulnerable people, with Disclosure and Barring Service (DBS) checks and references being undertaken. Personnel records did not include a full employment history.

●The registered manager told us they did not use a staffing dependency tool to assess staffing numbers, but instead relied on staff communication and observation. Whilst we did not observe people had to wait for

support, we did identify people were not supported to ensure they did not disturb others. For example, we saw people who use the service picking up other people's drinks, repositioning people's legs and feet and pulling at people's jewellery around their necks.
●People and relatives told us there were enough staff to provide care and support.

We recommend the provider adopts a staffing tool to help assess staffing numbers, and to help ensure the effective deployment of staff within the service.

Systems and processes to safeguard people from the risk of abuse
●Staff knew what action to take if they suspected someone was being abused, mistreated or neglected.
●The registered manager told us they had undertaken a higher lever safeguarding course with the local authority and spoke confidently about their responsibilities.
●People told us they felt safe living at the service, commenting, "I believe I'm much safer now I'm here. I sleep well at night", "I feel very safe", and "The family know [person's name] is safe here, so we can take a step back and not worry so much all the time anymore."
●People's personal money, which was kept by the provider for safety, was handled securely.
●Disciplinary procedures were in place and used when needed, to safeguard and protect people from poor practice.

Using medicines safely
● People's medicines were stored and managed safely. One person told us, "I don't need to worry about forgetting my tablets or taking too many."
● The staff sought advice when a person was refusing their medicines, so that possible alternatives or support could be offered.
● Staff administering people's medicines had received training, however did not have their ongoing competency assessed to ensure continued knowledge and skills.

We recommend the provider uses the National Institute for Clinical Excellence (NICE) guidance to implement competency assessments for staff who administer medicines.

Preventing and controlling infection
●The provider's training records showed that only 19 out of 32 members of staff had undertaken infection control training, but despite this, staff followed and understood correct infection control practices. However, on day one of our inspection, we saw one member of staff not following best practice. We spoke with the registered manager about this, who told us they would act to speak with them.
● No cleaning staff had undertaken infection control training, however despite this people lived in a clean and odor free environment.
●There was soap, paper towels and bins available in bathrooms.

Learning lessons when things go wrong
● An indication of the findings of this inspection and of this key question was an indication the provider and registered manager did not always learn when things had gone wrong.
●There was no monitoring system in place to learn from accidents and incidents.

Requires Improvement

Is the service effective?

Our findings

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

Requires improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations had not been met.

At our last inspection in 2018 we asked the provider to act to ensure people's human rights were protected in line with the Mental Health Act 2005. At this inspection we checked to see if improvements had been made and found that action was still required. Therefore, the rating of this key question continued to be requires improvement.

Ensuring consent to care and treatment in line with law and guidance

● We checked whether the service was working within the principles of the Mental Capacity Act 2005, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. The 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). (DoLS do not apply to the domiciliary/care in people's own home).

●The registered manager had a limited understanding of when DoLS applications might need to be made and told us they did not feel confident in assessing people's mental capacity.

●Staff also had a limited understanding of the MCA, with only eight out of 32 members of staff had undertaken training in respect of the legislative framework.

●People's care plans detailed their mental capacity, but this had not always been suitably assessed in respect of specific decisions, such as care and treatment.

● When DoLS applications were in place, they were not always being followed in line with the details imposed by the supervisory body.

●For one-person financial rewards were being used to encourage positive behaviour. Whilst the registered manager told us that this had been occurring for over 10 years, and that the decision had been made in the person's best interest, in line with the MCA, the multi-agency decision had not been formally recorded.

●Some people's bedrooms were shared. However, there was no recorded information of a best interest's process being followed where people were unable to make the decision to share a bedroom themselves.

Not ensuring people's human rights were protected in line with the Mental Capacity Act 2005 was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We spoke to a professional who was supporting one person who was subject to a DoLS application and had supported other people at the service. They told us the service knew the person very well and were supporting them appropriately, and that they felt the service had been successful in caring for individuals with complex needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●People living with dementia and mental health needs did not always receive effective support in line with best practice. For example, people were not always helped to be socially stimulated and spent time staring into space or walking around the service.
●People's care plans were also not designed and reflective of best practice principles in the delivery of their care.

