Shaftesbury Care GRP Limited

Hamilton House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Hamilton House is a nursing home which provides accommodation, personal care and nursing care to 60 older people, some of whom were living with dementia. The home has three floors, with a passenger lift which gave access to all floors and all bedrooms had en-suite facilities. At the time of the inspection, 48 people were living at the home.

The inspection was unannounced and took place on 19 and 20 April 2018. There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection, in September 2017 we identified widespread and systemic failings and rated the service 'Inadequate' overall. We identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. Medicines were not managed safely; risks to people were not managed effectively; staff did not always act in an open way when accidents occurred; allegations of abuse were not always investigated; safe recruitment procedures were not followed; staff training was out of date; people's rights were not protected; care plans did not always reflect people's needs; quality assurance systems were not effective; and notifications of important events were not always submitted.

Following the inspection, we placed the service in special measures in order to monitor it closely. The provider wrote to us detailing the action the intended to take to meet the regulations and sent us weekly updates of their action plan.

At this inspection, we found improvements had been made under the leadership of a new management team. However, we identified that quality assurance systems needed further development and time to become fully embedded in practice. There continue to be two breaches of regulations in relation to safe care and treatment and good governance.

The provider had clear recruitment procedures in place, but these were not robust and were not always followed.

People were supported to receive their medicines safely and as prescribed. However, there was insufficient guidance about two medicines that were used on an 'as required' basis and the temperature of medicines that needed to be refrigerated was not monitored effectively.

Staff were suitably trained and supported in their roles. However, we found some nurses did not follow evidence based practice when supporting people with diabetes or pressure injuries.

Each person had a care plan that was centred on their needs and reviewed regularly, although we found some care plans contained conflicting information.

People felt safe living at the home. Staff knew how to identify, prevent and report abuse. They assessed and managed risks to people and risks posed by the environment effectively.

Individual and environmental risks to people were managed effectively. The home was clean and hygienic and staff followed best practice guidance to control the risk and spread of infection.

There were enough staff to meet people's needs in a timely way. They acted in the best interests of people and followed legislation designed to protect people's rights and freedom.

People's dietary needs were met and they received appropriate support to eat and drink enough. Adaptations had been made to the home to make it supportive of people living with dementia.

People were supported to access other healthcare services when needed. Staff made information available to other healthcare providers to help ensure continuity of care.

People were cared for with kindness and compassion. We observed positive interactions between people and staff throughout the inspection, with one isolated exception.

Staff protected people's privacy and dignity. They encouraged people to remain as independent as possible and involved them in planning the care and support they received.

People's needs were met in a personalised way. Staff empowered people to make choices and were responsive to people's needs changed. People were supported at the end of their lives to have a comfortable, dignified and pain-free death.

People had access to a wide range of activities based on their individual interests, including regular access to the community. They knew how to make a complaint and a complaints procedure was in place.

Managers were visible and approachable. Staff were organised and felt engaged in the way the service was run. They demonstrated a commitment to the values of putting people first.

The service had an open and transparent culture. People were consulted about the way the service was run. Visitors were welcomed and the registered manager notified CQC of all significant events.

We identified two breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory enforcement response.

Although improvements have been identified, we have taken the decision to keep the service in special measures to enable us to keep it under review and monitor the sustainability of the improvements.

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 again and it is not 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?

Requires Improvement

The service was not always safe.

Appropriate recruitment procedures were in place, but were not always followed.

Medicines were usually managed safely; however, there was a lack of information about some 'as required' medicines and the storage temperature of the medicines fridges was not always monitored effectively.

People felt safe and staff had received training in safeguarding adults. Individual and environmental risks to people were managed effectively.

There were appropriate systems in place to protect people by the prevention and control of infection.

There were enough staff deployed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Nurses did not always follow evidence based practice when supporting people with diabetes.

Staff followed legislation designed to protect people's rights, although the views of relevant people were not always recorded when decisions were made in people's best interests.

Staff had completed a programme of training and were appropriately supported in their role by managers.

