Lett's Care Ltd

Hamilton's Residential 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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Summary of findings

Overall summary

This inspection took place on 9 August 2017 and was unannounced.

Hamilton's Residential Home is registered to provide accommodation and personal care for up to 17 people. Most people were living with dementia. Some people could become anxious or distressed and displayed behaviours that could challenge. There were 15 people living at the service at the time of the inspection.

There was not currently a registered manager in post. The acting manager had applied to the Care Quality Commission (CQC) to become registered and was waiting for their registration interview. A registered manager is a person who has registered with the 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. The acting manager led the day-to-day running of the service and was supported by the provider and their representative.

We last inspected this service in February 2017. We found significant shortfalls and the service was rated inadequate and placed into special measures. People were not always receiving their medicines safely. Risks relating to people's care and support were not always adequately assessed or mitigated. The provider and registered manager had not ensured the premises were safe. The provider and registered manager had failed to report serious safeguarding concerns to the local authority and the Care Quality Commission. Full recruitment checks were not always carried out. Staff had performed a physical restraint on a person and caused a physical injury. People were not always treated with dignity and respect. People did not always receive care and treatment that met their needs or reflected their preferences. CQC had not been notified of important events that had happened within the service. The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided and failed to maintain accurate and complete records.

We took enforcement action and cancelled the registered manager's registration. We required the provider to make improvements. This service was placed in special measures. Services that are in special measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. The provider sent us regular information and records about actions taken to make improvements following our inspection. At this inspection we found that improvements had been made in many areas. However, there were still areas where improvements were required.

Medicines were still not managed safely. Although people's medicines had been reviewed and changes had been made there was no medicines policy in place, which meant that safe systems and processes were not embedded. We found some pain relief tablets were missing. There was no guidance in place when people were prescribed 'as and when' medicines for pain relief or anxiety and their administration was inconsistent.

Records were not always accurate and did not contain the level of detail necessary to mitigate risks. Risk assessments and care plans were not always updated when people's needs changed. There were still no step by step guidelines in place to ensure staff supported people consistently when they became distressed or displayed behaviours that challenged. The acting manager analysed accidents and incidents, however staff did not always record incidents when people became distressed or aggressive towards staff meaning this analysis was not complete.

Some people experienced urinary tract infections (UTIs) and although staff recorded the amount that people drank on an online system they did not know how to total these to check people had been drinking enough. One person had lost weight and staff had not taken action.

The guidance in place relating to moving people in an emergency was inaccurate and staff were unable to tell us how they would move people safely in the event of a fire.

People and their relatives said that the acting manager had made a positive impact on the service. Staff said there was a good teamwork and open culture in the service and that the acting manager was supportive. However, improvements the acting manager had made had not had time to be implemented fully. Checks and audits had not picked up the issues we identified relating to medicines, fire safety and the quality of information in people's care plans.

The environment was now safe. Healthcare professionals fed back that they felt there had been improvements within the service and that listened to their advice and guidance. Staff had received updated training and met regularly with their line manager to reflect on their practice.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. These safeguards protect the rights of people using services by ensuring that if there were any restrictions to their freedom and liberty, these had been agreed by the local authority as being required to protect the person from harm. The acting manager had applied for DoLS when necessary. People were supported to make day to day choices about their lives, such as what they ate and where they spent their time.

People told us that staff were kind and caring. There was enough staff to keep people safe, and staff spent time with people. They stopped and spoke with people and treated them with respect and dignity. People engaged in a variety of group and individual activities. People were supported to eat a range of healthy and nutritious foods.

People and their relatives had been asked their feedback on the service. Responses seen were positive and people's relatives had fed back they were pleased with the changes being made within the service. Not all complaints were currently documented to ensure the acting manager was able to look for any trends and reduce their recurrence. This was an area for improvement,

There were enough staff to keep people safe and staff were recruited safely. The acting manager had submitted notifications when important events had happened within the service, as required by law. They had made safeguarding referrals to the local authority when necessary.

