Tudor Views Limited

Hamilton Court

Inspection report

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Ratings

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

Overall summary

The inspection took place on 12 and 13 March 2015 and was unannounced.

We last inspected Hamilton Court on 14 January 2014. At that inspection we found the provider was meeting all the regulations.

Hamilton Court provides accommodation and support for up to 13 people with a learning disability and enduring mental health support needs. There were nine people living at the home when we inspected.

Hamilton Court is required to have a registered manager. 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 the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A registered manager was not in post. However, following the recent resignation of the manager the provider had promptly appointed a new manager who was not yet registered with CQC.

People who could tell us told that they felt safe living at the home. Relatives that we spoke with told us that their family member was safe and well cared for at Hamilton

Summary of findings

Court. Staff understood their responsibility to take action to protect people from the risk of abuse and harm because the provider had systems in place to minimise the risk of abuse.

Staff had a limited understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We found that the provider was not meeting the requirements of this legislation which serves to protect people's human rights.

Staff were caring and had an understanding of the needs of the people they were supporting. Improvements were in place so that staff received the training and supervision that they needed to carry out their role.

People, relatives and staff told us that there were enough staff to care for people and keep them safe.

The maintenance and up keep of the home had not always ensured that people's privacy and dignity was respected. Although steps were in place to ensure that the home was refurbished so it was safe and suitable for people.

People received their medication as prescribed and medication was stored safely.

There were some systems in place to assess and monitor the quality of the service. However they had not been timely and effective. We identified two breaches in the regulations. The action we told the provider to take can be seen at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe

People told us they felt safe. Procedures were in place to manage risks and steps had been taken to ensure these were consistent.

Improvements were being made to the building so it was safe and comfortable for people.

People received their medication as prescribed.

Good

Is the service effective?
The service was not effective.

Arrangements were not in place to ensure the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were understood and followed.

Improvements had been made so that staff received the training and support they needed to carry out their role effectively.

Requires improvement

Is the service caring?
The service was not always caring

People told us staff were caring and kind.

The home had not been maintained in a way that respected people's privacy and dignity.

Requires improvement

Is the service responsive?
The service was responsive

People could speak with staff if they needed to. Steps had been taken to ensure that a system was in place for the monitoring of concerns and complaints.

Good

Is the service well-led?
The service was not always well led

People and staff were pleased with the new management arrangements.

Quality assurance processes were in place to monitor the service so people received a good quality service but they were not always effective and timely.

Requires improvement

Hamilton Court

Detailed findings

Background to this inspection

We carried out this inspection under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 12 and 13 March 2015. The inspection team included one inspector. The first day of our inspection was unannounced. On the first day of our inspection we focused on speaking with people who lived in the home, staff and observing how people were cared for. We returned to the home the next day to look in more detail at some areas and to look at records related to the running of the service.

We reviewed all of the information we held about the home. This included statutory notification's received from the provider about accidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law.

We spoke with the Local Authority who are responsible for monitoring the quality and funding many of the placements at the home and they told us they had no concerns.

We spoke with six people that lived at the home. We were unable to speak with some people due to their limited verbal communication skills so we also spent time observing people's care in the communal areas of the home.

We spoke with four staff, the manager, operations manager and the provider. We looked at three people's care records and other records that related to people's care. We also looked at medication records, staff employment records, staff training records, and quality assurance system and audits, complaints and incident and accident records.

Good

Is the service safe?

Our findings

People who could tell us told us that they felt safe living at the home. One person told us, "I didn't feel safe for a while one of the people living here was going into the bedrooms. But it is fine now and I feel safe". Another person told us, "The staff are okay I never hear them shout or seen anything of concern".

All staff spoken with knew the different types of abuse. Staff told us if they had concerns then they would pass this information on to the manager. One member of staff said, "I would report any concerns to the manager". One staff member's knowledge was limited about safeguarding procedures. However most staff that we spoke with knew the different agencies that they could report concerns to should they feel the provider was not taking the appropriate action to keep people safe. The provider had followed safeguarding procedures where allegations had been made and had notified the local authority and us.

Staff spoken with were able to tell us about risks to people's safety and the actions they needed to take to manage the risks. For example, staff told us about how people were supported to safely access the community with staff support and how people were supported to access the homes vehicle safely. However, there were some inconsistencies about how some risks were managed. For example, we were told different information about access to the kitchen. Some staff told us it was locked at all times and other staff told us that the kitchen was only locked during food preparation. We saw during our inspection that it was only locked during meal preparation times when there were obvious risks to people's safety. The manager told us and we saw that work was taking place to ensure care records in place for staff to follow were consistent with people's needs.

Staff knew what to do in an emergency situation and how to keep people safe. They told us that a manager was always contactable in an emergency situation if they needed help or support. We saw that arrangements were in place to service equipment including electrical and fire equipment. However, the building had not been well maintained and work was taking place when we inspected to improve the safety and living standards of the building. Risk assessments were in place to ensure the safety of people during this time.