People's nutrition and hydration needs were met. When people needed support to eat, this was usually provided done a dignified way.

Adaptations had been made to the home to make it supportive of the people who lived there.

People were supported to access other healthcare services when

needed.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They usually interacted positively with people and promoted their independence.

Staff protected people's privacy and respected their dignity.

People and family members, where appropriate, were involved in planning the care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans contained information to support staff to provide care in a personalised way. However, some care plans contained conflicting information.

Care and support were centred on the individual needs of each person, although some staff were not aware of the communication needs of one person.

Staff responded promptly when people's needs or preferences changed.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death.

People were empowered to make choices about all aspects of their lives. They had access to a range of activities suited to their individual interests.

People knew how to raise concerns. Information from complaints was used to drive improvement.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a comprehensive quality assurance process in place, but this had not identified concerns we found during the inspection. Further time was needed to develop and fully embed the quality assurance systems in practice.

People and their relatives told us they had seen significant improvements in the service since the appointment of the current registered manager.

There was a clear management structure in place. Staff were organised and communicated effectively between themselves. They felt engaged in the way the service was run and were committed to putting people first.

The service had an open and transparent culture. People were consulted about the way the service was run. Visitors were welcomed and the registered manager notified CQC of all significant events.

Hamilton House

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 and 20 April 2018 and was unannounced. It was completed by two inspectors, a specialist advisor in nursing care 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.

Before the inspection we reviewed all information we had received about the service, including previous inspection reports, the provider's action plan and notifications. Notifications are information about specific important events the service is legally required to send to us.

We spoke with 12 people who used the service and nine family members or friends of people who used the service. We spoke with the registered manager, the deputy manager, a unit manager, four registered nurses, seven care staff, an agency care worker, two activities coordinators, an administrative assistant, a maintenance worker, two kitchen staff and two housekeepers. We received feedback from two health or social care professionals who had contact with the service.

We looked at care plans and associated records for 12 people and records relating to the management of the service, including: duty rosters, staff recruitment files, records of compliments and complaints, accident and incident records, maintenance records and quality assurance records.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We last inspected the service in September 2017 when we rated the service 'Inadequate' overall and placed it in Special Measures. At that inspection, we identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Registration Regulations 2009.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, in September 2017, we identified breaches of Regulations 12, 13 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe recruitment procedures were not always followed; medicines were not always managed safely; people were not protected from the risk of abuse; individual risks to people were not always managed appropriately and staff did not always follow infection control guidance.

At this inspection, we found improvements had been made and, although there were no longer breaches of Regulations 13 and 19, there was further improvement required as detailed in the paragraphs below. There was a continued breach of Regulation 12 which is detailed in the Effective section of this report.

The provider had clear recruitment procedures in place, but these were not always followed. They required applicants to complete an application form, to provide a full employment history and to be subject of pre-employment checks, including references, before they started work at the home. References enable an employer to check the applicant's past performance and behaviour when considering their suitability to work with adults at risk. We found one staff member had started work before one of their references had been received; when it was received, the employment dates detailed in the reference did not correspond with the employment dates on the staff member's application form. This was not followed up until we identified the anomaly. Although the registered manager was satisfied by the subsequent explanation given by the staff member, we could not be assured that the provider's procedures were robust. Another staff member's employment history contained unexplained gaps of up to twelve months. This meant the provider was unable to confirm what the applicant had been doing during these periods and whether this might impact on the applicant's suitability for employment.

However, in all cases, we found checks had been completed with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions by disclosing any previous convictions held by the applicant. Furthermore, the registered manager took immediate action during the inspection by introducing a recruitment check list, together with a manager's 'sign-off', before any staff member was employed. This would help ensure safe recruitment procedures were followed consistently in future.

People were supported to receive their medicines safely and as prescribed. One person told us, "They [staff] keep me well supplied with medication." There were clear processes in place to obtain, store, administer, record and dispose of medicines. Medicines were only administered by nurses. They had been suitably trained and their competence to administer medicines had been assessed by one of the managers.