Not ensuring people's care was designed to ensure their care and support needs were met in line with their wishes and preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A pre-assessment of people's needs was carried out prior to them moving into the service, to help ensure their needs could be met.

Staff support: induction, training, skills and experience
● People were being supported by staff who had not received training in essential areas associated with their needs. The provider's training records showed significant gaps in staff training relating to safeguarding, mental health, dementia care, and behaviour that could challenge. Some staff also told us they did not feel adequately skilled to meet people's individual needs.
● The registered manager told us the care certificate (a national health and social care induction) was not used for new members of staff because all staff recruited had undertaken a National Vocational Qualification (NVQ) in health and social care. However, the provider's training records showed this information was not accurate.
●Personnel records did not demonstrate staff working at the service had previous experience of working with people living with mental health and/or dementia needs.
●Following the inspection, we ask the provider to submit an up to date account of all staff training. This was issued twice as there had been errors made with the first submission. The records showed significant gaps and some staff training was ten years was out of date.

Not ensuring staff receive training to enable them to carry out the duties they are employed to perform is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff told us they received one to one supervision of their practice, and were happy with the support they received.

Supporting people to eat and drink enough to maintain a balanced diet
● People were complimentary of the meals, commenting, "The meals are really good. No complaints", "The cook's make sandwiches if a big meal is too much for me", and "The food is plentiful. The menu can be predictable, but it's all nicely cooked".
● People's special occasions were celebrated with a cake.
● People were supported with their hydration and nutrition as needed.
●The chefs told us they were informed of people's changing nutritional needs, so they could provide meals accordingly.

●The menu was designed in line with people's likes and dislikes. However, people who did not understand the written word were not always shown a pictorial menu to help select their choices. The pictorial menu in the dining room was also displayed high up on the wall, which meant people could not easily view it.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support

●People were encouraged to take in fresh air and access the community.

● People and their relatives told us there was access to external health and social care professionals, telling us, "I let them know if I'm unwell or need the doctor, and they'll book an appointment for me" and "The staff notice if [person's name] is feeling unwell and will arrange for them to be seen."

● People's records detailed involvement of professionals such as GP's, the mental health team, opticians and chiropodists.

●The registered manager was passionate about working with others, to ensure people were effectively supported.

Adapting service, design, decoration to meet people's needs

●The provider had not always ensured the design and decoration met with the principles of dementia care and the Accessible Information Standard (AIS). Signage was not always pictorial and was not always clear.

●The provider had recently designed the garden, to ensure that it was safe and accessible to everyone, despite their level of mobility.

We recommend the provider takes account of dementia research and the Accessible Information Standard (AIS) in the design and decoration of the service.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires improvement: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations had not been met.

At out last inspection in 2018, this key question was rated Good. At this inspection we found improvements were required and the rating has deteriorated to requires improvement.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always treated with kindness and respect, and we observed a task orientated culture, rather than a person centred culture. For example, one person who was fast asleep in the lounge was woken up because they were told it was "toileting time". When staff approached the person, the person had their hand down their trousers. The staff member commented "Get your hand out of there…. I need to check you."
- Some ladies had facial hair and some did not always wear socks or tights. Whilst we were told by the registered manager this was people's choice, it had not been reflected in their care plans.

Respecting and promoting people's privacy, dignity and independence

- Overall, people's privacy and dignity was respected. However, some staff were not respectful in how they spoke about people in front of others. Staff referred to people as "wanderers" and "wheelchairs", and stated that they were "feeding people", when assisting them with their meals.
- People's care plans did not always reflect how their independence should be promoted.

Not treating people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and their relatives told us staff were kind and showed patience.
- Staff told us people were treated as individuals regardless of their age, race, sexuality or religious or spiritual needs.

Supporting people to express their views and be involved in making decisions about their care

- Staff told us they tried to involve people as much as possible in their care. For example, by encouraging them to choose their clothes.
- People's personal histories were used to help encourage meaningful conversations with people.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires improvement: People's needs were not always met. Regulations had not been met.