Although we acknowledge that this is an improving service, there are still areas which need to be addressed to ensure people's health, safety and well-being is protected. We identified a number of continued breaches of regulations .The service will therefore remain in special measures. We will continue to monitor Hamilton's Residential Home to check that improvements continue and are sustained.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe

Medicines were not managed safely.

Risks relating to people's care and support were not always assessed or mitigated.

The acting manager had reported safeguarding concerns to the local authority.

There were enough staff to keep people safe. Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not taken action when people were losing weight.

People were supported to eat and drink safely.

Staff had received updated training and met regularly with their line manager.

People were supported to make decisions about their lives. Any restrictions had been imposed lawfully, and the acting manager had applied for Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always receive the care they needed, therefore they were not always treated with respect.

People were treated with kindness and compassion. Staff took the time to get to know people and find out how they wanted to be supported.

People said they were listened to and involved in decisions about their care.

Staff encouraged people to maintain as much independence as they were able to.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Records were not always updated to reflect changes in people's care.

People participated in a range of activities throughout the inspection.

Not all complaints were recorded to look for trends or ways of improving for the future.

Is the service well-led?

Inadequate

The service was not consistently well-led.

There were continued breaches of regulations.

Staff told us the acting manager had a positive impact on the service and the culture had improved, but changes had not had enough time to become embedded within the service.

The provider and acting manager's checks and audits had not picked up the issues identified at this inspection.

People, their relatives, staff and other stakeholders had been asked their views on the service.

Notifications had been submitted, as required by law.

Hamilton's Residential 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 checked 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 9 August 2017 and was unannounced. The inspection was carried out by two inspectors and a specialist pharmacy inspector.

Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we inspected the service sooner than we had planned. Before the inspection we looked at previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with four people using the service, two relatives, the provider's representative, the acting manager, the deputy manager and three members of staff. We observed staff carrying out their duties, communicating and interacting with people. Some people were unable to tell us about their experience of care at the service so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at nine people's care plans and the associated risk assessments and guidance. We looked at a range of other records including four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

After the inspection we spoke with the local safeguarding and commissioning team.

We last inspected Hamilton's Residential Home in February 2017 when six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified and one breach of the Care Quality Commission (Registration) Regulations 2009. At this inspection, improvements had been made but there were three continued breaches of the regulations.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. One person told us, "If I need staff they are always around. They will come and help me move around. I feel safe in the hoist." A relative told us that they were confident that their loved one was safe and secure. We saw feedback which stated, "Very clean…was very impressed with what you have done to the home so far. Well done." A healthcare professional told us, "They are keen to learn and turn things around." Although feedback was positive we found that necessary improvements had not been made regarding medicine and risk management.

At our previous inspection, medicines were not managed safely. There was a 'stock' of medicines held at the service that were not prescribed to anyone. People were on high levels of anti-psychotic medication. Sometimes the dose and timings of people's medicines had been changed and there was no evidence that this was on the advice of a medical professional. There had been no guidance for when 'as and when' medicines for pain relief or anxiety should be administered. Checks on medicines had not been effective and we could not be certain people received their medicines as required.

At this inspection some improvements had been made. All excess medicines had been disposed of, and there was no longer a 'stock' of medicines held. People's medicines had only been changed with authorisation by a health care professional. People's medicines had been reviewed and the number of people receiving anti-psychotic medicine had reduced significantly. However, we still found multiple concerns regarding medicines management.

There was a lack of systems and processes to ensure that medicines were managed safely. There was no medicines policy in place, to ensure staff followed consistent practices. One person was prescribed pain relieving medicine on an 'as and when' basis. We counted this person's medicine and it did not match the amount recorded on their medicine administration record (MAR). Daily medicine counts completed by the acting manager and staff had failed to pick up this discrepancy. We asked the acting manager to raise a safeguarding alert regarding the missing medicine, and this was done during the inspection.

After the inspection the acting manager wrote to us to inform us that there had been none of the person's pain relieving medicine in stock for a period of five days between 28 July 2017 and 2 August 2017. There was a risk that the person's pain may not have been managed effectively as staff were unable to offer the person their prescribed pain relief during this time.