For people prescribed 'as required' medicines (PRN), we found there was usually clear information about when and how these medicines should be given. However, for one topical cream we found there was a lack of guidance about when it should be used and staff had conflicting views about this. For a person prescribed a pain killer, there was conflicting information about how often the medicine could be given within a 24 hour period. The lack of guidance meant the person might not have received the medicine when they would have benefitted from it. We discussed this with one of the nurses who undertook to update the guidance.

Medicines that needed to be stored at cool temperatures were kept in secure medicine fridges on each floor. Although staff monitored the temperature of the fridges, they did not always check the minimum and maximum temperatures over a 24 hour period and we found they had not taken action when the temperature had been outside of the safe range in two of the fridges. This posed a risk that the medicines may no longer be safe for use. We discussed this with the registered manager who put new procedures in place to ensure fridge temperatures were monitored effectively in future.

When asked if they felt safe at Hamilton House, one person said they did because "There are plenty of people about". A family member told us, "It was difficult for me when [my relative] was at home, but I feel she is very safe here." Staff had received safeguarding training and knew how to identify, prevent and report abuse and how to contact external agencies for support. One staff member told us, "No one is going to hurt a resident when I am on duty, doesn't matter who it is I will challenge them." Staff were confident managers would respond promptly to any concerns raised. Records confirmed that the registered manager had reported incidents appropriately to the local safeguarding authority and had completed prompt and thorough investigations where required.

Individual risks to people were managed effectively. Risk assessments had been completed for all identified risks, together with action staff needed to take to reduce the risks. For example, some people were at risk of developing pressure injuries and we saw special pressure-relieving mattresses had been provided. Staff understood how to adjust the mattresses and there was a clear process in place to help ensure they remained at the right setting according to the person's weight. Choking risk assessments were routinely conducted when people moved to the home and, where necessary, referrals made to speech and language therapists for further assessment. Where thickened fluids were recommended, we saw people received these consistently. Suction machines were available on each floor of the home and were checked regularly to make sure they were working properly.

People were also protected from the risk of falling. Some people had been given walking aids to help them mobilise independently. Staff made sure these were accessible and prompted people to use them correctly. Other people were at risk of falling out of bed and bed rails were being used where appropriate to reduce the risk. Comprehensive assessments of the risks posed by bed rails had been completed and were reviewed regularly. When people experienced falls, staff monitored them for signs of injury, including head injury using appropriate monitoring tools. In addition, their risk assessments were reviewed and additional measures considered to keep them safe. As a result of one review, we saw a chair alarm was being used for a person with a history of falls, to alert staff if they tried to mobilise without support. The registered manager reviewed all falls in the home on a monthly basis, including during 'falls meetings' to identify any patterns or trends. None had been identified, but they described the action they would take if a common theme emerged.

Environmental risks were also managed effectively. Gas and electrical appliances were serviced routinely and fire safety systems were checked regularly. Staff were clear about what to do in the event of a fire and had been trained to administer first aid. In addition, each person had a personal emergency evacuation plan detailing the support they would need if the building needed to be evacuated. A new fire safety risk assessment had been completed in the previous year. This had identified additional safety measures, all of which had either been implemented or was in the process of being implemented.

There were appropriate systems in place to protect people by the prevention and control of infection. One person told us, "They [housekeepers] come every day and clean and tidy my room." All areas of the home were clean and records confirmed they were cleaned regularly and in accordance with a cleaning schedule. Staff had completed infection control training, had access to personal protective equipment (PPE) and wore

this whenever appropriate. They described how they processed soiled linen, using special bags that could be put straight into the washing machines in the laundry. The layout of the laundry had changed since the last inspection and now had an 'In' door and an 'Out' door for staff. This helped reduce the risk of cross contamination. In addition, since the last inspection, hand washing sinks had been installed in the kitchen areas on each floor which we saw staff using before they prepared or served food to people.