At out last inspection in 2018, this key question was rated Good. At this inspection we found improvements were required and the rating has deteriorated to requires improvement.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
●People had care plans in place and staff told us they found them to be informative. However, care plans were not always complete and reflective of people's health and social care needs. For example, one person had diabetes, but there were no care plans in place regarding their optical and foot care.
●Information in people's care plans was not always up to date. One person's care plan detailed a trial of a new care and support approach which was agreed with health professionals in March 2017 and was to be reviewed in April 2017. However, there was no information as to the outcome of the review.
●People who had specific communication needs did not always have them documented to enable their support to be delivered consistently.

Not ensuring people's care records were complete and accurate is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People who did not need specific support from staff, told us they had enough to do, commenting "I have a professional music background and I have brought my guitars and music here. I play for myself and sometimes we get together to sing"; "I've always liked ironing laundry, and they let me iron the clothes for everyone every day" and "I can do my art in my room most days; drawing, painting, modelling". The registered manager explained they used external entertainers such as musicians to provide entertainment. Photographs also showed people participating in cake decorating and card making. However, on the days of our inspection, people were mostly sat around the room in chairs, with limited social stimulation. One person walked around the service, with staff offering little opportunity for social engagement.

We recommend the provider researches and develops the social opportunities for people living with dementia and mental health in line with best practice.

●People told us they felt they received individualised care.

Improving care quality in response to complaints or concerns
●People told us they felt confident to raise a concern or complaint with staff or to the registered manager and told us action would be taken.
● The provider had not received any complaints but told us there was a complaints policy in place which would be followed in the event of a complaint being made.
●The registered manager told us complaints were seen positively and used to help improve the service.

End of life care and support

● People at the end of their life did not have personalised care plans in place to ensure staff would know how they wanted to be cared for in the last weeks and days of their life.

●The provider's training records showed that only two out of 32 members of staff had completed end of life training.

●People's resuscitation wishes were known and documented, and treatment escalation plans (TEPs) were in place as required.

We recommend the provider uses the National Institute for Clinical Excellence (NICE) guidance to implement end of life care planning.

Inadequate

Is the service well-led?

Our findings

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At our last inspection in 2018, we asked the provider to act to improve their systems to ensure the service was effectively monitored. At this inspection we found improvements were still required, and additional breaches of regulation were found. Therefore, the rating for this key question has deteriorated to inadequate.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The provider continued to have ineffective systems in place to monitor the safety and quality of the service. Whilst there were some checks and audits in place, they had failed to identify where improvements were required, as cited throughout this report. The impact of which had caused a continued deterioration of the service.
- The providers audit to ensure Deprivation of Liberty Safeguards (DoLS) applications were managed effectively was inadequate. For example, DoLS applications were not always made in advance of the existing authorisation ending. One DoLS application had expired on 24 February 2019 but an application for renewal had not been made until 15 March 2019. This meant this person's human rights were not being protected.
- The registered manager told us the service was based on the values of person-centred care. However, we did not find this underpinned staff's practice, and it was not imbedded within the culture of the service.

Continuous learning and improving care

- The registered manager told us they attended learning and support workshops with the local authority, however had been too busy to put the learning into practice, to help improve the service.

Not having effective systems to review the leadership, culture and safety and quality of the service is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was a member of the Skills for Care outstanding managers network (a national health and social care forum) and told us they found it useful.

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

- Since our last inspection, the ratings of some key questions had remained the same and/or had deteriorated, with additional breaches of regulations found.
- There was a management structure in place, however managerial roles and their responsibilities were not

always clearly defined.

●People, staff and relatives told us the service was well managed, with one member of staff telling us, "I think the [registered manager] is the best boss I have ever had."

● The provider and registered manager were open and transparent throughout the inspection, about how the failings have emerged and the reasons for the deterioration at the service, thus demonstrating the principles of the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and their relatives were asked for their feedback about the service.

● The registered manager acted on professional feedback to help improve the service.

Working in partnership with others

● The registered manager told us they embraced working with external professionals, such as the local authority quality improvement team (QAIT) to help improve the service for people.

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 9 HSCA RA Regulations 2014 Person-centred care Service users care was not designed to ensure their care and support needs were met in line with their wishes and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect.