Mrs Janet Walters

Hamilton Rest Home

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This was an unannounced inspection which took place on 19 January 2016. This was the first inspection since the provider had registered the service with the Care Quality Commission (CQC) in September 2015.

Mrs Janet Walters is registered to provide accommodation at Hamilton Rest Home for up to 23 older people who require personal care. Hamilton Rest Home is a large detached property situated on a main road in Whitefield. It is within easy reach of local shops, public transport and the motorway network. Accommodation is provided in mainly shared rooms. At the time of this inspection there were 20 people using the service.

The service did not have a registered manager in place. A registered manager is a person who has registered with CQC 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. We were told that the previous registered manager had left the service in November 2015. A new manager had commenced employment at the service on the day before this inspection. They were experienced in managing residential care services and told us they intended to apply to register as manager for Hamilton Rest Home.

During this inspection we found four breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. This was because improvements needed to be made to the premises in order to ensure the safety of people who used the service. Staff had not received recent training to ensure they were able to deliver effective care. Arrangements to ensure the safe management of medicines and to identify and manage risks to people who used the service needed to be improved. The provider also did not have robust quality monitoring systems in place. You can see what action we have told the provider to take at the back of the full version of the report.

People who used the service told us they felt safe in Hamilton Rest Home. Visitors we spoke with said they were happy with the care their relative received and had no concerns about their safety.

Staff had been safely recruited and there were sufficient number of staff available to meet people's needs in a timely manner. Staff had received training in safeguarding adults. They were aware of the correct action to take should they suspect or witness abuse. They told us they would also be confident to report poor practice should they observe this taking place.

Staff told us they received an induction when they started work at the service. Systems were in place to record the training staff had completed and any supervision or appraisal sessions. However, records we reviewed showed some staff had not completed training in areas such as infection control and moving and handling since 2014. Staff had also not received supervision since the registered manager left the service in November 2015.

People we spoke with told us that the staff at Hamilton Rest Home were kind and caring. During the inspection we observed kind and respectful interactions between staff and people who used the service. We saw that people who used the service were encouraged to discuss the care they wanted at the end of their life with their relatives and staff.

Staff showed they had a good understanding of the needs of people who used the service. However, care plans did not always contain accurate information about people's current needs. Advice received from a speech and language therapist (SALT) had also not been fully included in the care plan for one person who used the service. This meant there was a risk people might not always receive safe care.

Although we found evidence that people received their medicines as prescribed, systems relating to the stock control and storage of medicines needed to be improved.
We saw that all areas of the home were clean. Staff wore personal protective equipment (PPE) in order to protect people from the risk of cross infection.

We saw that appropriate arrangements were in place to assess whether people were able to consent to their care and treatment. We found the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions. However, staff we spoke with did not have a clear understanding of the impact of these legal safeguards on their practice. This meant there was a risk people's rights might not always be upheld.

People told us they enjoyed the food provided in Hamilton Rest Home. There were systems in place to monitor the nutritional needs of people who used the service.
A programme of activities was in place to help stimulate people and maintain their contacts within the local community. People told us they enjoyed either participating in or watching the activities which took place, particularly those involving local school children.

A local GP held a weekly clinic at Hamilton Rest Home. This meant people who used the service had regular reviews of their health needs.
Records we reviewed showed people had opportunities to comment on the care provided in Hamilton Rest Home. All the people we spoke with told us they would feel confident to raise any concerns with the staff and the newly appointed manager.

Staff told us they enjoyed working in the service. They told us they were optimistic that the appointment of new staff and manager would lead to improvements in the service. The new manager told us they intended to re-introduce staff meetings and supervision sessions as soon as possible. This would provide opportunities for staff to provide feedback on the service.

A system of audits and quality assurance monitoring was in place. However the environmental audits completed had not been sufficiently robust to identify the risks we found during the inspection. The new manager told us they would ensure all audits were brought up to date as soon as possible.

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.

People told us they felt safe in the service. Staff had been safely recruited and there were enough staff on duty to meet people's needs in a timely manner.

Improvements needed to be made to the premises to ensure people were adequately protected. Infection control measures in the service also needed to be improved.

Although we found evidence that people received their medicines as prescribed, systems relating to the stock control and storage of medicines needed to be improved.
Risk assessments were not always updated to help ensure people received safe care.