There were enough staff deployed to meet people's needs. One person told us, "They [staff] come quite quickly [when I press my call bell]." A family member added, "There's plenty of staff. If [my relative] needs the toilet [they] only wait a few minutes; staff are always about." Another family member told us, "They seem to be less reliance on agency staff now. The staff I see are all okay. I'm pretty comfortable with the staff numbers." The registered manager used a tool to calculate the number of staff needed, based on people's needs and also took account of the layout and size of the building. The staff rotas showed that the number of staff on duty each day consistently exceeded the minimum number specified by the tool. Throughout the inspection, we saw staff were available to support people and people's call bells were responded to promptly.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, in September 2017, we identified breaches of Regulations 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff did not always follow legislation designed to protect people's rights and not all staff were suitably trained.

At this inspection, we found improvements had been made and there were no longer breaches of these regulations. However, we identified that further improvement was still required and that Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been breached in respect of safe care and treatment.

People and their relatives felt they received effective care from competent staff. For example, a family member told us, "I can't fault the care and support. Some staff go above and beyond." Another family member described the care as "extraordinary". They added: "I honestly don't have a concern, knowing that [my relative] is being well cared for."

We found staff were competent in respect of most aspects of people's care, but we identified that nurses did not always follow evidence based practice when supporting people with diabetes. The home had two blood glucose meters to check people's blood sugar levels, but these were not calibrated on a regular basis to ensure they were working correctly. Therefore, staff could not confirm that the treatment they were providing to people was based on accurate information about their blood sugar levels. We discussed the treatment of hypoglycaemia (low blood sugar levels) with three nurses and found two were not clear about when to use fast acting glucose gel that had been prescribed for some people.

One person required regular injections of insulin to control their diabetes. Records showed that on one day their blood sugar level was low immediately before they received insulin, but staff had not checked the blood sugar level afterwards to make sure they did not experience a hypoglycaemic episode. This was necessary as the administration of insulin can cause a person's blood sugar level to fall further. The failure to do this, coupled with our discussions with the nurse, showed they had not taken an evidence based approach to the management of the person's diabetes.

Another person with diabetes had a percutaneous endoscopic gastrostomy with jejunal tube JPEG. This is a tube that allows food and medicines to be given directly into the stomach. The person had a detailed hypoglycaemia care plan in place. However, this did not specify when a prescribed injection for treating hypoglycaemia should be administered if the person did not respond to glucose given via their JPEG. After discussion with the registered manager, this was amended. The registered manager told us all the nurses had recently refreshed their knowledge in the management of diabetes, but acknowledged that further support was needed.

The failure to follow evidence based practice and ensure the safe management of diabetes put people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who had developed pressure injuries were supported appropriately by the use of pressure-relieving mattresses and regular repositioning. Photographs were taken of the injury to monitor its progress. However, in one case a tape measure had not been used to show the size of the injury and this made it difficult for nurses to assess whether the injury was healing or getting worse. The registered manager told us they would remind nurses to use the tape measures already provided in the home's wound packs.

A comprehensive training programme was in place for all staff. This was coordinated by the deputy manager, who also delivered some of the training. A staff member told us, "If you don't understand any of the training, the deputy manager will spend time and go through it with you. He is really helpful." New staff completed an effective induction into their role. This included time spent shadowing, (working alongside experienced staff) until they felt confident they could meet people's needs. Staff who were new to care were supported to complete training that followed the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. Experienced staff received regular training in all key subjects.

Staff were appropriately supported in their role. They described the managers as "supportive" and "approachable". One staff member told us, "I want to develop and have been told I can do a [course relevant to my role] to get a qualification." Staff were also supported through the use of one-to-one sessions of supervision with a manager, up to six times a year. These sessions were used to discuss their progress and any concerns they had. In addition, each staff member received an annual appraisal to assess their performance over the past year. The registered manager had recently enhanced this appraisal process to include discussions about the staff member's professional development. However, they acknowledged that further work was needed to add time-specific objectives to help enable staff to achieve their full potential. Nurses were supported to undertake additional training and continued professional development to meet the requirements of their professional registration.

