Care Quality Commission

Hamilton Community Homes Limited

Hamilton House

Inspection report

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Ratings

Overall rating for this service	Inadequate ●

Is the service safe?	**Inadequate** ●
Is the service well-led?	**Inadequate** ●

Summary of findings

Overall summary

Hamilton House provides accommodation and personal care for up to 19 adults with mental health needs, including alcohol and substance abuse. There were 16 people using the service at the time of the inspection.

The property spans over two converted houses, with all areas being accessible to people using the service.

People's experience of using this service and what we found
The systems in place to assess, monitor and manage risks to people's health, safety and welfare were ineffective. High risk areas of concern identified in the last fire risk assessment still continued to be in place. People were at risk of harm because risk assessments were not always in place for identified issues. Some risk assessments were out of date and not regularly reviewed.

Care plans did not always contain adequate information for staff to know how to support people safely. They did not record people's goals or celebrate their achievements.

Government and best practice guidance to protect people living in care homes during COVID-19 were not always adhered to.

Robust recruitment checks had not been completed to ensure only suitable people were employed to work at the service. Insufficient staffing levels and the deployment of staff placed people at risk of harm.

Staff training was not always undertaken in line with current best practice guidance.

We have made a recommendation about the frequency of staff training.

There were no lessons learned protocols in place so the provider could learn and prevent incidents and accidents, safeguarding concerns and complaints and improve the quality of the service.

There were inadequate quality assurance processes in place to monitor the quality and safety of the service. There was a lack of managerial oversight to ensure the provider's policies to keep people safe were adhered to.

Feedback from people was not sought on a regular basis. Staff meetings and supervisions had not been held and there was no evidence that meetings for people using the service were taking place.

People and their relatives felt that Hamilton House was a safe place to live. Staff were aware of the whistleblowing procedures and said they would report any concerns they had.

People's medicines were safely managed, and people received their medication as prescribed.

People and relatives told us the registered manager and the owner were approachable and the atmosphere was open and friendly.

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

Rating at last inspection
The last rating for this service was Good (published 12 December 2018)

Why we inspected: We received concerns in relation to poor care planning, the smoking and drinking policy not being followed and a lack of safety and welfare checks for people. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hamilton House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to staffing, risk management and good governance.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration,

we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Hamilton House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Hamilton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
We gave the service a short notice period of the inspection on the first day of the inspection. We telephoned and informed the service of our inspection 10 minutes prior to entering the service. This was to help the service and us manage the risks associated with COVID-19.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and clinical commissioning group (CCG) who commission with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require provides to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke and met with three people who used the service and the registered manager who is also the Nominated Individual. The Nominated Individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with the owner. Following the inspection, we spoke with two family members on the telephone and a further two care and support staff members.

We reviewed a range of records. This included two people's care records and six medication records. We looked at three staff files in relation to recruitment. Plus, a variety of records relating to the management of the service, including monitoring of quality and risk, policies and procedures and the fire risk assessment.

After the inspection
We continued to seek clarification from the provider to validate evidence found in relation to the provider's smoking, alcohol use, substance abuse policies, medication audits and competency checks, and the staff training matrix.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- We found shortfalls in the assessment of risks to the health and safety of people living at Hamilton House. There were risks in relation to fire safety. We found evidence that some people smoked in their rooms. This was not in line with the provider's no smoking policy. In one room we saw evidence that the occupant had been burning incense sticks.
- One of the significant findings recorded in the fire risk assessment was that there was an accumulation of flammable material in some of the bedrooms and a significant number of cigarette lighters in [room number]. We found some people were hoarding bags in their rooms at the time of our visit. We also observed in some bedrooms a number of cigarette lighters posing a potentially serious fire risk.
- The fire risk assessment dated 15 April 2021 rated as an immediate action that people were educated in the dangers of accumulating excessive amounts of combustible material within their rooms. Further education should be had in respect of the dangers posed by flammable gas and the accumulation of cigarette lighters. We did not find any evidence that this had taken place.
- People's individual risk assessments had not always been dated or signed. They were not always reviewed regularly or when a person's needs changed. For example, one person's nutritional screening tool had not been updated since 2019. There was no record of their weight in their care file since January 2021, even though the weight chart stated weigh monthly.
- We saw in care plans areas of risk to people that were not supported by a risk management plan, to enable staff to provide safe care.
- Systems in place to ensure equipment and utilities at the service were safe and properly maintained were not consistently followed. For example, the Electrical Appliance Certificate dated 28 June 2018. The certificate stated that this check needed to be conducted annually. However, there was no evidence of checks being carried out in 2019, 2020 and 2021. This was also a recommendation in the fire risk assessment dated 15 April 2021.