Is the service effective?

Requires Improvement

The service was not always effective.

The necessary DoLS authorisations were in place where people were unable to consent to their care in the service. However staff had limited understanding of what this meant in practice.

Staff received an induction when they started work at the service. They were also supported to gain nationally recognised qualifications in care. However, some staff had not completed required training in areas including moving and handling and infection control for over 12 months.

People gave positive feedback about the food in Hamilton Rest Home. Systems were in place to monitor people's health needs, including weekly visits from a local GP.

Is the service caring?

Good

The service was caring.

People who used the service spoke positively of the kindness and caring attitude of the staff. We saw staff cared for the people who used the service with dignity and respect and attended to their

needs discreetly.

The staff showed they had a good understanding of the care and support that people required. People were encouraged to discuss the care they wanted to receive at the end of their life.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although people told us staff provided the care they needed, we saw that care records did not always reflect people's current needs

A programme of activities was in place to help maintain the well-being of people who used the service.

People had opportunities to comment on the care provided in Hamilton Rest Home. Systems were in place to investigate and respond to any complaints people might make.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had not had a registered manager in place since November 2015. However, a new manager had been in post since the day before our inspection. They had significant experience of managing services and told us they intended to register with CQC as manager at Hamilton Rest Home.
Staff told us they enjoyed working in Hamilton Rest Home.

Systems were in place for monitoring the quality of the service although they had not been maintained following the resignation of the registered manager. The audits completed had also not been sufficiently robust to identify the shortfalls we found during the inspection.

Hamilton Rest 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 January 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of residential care services for older people.

Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. We contacted the Local Authority safeguarding team, the local commissioning team and the local Healthwatch organisation to obtain their views about the service. Prior to our inspection of the service, we were provided with a copy of a completed provider information return (PIR); this is a document that asked the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

During the inspection we spoke with seven people who used the service, two visiting relatives and the local GP who visited the service each week. We also spoke with the provider, the manager, the assistant manager, four members of care staff, the domestic and a teacher from a local high school who attended the service during the inspection with two children as part of the "Art to Heart" project.

During the inspection we carried out observations in all public areas of the home and observed the lunchtime experience in the dining room.
We looked at the care records for three people and the medication records for eight people who used the service. We also looked at four staff personnel files and reviewed a range of records relating to how the service was managed; these included staff training records, quality assurance systems and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with who used the service told us they felt safe in Hamilton Rest Home. Comments people made to us included, "I'm safe here; I don't feel threatened or worried. They keep an eye on me here," "I feel very safe and happy here, they look after me very well" and "I like it here; I'm comfortable and feel safe. They [staff] are always making sure that I'm OK." The relatives we spoke with told us they had no concerns regarding the care their family member received. A relative commented, "He's safe and well cared for. They [staff] are very good with him. I've no concerns about his care."

During the inspection we checked to see if the premises were safe. Although the premises were generally well maintained we found a number of exposed pipes behind sinks in five bedrooms and in a corridor. We also found a total of three exposed radiators in an upstairs corridor, the lounge and dining room. All of these were hot to the touch and could present a risk of injury to people who used the service. Although two of the radiators had warning notices above advising people that they were hot, there was a risk these notices would not be understood by all people who used the service. We discussed this with the provider who told us they would take immediate action to rectify this situation. We also noted a window restrictor in one of the first floor bedrooms was broken. A review of the risk assessment aimed at preventing falls from windows stated window restrictors should be checked on a weekly basis by the maintenance person used by the home. However, records we reviewed did not provide evidence that such checks had been regularly completed.

This meant there was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records we reviewed showed that equipment including hoists and the stair lift were serviced and maintained in accordance with the manufacturers' instructions. Required checks had also been completed to ensure the safety of the gas, electrical and water supplies. This helped to ensure the safety and well-being of everybody living, working and visiting the home.

We saw a business continuity plan was in place for dealing with any emergencies that could arise. Inspection of records showed regular in-house fire safety checks had been carried out to ensure that the fire alarm, emergency lighting and fire extinguishers were in good working order. Personal evacuation plans (PEEPS) were in place to record the support people who used the service would need should the premises need to be evacuated. These were kept in a 'grab file' in the staff office to ensure they were easily accessible in the event of an emergency. Staff had completed fire training and were involved in regular evacuation drills. This should help ensure they knew what action to take in the event of an emergency.