There was still no guidance in place for when people were prescribed 'as and when' medicines for pain relief or anxiety. Some people became distressed and presented with behaviours that challenged. People's daily notes indicated that they became distressed regularly and their medicine was administered on some occasions and not others. There was no consistency with regards to when this medicine was administered. The acting manager told us that they believed that the person sometimes displayed challenging behaviour due to pain. Although they had been prescribed pain relieving medicine this had not yet been delivered to the service.

Although medicines were stored securely, some medicines had been removed from their original packaging and were not labelled for people. This meant that medicines may not be administered to the correct person or at the correct dose. Staff had not recorded the date when liquid medicines were opened so staff would not be aware when they were nearing their expiry date and they may not be as effective.

Some people had creams prescribed, but there were no details in people's care plans or body maps indicating where they should be applied. There was a risk that staff may not apply people's creams to the correct areas of the body, which may result in ineffective treatment.

Staff told us that a printed copy of people's electronic care plans was provided to the hospital if they were admitted or became unwell. These contained details of people's current medicines. However, when we checked medicines records in two people's care plans against their current MARs we found that these had not been updated and medicines did not match. This meant that people going to hospital may not receive the correct medicines which they were currently prescribed.

Some people had handwritten MARs. These did not always include details of the strength of medicines, or directions regarding how they should be taken. Staff had not double signed these to ensure the information was correct. Without accurate guidance there was a risk people may not receive their medicines as prescribed.

The provider had failed to ensure that medicines were managed safely. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staff monitored temperatures where medicines were stored and these were within a safe range. Unwanted medicines were recorded and disposed of appropriately. Medicines with special storage requirements were stored and disposed of safely. Two members of staff checked and recorded quantities when they were administered to people.

At our previous inspection, people had been at risk of dehydration. Staff recorded what some people drank but a daily total of what people actually drank was not calculated, so staff did not know if people had drunk enough. There was no guidance about what action staff should take if people were not drinking enough. The provider had now implemented an electronic care planning system. Staff recorded what each person drank and how much they had to drink each time, on this system. Some people had experienced urinary tract infections (UTIs). We asked to see the total amount of fluid consumed by people each day for a week before they became unwell. The acting manager told us they were unable to show us this information. Although the system logged what people had drunk it was only able to show totals for the day you were looking at and the day before. The acting manager had not done any analysis to see if people had been drinking enough before they became unwell. Nurses from the local authority had discussed with the acting manager the importance of ensuring there were accurate totals available of the amount people had to drink each day, but their advice had not been put in place. The acting manager wrote to us after the inspection and informed us they now knew how to calculate the total amount people drank each day over a period of time.

At our previous inspection, there was a lack of guidance for staff when people displayed behaviour that may challenge. There had been incidents when people had become aggressive and hurt others and staff had not dealt with these appropriately. At this inspection, some improvements had been made. Staff now documented when people were aggressive towards other people and these incidents were analysed by the acting manager. However, when people were verbally or physically aggressive towards staff these were not always documented appropriately. We found multiple instances in people's daily notes when staff had written people had been 'aggressive' or caused staff injuries. As these were not documented on separate

incident forms, so the acting manager was unable to analyse them fully and look for trends or triggers to reduce the risk of incidents happening again.

There were still no step by step guidelines in place to explain to staff how to support people in a way that suited them best with their behaviours. There was a risk that staff would be inconsistent in their approach to these situations and the risk would not be reduced. Staff told us one person became distressed during personal care. There was no information in their care plan about how to support them to remain calm or ease their distress. A visiting healthcare professional told us, "I think they need more education about how to deal with people with dementia when they are challenging."

The provider had failed to ensure that risks relating to people's care and support were adequately assessed and mitigated. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was now detailed information in place to support people with their catheter care. A catheter is a flexible tube used to empty the bladder and collect urine in a drainage bag.This information, along with the people's 'catheter passports' which outlined their care regime were stored on the back of people's bedroom doors to ensure the information was easily accessible to staff. A visiting healthcare professional told us, "I think they manage catheter care well."