Preventing and controlling infection

- COVID-19 checks were not completed for the inspectors on their arrival to Hamilton House in line with current best practice.
- The registered manager confirmed that she had not undertaken any infection control audits or spot checks of staff, particularly donning and doffing of Personal Protective Equipment (PPE).
- COVID-19 specific risk assessments for people and staff including BAME (black, Asian and minority ethnic) staff and those shielding had not been completed.
- The registered manager informed us that they had admitted a person from hospital but had not ensured they were supported to isolate for a 14-day period. Following the inspection the registered manager

Inadequate informed us that they were following the guidance available at the time.
● The registered manager confirmed in discussions about COVID-19 that not all people using the service were receiving monthly PCR tests and staff were not receiving weekly PCR tests in line with best practice.
● We were assured that the provider's infection prevention and control policy was up to date. However, these were not being followed consistently by staff. For example, people using the service and staff did not regularly take part in routine testing for COVID-19.
●We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

The provider had not ensured that the risks to the health and safety of people using the service had been assessed and had done all that is reasonably practicable to mitigate any such risks. These concerns constitute a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

Following the inspection, the registered manager sent us a dehydration risk assessment that she had developed for future use. The registered manager also sent us an email to confirm the Legionella Risk Assessment had been reviewed by the owner in October 2020.

Staffing and recruitment
● The providers recruitment process had not been consistently followed. For example, in two files we looked at there was evidence that the applicants had previous offences, but this had not been followed up by a risk assessment. Gaps in employment history had not been explored.
● We had mixed views from staff about whether staffing numbers were sufficient to meet people's needs. One told us, "There are enough staff to meet people's needs. Staffing levels have improved recently with the addition of three new staff being recruited." A second staff member commented, "It would be good to have more care staff members on so that more time could be given to people to talk and to provide independence training such as teaching people to cook."
● Staff rotas demonstrated that staffing varied from two staff to four staff on different days. There was no rationale for this. The registered manager did not use a dependency tool to review people's needs on an ongoing basis and determine staffing numbers were adequate to meet people's needs.
● Staff rotas demonstrated that some staff worked long, excessive hours. For example, some shifts were 16 hours. One person had worked 72 hours in one week. This meant a risk of staff being tired and fatigued which may impact how they support people.
● The registered manager told us, and staff rotas confirmed, there were two staff on duty at night who slept in. This meant there were no waking staff at night to conduct welfare checks on people.

The provider had not ensured that sufficient numbers of staff were deployed at night in order to keep people safe. These concerns constitute a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing

● The registered manager told us that staffing had not been at full capacity recently and she had been working to provide personal care. Recruitment drives had been undertaken and at the time of our visit the registered manager told us they were now fully recruited. The rotas showed that three staff were training on their induction.

Systems and processes to safeguard people from the risk of abuse
● Staff had last received safeguarding training in 2018. Skills for Care (the strategic body for workforce development in adult social care) recommend staff are provided with learning and development

opportunities in relation to safeguarding when identified or required and at least annually.

We recommend the provider consider current guidance about the frequency of safeguarding training for staff and take action to update their practice accordingly.

● People told us they felt safe living at Hamilton House. One person told us, "I feel safe, I have no concerns. We all get on; we are like family." A relative said, "Yes [name of family member] is safe. I know they feel safe from the things they tell me. When they come to visit me, they are always keen to get back."
● Most staff members were knowledgeable about reporting safeguarding issues to management and were aware of at least one external organisation they could contact if they needed to whistle blow. One said, "I would report concerns to my manager or to the owner. If they didn't do anything I would go to the police or CQC."
● Staff told us they had received safeguarding training in the past. However, one staff member could not describe any form of abuse apart from physical abuse. This meant they may not identify when a person was at potential risk of harm and may not take actions to safeguard the person.
● The registered manager mostly followed local safeguarding protocols and worked with the local authority to safeguard people and keep them safe. However, they had failed to notify the local authority about a serious incident that occurred.

Using medicines safely
● Staff told us they had completed training in relation to the safe administration of medicines. They then had their competency checked by the registered manager. They told us they had not received refresher training for two years. The staff training matrix showed that five of the seven staff had last completed their medication training in 2018. NICE (The National Institute for Health and Care Excellence) guidance recommends that learning for care home staff is refreshed and knowledge and competence assessed at least annually.