Staff told us they had completed training in safeguarding adults. They were able to tell us of the correct action to take should they witness or suspect any abuse. They told us they would not hesitate to report any poor practice they witnessed either to the managers in the service or the local authority.

We looked at the systems in place to ensure staff were safely recruited. We reviewed four staff personnel

files. We saw that all of the files contained an application form, two references, and confirmation of the person's identity. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

All the people we spoke with who used the service told us staff usually responded promptly when they needed support. One person commented, "I think there's enough staff here. There's a buzzer in my room, but I don't need it and never used it. But it's nice to know it's there." Another person told us, "Whatever help I need, they give me. Sometimes I might have to wait a bit, it depends how busy they are, but it doesn't really bother me." Our observations during the inspection showed there were enough staff on duty to meet people's needs in a timely manner.

We asked the assistant manager how they managed staff absence in the service. They told us that until recently they had needed to use agency staff due to a number of staff having left the service. However, they told us all vacancies were now filled. This was confirmed by our discussions with staff and our review of rotas during the inspection.

We reviewed the systems in place to ensure the safe administration of medicines. All the people who used the service told us they always received their medicines as prescribed. One person commented, "I have medicines three times a day; they [staff] sort it all out and make sure I get them at certain times." Another person told us, "They [staff] always give me my tablets on time; they look after everything like that."

We reviewed the medication administration record (MAR) charts for eight people who used the service. We found these to be fully completed to confirm people had received their medicines as prescribed. We also checked the records relating to the controlled drugs held in the service and found these to be accurate.

During the inspection we noted that there was a large amount of stock which staff told us was waiting to be returned to the pharmacist. This stock was held in a medication trolley which was stored in a corridor and was not secured to a wall as required for security purposes. Two boxes of medicines due to be returned were also stored in a store room which had been left unlocked. We also found some creams prescribed for people were kept in bedrooms which they shared with another person. This meant there was a risk people who used the service would be able to access medicines which were not prescribed for them.

We saw that staff had received training in the administration of medicines, although six staff had not attended refresher training in 2015. We saw there was a system in place to review the competence of staff to safely administer medicines. However, we could only find one recent competence assessment on the personnel files we reviewed for three staff who had been employed in the service for over six months. We did however note that staff supervision sessions had been used to discuss the safe administration of medicines.

We looked at the arrangements in place to ensure people who used the service received medicines prescribed on an 'as required basis' when they needed them. We saw that there were no protocols in place to provide guidance for staff on the reasons why a person might need an 'as required' medicine and the symptoms a person might display to indicate they needed the medicine if they were unable to ask staff directly.

We checked the records for three people who were prescribed 'thickeners'. Thickeners are added to drinks, and sometimes to food, for people who have difficulty swallowing, and they may help prevent choking. We saw that staff had signed the MAR charts to record thickeners had been administered four times per day. However, our observations showed people were given thickened fluids on a more frequent basis than four

times each day in order to meet their hydration needs. This meant an accurate record had not been maintained of the prescribed thickeners people had received.

The lack of appropriate arrangements in place to ensure the safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care records we looked at showed that most risks to people's health and well-being had been identified, such as the risks involved with reduced mobility, poor nutrition and the risk of developing pressure ulcers. We saw care plans had been put into place to help reduce or eliminate the identified risks. However, we saw that there were no risk assessments in place for one person in relation to the management of falls or the use of a wheelchair lap strap. This meant staff might not be aware of the correct action to take to ensure the person received safe care.

We looked at the systems to monitor people's nutritional needs. We were told that food and fluid charts were completed for people who were assessed as being at risk of not eating or drinking enough. However, we noted that food and fluid chards in place in one person's room were dated October and November 2015. When we discussed this with the assistant manager they could not explain why this was the case. The lack of records meant we could not be certain that appropriate monitoring had taken place. We also noted that, although this person's care plan had been updated following a visit from a speech and language therapist (SALT), the nutritional risk assessment had not been updated to take into account the advice given by the SALT. This meant staff might not be aware of the steps to take to manage the identified risks.