We reviewed documents relating to fire safety at the service. There was a fire risk assessment in place that had recently been reviewed and stated that risks were mitigated. Each person had a personal emergency evacuation plan (PEEP) in place. A PEEP sets out the specific physical and communication requirements that each person has to ensure they can be safely evacuated from the service in the event of an emergency. However, the PEEPs contained basic or inaccurate information and there was a lack of guidance for staff regarding how to evacuate people safely.

One person's PEEP stated they had, 'the following equipment attached to them: catheter.' The person no longer had a catheter fitted and although the person was unable to weight bear and required the assistance of two staff and a hoist to transfer, there was no mention of this fact. Another person's PEEP stated, '[the person] may become agitated and can be affected by loud noises' and 'they may get confused.' There was no information regarding how the person may present when becoming agitated and confused or how staff should support them to leave the building safely.

The acting manager showed us records of completed fire drills but individual staff were not named as having completed a fire drill, so there was no way of knowing who had participated and practiced what to do if a fire occurred. We spoke with staff regarding how to support people to leave the building safely. They gave us conflicting information about what they would do. One member of staff said, "I do not think I would move [the person]. I would leave the door shut and make sure the fire brigade knew where they were." And, "You could pull the sofa down a bit, if they were sitting on that." Another member of staff said, "[The person] is a one to one and is not mobile. We would have to get them into a wheelchair." In an emergency situation, when staff needed to respond quickly there was a risk that the lack of guidance and staff's conflicting views on what to do could leave people at risk of harm.

We asked the acting manager to contact the local fire officer for advice. We received confirmation that this had happened, the day after the inspection.

The provider had failed to ensure that risks relating to fire safety were adequately assessed or mitigated. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

At our previous inspection the environment was not always safe, leaving people at risk of harm. At this inspection improvements had been made, water temperatures were now taken regularly and the water in people's bedrooms was now at a safe temperature, reducing the risk of scalding. There were no longer exposed electrical wires hanging from a socket. Parts of the flooring had been replaced in the lounge and a programme of redecoration works was now ongoing. Staff carried out regular maintenance checks on systems like the electrics and gas supply. The hoists used to support people to mobilise had been serviced to make sure they were in good working order.

At our previous inspection the registered manager had failed to report serious safeguarding concerns to the local authority safeguarding team and the Care Quality Commission. At this inspection improvements had been made. There had been occasions when people had become distressed and displayed behaviour that could be challenging towards other people. The acting manager liaised regularly with the local authority regarding any concerns in the service and made safeguarding referrals when necessary. The local authority told us that the acting manager was transparent and acted on any suggestions made. Staff told us that they knew how to recognise and respond to abuse. One staff member said, "Every situation is different, it could be an issue between two residents or I could have concerns about a person's care. I would report it to management to begin with...or I could come to yourselves (CQC)…or if I remember correctly the local authority."

At our previous inspection, a volunteer had been working at the service unaccompanied, without the appropriate recruitment checks. At this inspection, improvements had been made. No one was working unaccompanied without thorough recruitment checks. Written references were obtained and checks were carried out to make sure staff were of good character and were suitable to work with the people. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

There were enough staff to keep people safe. Staff were visibly present throughout the inspection and were attentive to people. Staff interacted meaningfully with people. They had the time to sit with them and speak with them. One person was looking at a photo album on and off throughout the day and sometimes staff sat with them and discussed the people in the photos. The acting manager told us that they had recruited new staff since our previous inspection. This had reduced the amount of temporary agency staff being used.

Requires Improvement

Is the service effective?

Our findings

People told us that they received effective care. A health care professional told us, "They are always willing to take advice." Staff said they were well supported by the acting manager. A member of staff told us, "I couldn't ask for better, the [acting manager] is doing fantastic in their new role."