One person told us, "There seems to be enough staff around". Another person told us, "There is enough staff around accept in the evening there may only be one or two staff between six and eight at night". We saw adequate numbers of staff available to support people during our inspection. Where people had been assessed as needing one to one support we saw during our inspection that this was provided. There was a staffing structure in place and the manager told us that staffing levels were determined and based on people's care needs and that safe standards of staffing were in place day and night.

Most people needed support to take their medication. The provider representative told us that they would be providing lockable cupboards in people's own bedrooms. This would increase people's independence and ensure that medicine management was more person centred. Medication was stored in a lockable trolley. Staff told us that only staff who had been trained administered medication. We looked at some people's Medicine Administration Records (MAR), to see whether their medicines were available to administer to people at the times prescribed by their doctor. We found that medicines were available to people as prescribed.

Some people required some medication on a 'when required' basis. We saw that only limited information was available for staff to refer to and when required protocols were not available for us to see. These would detail the circumstances regarding when this medication would be given. Although two staff spoken with told us they knew when this medication would be given. A staff member told us. "We only administer when required medication as a last resort; it is not given to people very often". We saw that some medicine administration records (MAR) had been handwritten and had not been signed or witnessed, this practice would minimise any risks of errors made with the transcribed information.

The manager told us that some staff had transferred from another service within the company. A recent audit of staff files had identified that DBS checks for staff who had transferred needed to be renewed to ensure that staff were suitable to work in the home. We saw on staff files sampled that these checks were in the process of being obtained. This showed that steps had been taken to ensure robust recruitment was in place.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) sets out what must be done to protect the human rights of people who may lack mental capacity to make decisions to consent or refuse care. We saw that staff asked people for their consent before providing care. Where it was believed that people may lack capacity to make a decision for example in relation to their care, finances or medication there was no evidence in people's records that an assessment of the person's capacity had been completed. One person had refused medical treatment, however there was no evidence that a meeting or discussion had taken place to ensure that any decisions made were in the person's best interest. Staff demonstrated some understanding of MCA, however not all staff had received this training. Arrangements in place did not ensure that suitable arrangements were in place to ask and act on people's consent. This was a breach of Regulation 11of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty in order to keep them safe. Some staff spoken with were unable to explain the principles of Deprivation of Liberty Safeguards (DoLS). Their limited understanding of DoLS showed us that staff may not always recognise a situation that could be a restriction on people. We saw some restrictions in place that had not been considered as a deprivation of liberty. For example some people were closely supervised by staff and applications had not been made to the local authority for permission to do this. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they knew people's care needs well. One staff member told us, "We have vast experience as a staff team some of us have worked with the people living here for a long time. We know their care needs well". Staff that we spoke told us that they had completed some training however our discussions with staff confirmed that some training was also needed so they had up to date knowledge and skills. The manager told us that they had enrolled staff on training courses and we saw that a training plan had recently been implemented by the manager.

Staff told us that the management changes had been unsettling. However all the staff we spoke with felt reassured by the recent management changes. They told us that they were now receiving the management support they needed to carry out their role. Staff told us that they had received recent supervision with the manager and that a regular supervision plan was now in place.

Staff told us that they felt confident supporting people when they became upset or distressed. Staff were able to describe to us the early signs indicating that a person may be upset about something.

All the people we spoke with told us that they liked the food. People told us that they could make themselves a drink when they wanted one. However, one person told us that the kitchen was locked at night. A person told us, "I don't get a choice at meal times but the food is always nice". Another person told us, "They will make you something different if you want and you can have a snack whenever you want one". We saw people access the kitchen to make their own drinks. Where people needed more support we saw that staff offered people regular drinks so that that they remained hydrated. There was a four week menu in place and we saw that cultural appropriate food was provided.

People who could tell us told us that they could see a doctor when they were not very well. One person told us that they were due to have a health check up soon and would remind the staff to arrange this. Staff told us and records showed that people were supported to attend routine health checks including dental and optician appointments. Weight loss can be an indication that people are unwell and may require further investigation. We saw that some people's weight had not been monitored as detailed in their care plan. However, the manager had recently taken action to ensure that this would now be monitored.

Requires improvement

Is the service caring?

Our findings

We observed staff spoke to people in a kind and caring way. We spent some time in communal areas and observed the care provided to people and their interactions with staff. We saw that staff were respectful and spoke with people kindly. We saw that staff knew people and were able to respond to them in a way that ensured people could understand. We saw that staff used some basic sign language to communicate with some people. However, one person's care records said that picture and photographs should be used to assist with communication. When we asked staff about this they did not know where the communications aids were, or if they were still in use.

People spoken with told us that staff respected their privacy. Each person had a single occupancy room so that they had their own private space. People told us and we saw that staff knocked on people's doors and waited to be asked to enter before going into their room.

Some people invited us to look at their bedrooms. Major building work was taking place and some people were in the process of moving between rooms so that the refurbishment could take place. However, we saw that some bedrooms were in a poor condition. Some bedrooms had no curtains and we saw broken blinds that did not ensure people's privacy, bedding was in a poor condition and a bathroom door was not lockable. Although the provider was in the process of making the improvements needed, these living arrangements had not ensured that people's privacy and dignity was promoted.