The lack of robust arrangements in place to ensure people received safe care and treatment was a breach of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the systems in place to help ensure people were protected by the prevention and control of infection. We looked around all areas of the home and saw the bedrooms, dining room, lounge, bathrooms and toilets were clean and there were no unpleasant odours. We saw that personal protective equipment (PPE) was available for staff to use when providing personal care. Staff we spoke with demonstrated their awareness of their responsibilities to protect people from the risk of cross infection. Although the assistant manager told us staff wore gloves when handling laundry, we noted there were no handwashing facilities in place in the laundry room; the provision of such facilities is in line with best practice guidelines.

We saw infection prevention and control policies and procedures were in place and infection prevention and control training was undertaken by staff. However we noted only three staff had completed this training since the end of 2014. The housekeeper on duty confirmed they had completed this training and knew of the action they should take to help prevent the risk of cross infection.

We noted there had not been any recent infection control audits completed in the service. The new manager told us they had already identified this as a priority to complete. This should help ensure people who used the service, staff and visitors were protected from the risk of cross infection.

Requires Improvement

Is the service effective?

Our findings

We looked at the arrangements in place to ensure staff received the induction, training and supervision they required to be able to deliver effective care. We spoke with a staff member who had recently started working at the service. They told us they were in the process of completing their induction; this comprised of a one day introduction to the home as well as spending several days shadowing experienced members of staff. They told us they also had access to care plans so that they could read about the support people needed. They spoke positively about their impressions of the service since they commenced their employment.

Records we reviewed showed there was a system in place to monitor the training staff had received. The staff we spoke with during the inspection told us they had received training in safeguarding adults, moving and handling, first aid and fire safety. The acting manager told us staff were also supported to achieve nationally recognised qualifications in health and social care. However records we reviewed showed 50% of staff had not attended training in infection control and food hygiene since 2014. Seven of the 17 staff had also not completed moving and handling training since 2014.

Records we reviewed showed that prior to leaving the service the previous manager had held regular supervision sessions with staff. These sessions had been used to check staff knowledge of policies and procedures as well as learning and development needs. The acting manager told us no supervision sessions had been held since the previous manager left the service in November 2015. The new manager told us they would re-instate supervision sessions with all staff as soon as possible.

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). 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.

At the time of our inspection there were 10 people in the service subject to DoLS. CQC had received the required statutory notifications to confirm these DoLS authorisations had been made by the local authority. The assistant manager told us they were also in the process of submitting a DoLS application for a person who had been recently admitted to the service.

When we looked at the care records for one person subject to DoLS we could not find any information regarding the restrictions in place or the action staff should take to ensure the person received the care they required. Staff we spoke with also demonstrated limited understanding regarding the MCA and DoLS. None

of these staff were able to tell us if they had completed training regarding their responsibilities under the MCA and DoLS. The lack of understanding and knowledge of staff regarding these legal frameworks meant there was a risk people's rights might not always be upheld.

The lack of regular staff training and supervision was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records we reviewed contained information about individual's capacity to consent to their care in Hamilton Rest Home. We saw that systems were in place to ensure best interest meetings took place where there were any concerns that a person was unable to make a particular decision. The GP who visited the service on a weekly basis confirmed they had been involved in best interest meetings where decisions related to medical treatment.

People we spoke with who used the service told us they were able to make choices about the care they received. Comments people made to us included, "I get up and go to bed when I want. I just tell them I'm going to bed now", "I slept in late this morning. When I wake up I call them and they come and help me get up" and "They know what I like and don't like." People also told us they were confident in the abilities of staff.

All the people we spoke with told us they enjoyed the food provided in Hamilton Rest Home. Comments people made to us included, "The food is always lovely. There's always plenty of choice", "The food is OK; I eat well. They [staff] make sure you're eating properly; that's very important. They're always offering us drinks" and "There's a good choice of food."

At the time of our inspection the provider was taking the responsibility for cooking the meals several days each week due to the long-term sickness of one of the two cooks employed in the service. Records we reviewed showed the provider had recently completed food hygiene training. We saw that they were completing the required checks to ensure the safety of the food they prepared and the environment. We noted the kitchen was clean and well stocked. The most recent inspection from the environmental health department in February 2015 had awarded the service a 5* rating.

The provider told us they were aware of the likes and dislikes of people who used the service. A four week menu was in place but the provider advised they were always willing to make alternatives for anyone who did not want what was on the menu.