We found one instance where records showed a person had lost weight and staff had not taken appropriate action to ensure they had consulted with healthcare professionals. A health care professional could help to staff to identify why the person was losing weight and offer recommendations on how to help the person to sustain a healthy weight. One person had lost weight and the acting manager had spoken with the person's GP. A dietician had visited on 28 June 2017 and the person had been prescribed high calorie drinks. The person had continued to lose weight and had lost two further kilogrammes in a month; this was 6.4% of their overall body weight. The acting manager had not sought further medical advice or consulted with the dietician regarding this large weight loss after their visit. We asked the acting manager to contact the person's doctor whilst we were at the inspection. They spoke with the person's doctor and a referral was made to a dietician the next day.

The provider had not ensured that people received the support they needed to retain a safe and healthy weight. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting professionals told us the staff always asked for guidance and support if they were unsure about anything .They said when they gave advice to staff it was acted on. If a person was unwell their doctor was contacted. This was documented in a senior handover book that was available for staff to read. Visiting professionals such as the district nurses went to the service on regular basis and were available for staff if they had any concerns.

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 so that they can 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.

At our previous inspection we found evidence that staff had physically restrained one person and this had resulted in an injury. The previous registered manager had not recognised the seriousness of this incident. The person's care plan had not been reviewed and there had been no best interest decision around the intervention. This had been an unauthorised restraint. Since our inspection the provider and acting

manager had introduced a no restraint policy. Staff had been trained in de-escalation techniques and told us they no longer held people if they became distressed.

Some people were constantly supervised by staff to keep them safe. The acting manager had therefore applied to local authorities to grant DoLS authorisations. The applications had been considered, checked and granted for some people ensuring that the constant supervision was lawful. When the applications were due for renewal they were renewed in a timely manner.

Staff supported people to make day to day decisions about their lives. We observed staff asking people for their consent before they supported them to move and supporting them to choose what they wanted to do during the day. Best interest meetings had been held if decisions were made on people's behalf, such as if they were having their medicines administered without their consent.

There was an ongoing programme of training which included face to face training and online training. Staff completed basic training in topics such as safeguarding, mental capacity and first aid. The acting manager told us they were in the process of introducing new training material for staff, which they felt was more person centred.

Staff put their training into practice and spoke with confidence about people's needs. Staff told us and we observed that one person's behaviour was to get up from their chair, walk to someone else's table and take items from this table, which caused upset. One incident occurred when they took the person's drink. This was quickly diffused by staff intervention. There was always one staff in the lounge engaging with people in there. So apart from this one incident, they were able to divert the rest. When staff assisted people to move they spoke to them, asked for consent, reassured them, checked they were comfortable and moved at a slow and steady pace.

Staff received support during formal one to one meetings with their line manager. They discussed issues that had happened in the service and reflected on their practice. New staff worked through induction training which included working alongside established staff. New staff completed the Care Certificate as part of their induction, which is an identified set of standards that social care workers work through based on their competency.

People were supported to eat a range of healthy and nutritious foods. Lunch time at the service was calm and relaxed and people chose to eat their meals at the dining room table, on smaller, individual tables in the lounge or in their bedrooms. Meals were hot and looked appetising. People were provided with the appropriate equipment, such as plate guards to ensure they were able to eat their meals independently. The menu for the day was displayed visually in the lounge, so everyone was aware of what was on offer.

Some people did not want to eat their meal when lunch was served. Staff checked on people regularly and when they wanted to eat staff organised their meal. Staff helped people eat with care and sensitivity making sure they went at a pace that was comfortable for the person. The day of the inspection was hot and staff regularly offered people hot and cold drinks and encouraged them to drink plenty of fluids.

During the inspection the cook asked people what they wanted at each mealtime. Some people could not remember what they had ordered or changed their minds and the cook catered for this accordingly. On day of the inspection three different types of pastry rolls had been made and the cook told us, "All the food is homemade fresh every day and I make cakes every day, I love my job."

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that staff were kind and caring. One person told us, "The staff here are very good." A relative told us, "I'm very happy with the care. The staff are brilliant, I can't fault them. [Person] is so happy here, always laughing." A visitor to the service told us, "I can't fault the care here. They are superb. It has had its ups and downs. If I had to come into care I would be happy to come here."