We recommend the provider consider current guidance about the frequency of medication training for staff and take action to update their practice accordingly.

Following the inspection, the registered manager sent us an email to inform us that staff had their medication competency checks completed in 2019 and medication training in September 2020. We requested a copy of an updated training matrix to confirm this, however we have not yet received the records we requested.

● Medicines were received, stored, administered and disposed of safely. We saw records were fully completed.
● People had their medicines when they needed them. One person told us their experience of receiving medication was good and they received their medication when they wanted it.
● Medicines to be administered on an 'as needed' basis were administered safely following clear protocols. There was a medicines policy which gave guidance to staff on the safe management of medicines.
● Temperature checks of the medication room were carried out daily and we saw these were recorded. This ensured medicines were stored at the correct temperature to ensure their effectiveness.

Learning lessons when things go wrong
● Although accidents and incidents were recorded the registered manager told us there was no system in place to analyse accidents and incidents so that lessons could be learned, and improvements made to people's care and support.

- Although there was no formal process in place to learn lessons when things went wrong, the registered manager told us about the actions she had taken following a serious incident and how she had made improvements to the handover meetings to ensure information was shared with staff.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care

● A registered manager was in post and had worked at the service for over twenty years, which meant management had been stable. The registered manager was also the Nominated Individual, responsible for supervising the management of the service on behalf of the provider.
● There was a lack of managerial oversight to ensure the provider's policies and terms and conditions of residency were followed and adhered to, to ensure people's safety.
● There were no lessons learnt protocols in place so the provider could learn from incidents and accidents, safeguarding concerns and complaints to improve the quality of the service.
● Staff recruitment files demonstrated a lack of required employment checks. The providers quality monitoring checks had not identified the gaps.
● The provider failed to have effective systems in place to assess, monitor and improve the overall quality of the service. For example, quality monitoring checks had failed to identify the issues we found at this inspection.
● People's care did not always empower them to gain new skills, become independent and achieve good outcomes. Care plans did not record people's goals or celebrate their achievements. Care plans lacked details about how staff should support them safely.
● We found there was a lack of oversight in relation to assessing and providing safe staffing numbers and this placed people at risk of harm.
● The registered manager had not kept up to date with current guidance in relation to COVID-19 and infection control and prevention procedures. We found the service was not working in line with current best practice.
● There was a lack of managerial oversight to ensure staff training was provided in line with current best practice.
● The registered manager sent us the information required, such as notifications of changes or incidents that affected people who lived at the service. However, although the registered manager had notified CQC about a serious incident they had failed to notify the local authority.

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

● The provider did not always effectively involve and engage with people and staff. We asked to see the minutes for meetings held with people using the service. The registered manager confirmed that these had not taken place on a formal basis so were not recorded as taking place.

● The registered manager confirmed, when we asked to see the minutes for staff meetings that these had not been held regularly but said she did speak with staff on an informal basis when she was working with them. This was not recorded for us to check.
● The registered manager and staff we spoke with confirmed that staff had not received formal supervisions in line with the providers training and development policy. This stated staff supervisions will be held six times a year.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. This was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People and relatives told us the registered manager and the owner were approachable and the atmosphere of the home was open and friendly. One person said, "I have never been to a place like this where you are free to come and go." A relative commented, "[Name of registered manager] is always available to talk to. Communication is very good."
● Staff told us that the registered manager was supportive to them. They felt she had an open-door policy and they would be given time to discuss any issues or concerns. One staff said she was, "Open and transparent." Another commented, "The manager does a very good job, because of this, I would recommend the home to family and friends if they needed this sort of care."
● Staff members told us they felt valued by the registered manager. Staff were praised for the good work they had carried out with people. One staff member said, "I have never had a problem with this. The manager is always friendly and supports everyone."
● Staff told us the registered manager was always visible and worked with them to provide care and support to people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● There were systems in place to ensure compliance with the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Working in partnership with others
● The registered manager referred people to specialist services either directly or via the GP. Records confirmed the service had worked closely with the district nurses, the Parkinson's nurse, and people's GP's.
● The service had worked with the police to help support people living at the service.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective systems and processes were in place to assess, monitor and improve the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that sufficient numbers of staff were deployed at night in order to keep people safe.

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 ensured that the risks to the health and safety of people using the service had been assessed and had done all that is reasonably practicable to mitigate any such risks.

The enforcement action we took:

We issued a warning notice in relation to Regulation 12 Safe Care and treatment