Our observations at lunchtime showed that staff were unhurried in their approach, including when providing individual assistance to people to eat their meal. This meant that the lunchtime experience was sociable and relaxed. We heard people commenting favourably on their meal which was well presented.

Most of the people who used the service were registered with a local GP practice. A GP from that practice visited the home on a weekly basis to monitor people's health needs. They told us that, in addition to the weekly clinic in the home, staff were proactive in contacting them should they have concerns regarding an individual's health. We saw that, where necessary, staff also made referrals to district nurses, dieticians and other health professionals.

The visiting GP we spoke with told us they were confident that staff had an excellent understanding of the needs of people who used the service. They commented that they were "impressed with the care provided by staff."

Good

Is the service caring?

Our findings

All the people we spoke with during the inspection provided positive feedback about the staff in the service. They told us staff respected their dignity and privacy and always promoted their independence. Comments people made to us included, "The staff are very kind; we all get on well together and have a bit of banter. They pay attention to what I say," "They're kind and caring and they treat me like a human being" and "The staff are very good, very respectful and treat me as a person and talk to me by name. When my wife passed away a few months ago, they were very good to me, very sympathetic and compassionate. They helped me to get over my grief."

Our discussions with staff showed they had a good understanding of the needs of the people they were looking after. Staff also demonstrated a commitment to providing high quality care. One staff member told us, "I think people are really well looked after." Another staff member commented, "Everyone knows what's needed and they make sure it gets done."

During the inspection we observed warm and caring interactions between staff and people who used the service. The visiting GP told us they would be happy for any of their relatives to be cared for in Hamilton Rest Home. We observed there were several visitors to the service during the inspection. We noted that staff made all visitors welcome and took the time to chat with them. One person who used the service told us, "My wife visits every other day. She's made to feel welcome."

We saw that staff knocked and waited for an answer before entering bathrooms, toilets and people's bedrooms. We also noted there were privacy screens in place in all the shared bedrooms. This helped to ensure people had their privacy and dignity respected when staff were providing personal care.

Care records we reviewed included information regarding people's interests and their family and social history. This should help staff form meaningful and caring relationships with the people they supported. All the care records were held securely; this helped to ensure that the confidentiality of people who used the service was maintained.

We looked to see how people were supported to receive the care they wanted at the end of their life. We were told that most staff had completed Six Steps end of life training. This programme aims to guarantee that every possible resource is made available to people in order to facilitate a private, comfortable, dignified and pain free death. The assistant manager showed us a 'Six Steps board' they had made with the help and support of staff and people who used the service. The purpose of this board was to help people to discuss their past lives and make decisions about the end of life care they wanted to receive. The assistant manager told us this had been very successful in facilitating discussions. They told us they had also held a meeting with relatives to explain the purpose of the board. They commented that this meeting had been very helpful in supporting relatives to discuss end of life care with their family member. The assistant manager told us the board had won an award from the local hospice for its creativity and the involvement of people living in Hamilton Rest Home in its development.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff responded well to their needs. Comments people made to us included, "They look after me very well here; they've been very good" and "I'm very well looked after."

We looked at the care records for three people who used the service. We saw that people's likes, dislikes, preferences and routines had been incorporated into their care plans.

Although we saw the care plans had been reviewed regularly, two of the records did not fully reflect people's current needs. For example one person's records stated they would sit out of bed to eat their meals or being supported to have bed rest, staff told us the person was now fully cared for in bed. This person's records also referred to them presenting with uncooperative behaviour when staff were hoisting them from the bed. The records did not provide any detail about the actual behaviours the person might present. Staff were also not provided with any written guidance or information as to how they should support the person should they become resistive to interventions. This meant there was a risk the person might not receive effective care and support

We saw that there was a system in place for keyworkers to discuss how people felt about the care they received in Hamilton Rest Home. People who used the service told us they were generally aware of their care plans but had often chosen not to discuss their content with staff. One person commented, "I know about my care file. I haven't been involved in review meetings but I am happy with the care I receive." Another person told us, "I don't need much help, so not really had a conversation about my care plan with the staff. They know what I like and don't like." A visitor we spoke with told us, "[My relative] can talk to me, and if I think anything needs bringing to their [staff] attention, then I'll step in. When he was coming out of hospital, the home was uncertain about whether they'd be able to cope with his changed medical needs, but he didn't want to go somewhere new and different as he'd been settled here. So they said they'd give it a go and it's been fine."