At our previous inspection people were not always treated with dignity and respect. Confidential information about people was 'missing' and not stored securely. Continence pads were left exposed and untidy in people's bedrooms. People did not always receive the support they needed and a urine soaked cushion was left in the lounge for people to sit on.

At this inspection improvements had been made. Documents were now stored securely. The provider had implemented an electronic care planning system, which meant that people's daily notes and care plans were stored electronically. These were password protected. Incontinence pads were now stored in individual linen baskets in people's bedrooms.

Although we observed staff treating people with respect and dignity some of the shortfalls identified at this inspection indicated that people did not always receive dignified care. One person's pain relief medicine was not available for a period of four days. Other people received medicine to help keep them calm inconsistently. This inattention to detail left people at risk, and indicated that improvements had not been made to ensure people were respected fully.

Staff treated people with respect and dignity. Staff spent time with people and enabled them to share their life experiences so that this would inform the style of their care and were able to prompt meaningful conversations with people. One person used to be a cookery teacher and staff talked with them about food and cooking. The person liked to write and had been given a good supply of paper and pens.

One person walked around holding a baby doll, cuddling it and stopping to look at it and talk to it every so often. Staff spoke to the person and engaged in conversation with the person referring to the baby doll. This looked like it meant something to the person. They looked content a lot of the time and when they looked up and around or maybe stopped, stood and leant a bit against the wall, staff spoke with them to check if they were ok and if they needed to rest.

People visibly brightened up from staff attention. Some people had health conditions that meant that they were tired and dozed off. Staff were respectful to people, sometimes they left them and sometimes they woke them gently to make sure they drank enough. A member of staff explained that a person had difficulty speaking at times, particularly if they were ill, but the person could remember the lyrics to their favourite songs, so staff sang to them and this seemed to cheer the person up.

People were given the opportunity to talk about their care preferences and said that staff listened to them. If people were living with dementia or had difficulty expressing themselves they were supported to make their

needs known using communication aids. A member of staff explained that they held one-to-one key worker meetings with people and adjusted the way these were conducted according to the person's needs. They used photos, picture cards and objects to help people understand and make choices. Staff found out people's likes and dislikes, checked that they were happy and if there were any concerns or anything they would like done differently. Staff showed us the form that they completed during these meetings.

A person wanted to go to the toilet. Staff were responsive, got the person's walking aid and asked the person if they could remember where the toilet was, reminding them that it was the one with the red door. The person started to get up and then became anxious, staff gently reassured them and asked for another member of staff to assist saying, "[Person] can't get up today, it's a bad day." The person visibly relaxed and with some support from the two staff was able to stand and then walk. Afterwards the person was laughing and joking with the staff and was more relaxed.

Throughout the inspection staff checked that people had what they needed in their bedrooms to keep them comfortable. A person talked about the things they liked in their bedroom, commenting, "I want a bit of comfort."

Visitors were made welcome and offered refreshments of tea and cakes.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff were responsive to their needs. We saw feedback about the service which stated, "Fantastic relationship and care; bubbly, cheerful staff, very relaxed and natural atmosphere." "Very good care and consideration shown to all concerned." "Welcoming and homely, carers were attentive and friendly." And, "Very loving and helpful staff." Although feedback was positive we found that necessary improvements had not been made regarding the quality of information and guidance given to staff to ensure people received consistent, person-centred care.

At our previous inspection, care plans were not always accurate and did not contain the detail necessary to give staff guidance to support people effectively. At this inspection, a new electronic care planning system had been introduced. Staff told us they thought this was beneficial, and that it made recording what happened each day easier. Although people's daily records were more detailed, the guidance regarding how to support people was often inaccurate or conflicting. Care plans, used by staff, that were not up to date placed people at risk of receiving inconsistent care. Clear up to date care plans were important, as some people could not tell staff about their needs due to their dementia.