Some people were supported to be independent. We saw one person brought their washing to the laundry and some people collected their meals from the kitchen and made their own drinks. Two people told us that they went out independently to the local shops. One person told us that they managed their own finances. One person told us that they did have a kettle in their room to make a drink but this was stopped for safety reasons. We saw that not all the people living there were encouraged to be independent and to take part in daily living skills. The manager told us that there were plans in place to involve people more in daily living tasks and to promote people's involvement and wellbeing.

People told us that family members could visit. We saw two people had visitors during our inspection. A relative told us that they were made to feel welcome by staff when visiting their family member. Staff told us that some people regularly visited their relatives and staff supported these visits and recognised the importance of people's relationships with their family and friends.

Good

Is the service responsive?

Our findings

One person told us, “The staff are pretty good and they help you to do things”.

Staffs were able to tell us about people’s individual needs, interests and how they supported people. We saw that some information had been set out in peoples care records and staff were aware of people’s preferences and knew how to respond to the person’s needs. One staff member told us that they had transferred recently from one of the providers other services. They told us that they had been given time to read care records but was still getting to know some people and how they liked to be supported.

People told us they could take part in some activities if they wanted to. One person told us that they enjoyed do writing and maths and we saw that they were supported by staff to do this. Two people told us that they go out independently when they want to. On both days of our inspection people were supported as a group to attend activities in the community including visiting a local leisure and entertainment centre. Another person was supported by staff to attend a college course and they indicated to us by smiling and signing that this was something that they liked to do. The manager explained to us that whilst the building work was taking place they had encouraged people to go out for the day and most people had chosen to do this. However, she told us that when the building work was completed they would be looking at supporting people to engage in more personalised activities both at home and in the community.

People who could tell us told us that they knew how and who to complain to. One person told us, “If I was not happy I would talk to any of the staff or the manager”. Another person told us, “I would speak to one of the staff, they do listen to you”. Staff spoken with told us how they would handle complaints and confirmed they would follow the complaints process and let the manager know. Staff told us that they were confident the manager would respond to people’s complaints and concerns appropriately. We looked at the records of complaints. We saw that a recent complaint had been made and that this had been investigated appropriately. However, we were told that records of previous complaints and there outcome could not be found.

Requires improvement

Is the service well-led?

Our findings

One person told us, “Things have been a bit upside down but are getting better.” Another person told us, “I liked it when [previous registered manager’s name] managed the home. But I think [new manager name] will be good”. The registered manager left in June 2014. Another manager was appointed and left in January 2015. The provider had recently appointed another manager who worked in one of their other services. We were told that she would be applying to be registered with CQC. They were present throughout the inspection. The provider had notified us about events that they were required to by law.

Staff were complimentary about the new manager. They told us that they already noticed improvements in the home since she was appointed. A staff member told us, “She is really good and hands on, she is not stuck in the office she talks to the people living here, finds out about how they are and she really supports us to do our job”.

Some people told us that they attended residents meetings. One person told us, “We do have occasional residents meetings but it is the same couple of people who speak out. We asked about going on a trip to Blackpool. It gets talked about but never happens. There have been trips to Drayton Manor and Tamworth and people enjoyed them. I think [new managersname] will be different and will sort things out”.

The provider representative had completed visits to the home and had reported on the quality of the service. We saw the records of some of these visits. The most recent report of January 2015 was very detailed with clear actions recorded and had identified what needed to be done to bring about the improvements in the service. In addition to this the provider had regular senior management team meetings where each service including Hamilton Court was reported on. At the time of our inspection we saw that significant work was taking place to bring about improvements to the environment. The provider told us and we saw records confirming that discussions had taken place to agree and manage the refurbishment work to minimise the disruption to the people that lived there. However, it was unclear why there had been a delay with the improvements especially in relation to the physical standards of the home and with replacing items such as worn bed linen and broken and damaged furniture. This did not show that systems in place to monitor quality had been timely.

The new manager and operations manager had recently implemented an internal audit system that covered a number of areas including care records, health and safety, medicine management, infection control. We were told that some audit records completed by the previous manager could not be located and in addition some records we asked to see could not be found including complaint records. An audit of staff records and staff training had taken place and we saw that the manager and operations manager had already made progress to ensure that staff received the training they needed and that all staff employed had the appropriate documentation in place to prove their suitability to work at the home.

We saw that where people became distressed or they had been an incident or accident records were made of these. However, there had been no analysis of these records so that themes and trends could be identified and steps could be taken to minimise the likely hood of a reoccurrence.

We met with the provider and they assured us and we saw evidence that significant work was and would be taking place to ensure that the home was run and maintained in the best interest of the people that lived there.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that the registered person had not protected people against the risk of ensuring arrangements were in place to act on people's consent. This was a breach in regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment We found that the registered person had not protected people against the risk of ensuring arrangements were in place to protect people against from the risk of improper treatment. This was a breach in regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014