We asked the assistant manager about the activities available for people who used the service. They told us a programme of activities was in place. A noticeboard was on display in the reception area of the home to inform people of daily events. We saw that these included armchair exercises, a knit and natter group, sing along sessions and hand and nail therapy. On the afternoon of our inspection the weekly arts and crafts group was taking place. This involved a teacher from a local high school and two pupils assisting people who used the service to make items such as candles or paintings. We observed that people who used the service appeared to enjoy either watching or participating in this activity. One person who used the service told us, "I enjoy the knitting on Thursdays. Today the children come in with Arts & Craft. I don't do that but I enjoy seeing the children."

We saw that the complaints procedure was on display in each bedroom. This provided information about the process for responding to and investigating complaints. We looked at the complaints log which showed that there had not been any complaints since the provider had registered the service in September 2015.

People we spoke with told us they would not hesitate to speak with staff if they had any concerns about the care they received. We saw that a suggestion box had also recently been installed in the reception area of the home. This meant people who used the service and any visitors were able to provide feedback on the care provided and to suggest any improvements which could be made. One person told us, "All the family visit and think it's a wonderful place. I'd be telling lies if I said there was anything wrong about this place."

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in place. This was because the previous registered manager had left the service in November 2015. The assistant manager told us they had been working to support the new provider since this time. An experienced manager had been appointed and had started work at the home on the day before the inspection. However the lack of consistent leadership in the service had led to the shortfalls we identified during the inspection.

When we spoke with people who used the service they told us the new manager had already spent time with them to gather their views about the home. One person commented, "I met the new manager yesterday. He seems very nice. I wouldn't mind going to see him about anything." Another person told us, "I met the new manager this morning, he seems alright. If I needed to talk to him, it wouldn't bother me. They look after me very well here, they've been very good."

The new manager told us that their conversations with people who used the service confirmed that they felt well cared for. They told us that staff seemed to have worked well together over the previous two months to help ensure the service continued to run smoothly. They advised us that they had already begun to identify some areas for improvement in the service, including ensuring all paperwork was brought up to date.

We saw that a quality assurance report completed by the previous registered manager in March 2015 was on display in the home. This was completed following feedback received from people who lived in the home and their families in the annual questionnaire sent out by the service. This provided evidence that people who used the service, their families and professionals who visited the service considered that the quality of care provided in Hamilton Rest Home was very high.

The four care staff and domestic we spoke with told us they enjoyed working in Hamilton Rest Home. They commented that things had been difficult over the last two months since the previous registered manager had left. There had been a number of staff vacancies and staff sickness had risen.. However they told us they were now more optimistic as staff vacancies had now been filled. They told us that the new staff members had already made a positive impact on the service. Comments staff made to us included, "We all pulled together, we've supported each other," "We all get on and work as a team," "The team is now more settled" and "The assistant manager and seniors have been holding it together."

We asked the provider about policies and procedures in place to provide guidance and support to staff. We were told that they had recently purchased a suite of policies covering all areas of care, personnel and health and safety matters. The provider told us they were in the process of adapting these policies to ensure they were appropriate to their service. They advised us that once this process was complete, the policies would be made available to all staff as well as being discussed in staff meetings and supervision sessions.

We reviewed the systems in place to monitor the quality of the service provided. We saw that the previous registered manager had completed regular audits of areas including medication, care plans and the environment. However we noted the environmental risk assessments completed had failed to identify and

address the shortfalls we found during this inspection. The assistant manager also told us they had been unable to keep up with the timetable of audits since November 2015. This was because they had been required to deliver personal care to people due to staff vacancies. The lack of robust quality monitoring processes was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we checked our records prior to the inspection to see if the provider had submitted required statutory notifications, we noted no notifications had been received. The provider confirmed to us they were aware of the statutory notifications which needed to be submitted. Records we reviewed confirmed no incidents had taken place of which we were required to be notified.

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 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 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not taken the necessary steps to ensure staff received the necessary supervision and training to carry out their role effectively.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken proper steps to ensure people received safe care and treatment

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust monitoring systems in place to ensure the quality and safety of the service.

The enforcement action we took:

Warning notice