One person had a pressure sore and was receiving assistance from the district nursing team. They told us the pressure sore was being managed well and it was healing. The person's care plan stated that the person required, 'half hourly turns during the day and hourly turns during the night.' It also stated that they should not be placed on their back, due to the location of the pressure sore. Staff had documented that they were turning the person every two hours, and were regularly supporting the person to lie on their back. We spoke with the acting manager who told us that the person had fallen and hurt their right hip in July, and staff were unable support the person to lie on their right side as it was too painful. They told us that as the sore was healing they had been advised to turn the person every two hours instead. The person's care plan had not been updated to ensure all staff followed this updated guidance.

At our previous inspection information regarding some people's risk of choking and the way they wanted their food served was incorrect. At this inspection we found the same issues. Information regarding some people's choking risk was inaccurate and information regarding how people wanted their food served had not been recorded.

Senior staff assessed people's needs before they moved in, with involvement from the person and their relatives. A care plan and associated risk assessments was written using this information. We reviewed some care plans that had been since the last inspection. Some contained conflicting information. In the about me section it stated that the person dementia and it was a controlling factor in their daily life Immediately below it, it stated that the person, does not have a diagnosis of dementia, so it was not clear for staff.

The provider had failed to ensure that records were person-centred and accurate. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a variety of planned and spontaneous activities for people to join in with in the main lounge.

During our inspection there were 40s style music and dance songs playing and a member of staff was encouraging people to dance to the music or wave their arms around and sing along. Some people participated in this and said they were enjoying themselves. Other people said they were happy watching.

A person commented, "I like it here, it's a nice place to come on a Saturday afternoon." Another person told us, "I like reading and there are some nice photos and pictures to look at here."

A member of staff sat at the table with a person assisting them to sew felt toys that had holes punched in them with a large needle. The person was engaged with this activity for some time visibly enjoying it.

Seating was arranged in two groups so that people could socialise with each other and group activities were focused in one area at a time. People had the choice of whether to participate in the current group activity or have something else to occupy them.

Staff asked people if they would like a memory cushion and handed them out to people. These were soft knitted tubes that people could hold or put their arms in with different objects attached and people put their arms through them, looking and feeling the attached objects. Every so often staff would sit with a person and talk about the objects and then this would prompt conversation. For example, there were some keys on one and staff and the person started talking about their front door, what colour it was and about their house. The person was smiling throughout. Staff made sure that each person had something to do if they wanted. Some people were happy reading and doing puzzles. A person commented, "It's good to keep the brain working."

Relatives told us that staff and the management team were approachable and if they had any concerns they were able to talk them through. People had the opportunity to express their views in one to one meetings with staff and could also have meetings with the acting manager. Some people had family and friends to help them air their views.

The acting manager told us there had been no formal complaints since our last inspection. Small issues that arose were responded to and dealt with, however, these were not systematically recorded and reviewed to see if any lessons could be learnt. One visitor had raised that they had travelled to see their loved one, but when they arrived they were unable to come inside as people were unwell. No one had informed the relative of this. They had requested to be informed in the future to ensure they did not have a wasted journey. Although this had been dealt with, the acting manager agreed it would be helpful to have a formal record of all level complaints so they were able to identify any trends and prevent incidents from happening again. This was an area for improvement.

Inadequate

Is the service well-led?

Our findings

We last inspected Hamilton's Residential Home in February 2017 when six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. We identified breaches relating to safe care and treatment, safeguarding, person-centred care, respect and dignity, good governance and fit and proper persons employed. There was an additional breach of the Care Quality Commission (Registration) Regulations 2009. The provider and registered manager had failed to notify us of important incidents that had occurred within the service. We took enforcement action and cancelled the registered manager's registration.

Since the previous inspection we had now been made aware of all important events that had happened within the service. The acting manager and the provider's representative had kept us fully briefed of events that had occurred.

Improvements had been made with regard to implementing the checks and audits of the service; however, these were still not effective, as they did not pick up the shortfalls found at this inspection. Although the acting manager had implemented daily medicines checks these had not identified that one person's pain relief medicine did not match the stock recorded. They had also not ensured that the person's medicine was always in stock.

Guidance regarding how staff should respond if people became distressed or anxious was not detailed. Some people were prescribed medicine if they became anxious or displayed behaviour that challenged and there was no guidance for staff on when these should be administered. Administration of these medicines was inconsistent. Although staff recorded when people displayed behaviour that challenged towards other people they did not always record when this occurred with staff. This meant the acting manager's analysis of incidents was incomplete, leaving people at risk of receiving inappropriate support.

The acting manager had not implemented recommendations regarding monitoring people's fluid intake from health care professionals. People's care plans were not always accurate and did not contain necessary information to guide staff. When people's needs had changed, such as after a fall or injury their care plans had not been updated accordingly. We found multiple instances where staff had written incorrect or conflicting information such as regarding people's diagnosis of dementia or their choking risk. The acting manager told us they regularly reviewed people's care plans, but these reviews had not identified any of these shortfalls.

Emergency evacuation plans lacked necessary detail to guide staff if they had to support people to leave the service unexpectedly. Staff were unable to tell us what action they would take in the event of a fire.

We reviewed people's daily notes and found that they were not always completed accurately. Staff had documented that one person's legs had, 'slipped down the side of the bed and got caught underneath the bars.' We asked the acting manager if they were aware of this incident and they told us they had not been informed. Staff checked the person's legs and there was no sign of any injury. Staff later confirmed that the

person's legs had not been caught, and they meant they had slipped down the side of the mattress. The acting manager confirmed that all staff would be sent on communication and record keeping training following this incident.

Complaints were not always documented and recorded to ensure the provider was able to look for trends or ways of improving the service for the future.
The provider had sent us an action plan stating they would be compliant with all of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by May 2017. Although improvements had been made we found continued breaches of regulations 12 and 17.

The provider had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided and failed to maintain accurate and complete records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our previous inspection a new, acting manager had been appointed and they were applying to become the registered manager. People and their relatives told us that they felt the acting manager had made a positive impact on the service. Staff said they felt able to speak out with any concerns and that the acting manager would listen to them. One staff member told us the acting manager was, "More involved and more confident. They are very approachable and they do listen." A relative told us, "We are very happy…we were a bit concerned when we saw the inspection report but so far so good." However, the acting manager had only been in post for four months so it was too early to see that improvements had been embedded or sustained.

At our previous inspection a large number of documents were 'missing.' The information we needed to ensure the service was safe was not always available. We told the previous registered manager to report the missing documents to the Information Commissioners Office, but there was a delay of three weeks in doing so. At this inspection documents were now secure. We were provided with all of the information we needed, and when we identified gaps or errors the acting manager responded appropriately, however, this was prompted by our inspection rather than by the checks the manager and provider made.

Regular staff meetings were held for staff to come together and share their thoughts on the service. The acting manager told us that since the last inspection they felt the culture of the service had improved and these meetings were important to ensure this was embedded within the entire staff team. The acting manager said, "I treat the residents like they are my family. I want to be here for the residents. I want good staff; caring, reliable staff. It is not about me, it is about them at the end of the day." Staff we spoke with confirmed this vision, stating, "It is all about quality life. We want to make sure they [people] are comfortable and it is better here than then being at home alone."

People, their relatives, staff and other stakeholders had been asked their views on the service. Surveys had been given to everyone and these could be returned via the suggestion box in the hallway so could be completed anonymously if preferred. The providers and acting manager had recently organised a meeting and BBQ to enable people and their relatives to give feedback and hear what the plans were for improvements since the last inspection. Feedback was sought at this event and shown to us at the inspection. All of the comments received were positive and included, "As always very good. A really good day for everyone." "Thank you for a perfect afternoon. We enjoyed it very much and much appreciate all the efforts that you put in for the residents and their families at all times." "A lot of hard working staff with their efforts went into making the afternoon such a splendid occasion." Comments from people's relatives regarding the decoration of the building and flooring were listened to and acted on, and some improvements had already been implemented such as areas of the flooring being replaced.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the entrance hall.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that medicines were managed safely. The provider had failed to ensure that risks relating to people's care and support were adequately assessed and mitigated. The provider had failed to ensure that risks relating to fire safety were adequately assessed or mitigated. The provider had not ensured that people received the support they needed to retain a safe and healthy weight.