Staff followed the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

Where people lacked capacity to make specific decisions, staff had completed MCA assessments and made best interests decisions on behalf of the person. These included decisions relating to the provision of personal care, the use of bedrails and the administration of medicines. Records showed the decisions had been made after consultation with family members, although we found the views of those consulted were not always recorded. We discussed this with the registered manager who acknowledged this was an area for improvement.

Staff described how they sought verbal consent from people before providing care and support. They said they were led by the person and always acted in the person's best interests. A staff member told us, "Most people on the ground floor have capacity. They are the bosses and we work around them. Those on the top two floors have more variable capacity and we sometimes have to anticipate care for people, making decisions in their best interest." They added, "Everyone is assumed to have capacity unless it is assessed otherwise."

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 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. We found staff were following the necessary requirements. Some DoLS authorisations had been made and others were awaiting assessment by the local authority. Conditions had been attached to the DoLS authorisation for one person and we saw these had been followed. Clear processes were in place to monitor the expiry dates of the DoLS and to submit renewal applications in good time.

People's nutrition and hydration needs were met and people were usually satisfied with the quality of the food. For example, a family member told us, "The food can be a bit hit and miss and I have addressed this with the manager. There was a meeting where the chef attended. It was useful. Since the meeting there have been improvements but you still get the odd [not so good] meal. It needs to be attractive and taste good."

Each person had a nutritional assessment to identify their dietary needs. Some people needed a special diet or needed their meals and drinks prepared in a certain way to meet their individual needs and we saw these were provided consistently. Staff monitored the intake for people at risk of malnutrition or dehydration using food and fluid charts. They also monitored people's weight and took action when people started to lose unplanned weight. For example, they enriched people's meals with additional calories or sought advice from dieticians. Where food supplements were prescribed, people were offered these regularly.

Staff were attentive to people during meals. They offered choices and extra portions and made sure people's drinks were topped up. When people needed support to eat, this was usually provided in a dignified way on a one-to-one basis. For example, a care staff member supporting one person engaged with them and used supportive prompts such as: "Are you ready for some more [person's name]?", "Have you had enough?" and "Would you like some juice?" We have commented in the Caring section of this report about one person who was not supported to eat in a dignified way.

Hamilton House was built as a care home and was suitably designed to support the needs of people living there. A family member told us, "[The environment] is lovely here. We are really happy." A passenger lift gave access to all floors and all bedrooms had en-suite facilities. There were handrails throughout the communal areas in contrasting colours to make them easy for people to spot. Some bedroom doors had been painted in distinctive styles to make it easier for people to find their own rooms and large signs were in place to help people navigate their way around the home. Objects to stimulate people living with dementia were readily available including 'rummage bags', hats and coats for people to explore. On one corridor there was a large keyboard that played music when keys were pressed and tactile pictures on the walls, as well as cots with dolls and soft toys for cuddling. There was level access to the building and to a garden on the ground floor.

The home had experienced significant problems with its boilers over the winter period and had put contingency arrangements in place to heat the home. However, new boilers had recently been installed and were working effectively. One person told us, "It's okay now the boiler is sorted. We had no proper hot water for six weeks." They explained that this meant they weren't able to shower at their usual time as the hot water ran out in the afternoon. However, they said "Big industrial heaters" were placed in the corridors to keep people warm.

Staff worked collaboratively with other healthcare providers to help ensure the delivery of effective care and support. One person told us, "They [staff] get the doctor for you if needed." A family member said, "The psychiatrist is coming this week and the occupational therapist next week [to see my relative]." Doctors and healthcare specialists visited regularly and if people required a doctor in between these visits, their names were collated, so the home only made one call to the GP practice. This had helped improve relationships with practice staff.

When people transferred to hospital or to another care setting, staff used specially designed forms to help ensure all key information about the person's needs was passed on. A re-admission assessment was also completed before the person returned to the home, to help identify any changes in their needs. These arrangements helped ensure continuity of care for the person.

Good

Is the service caring?

Our findings

People were supported by kind, caring and compassionate staff. Everyone we met spoke positively about the attitude and approach of staff. Comments from people about the staff included: "I think [staff] are more helpful than they used to be. I think they are more aware and they ask me more if I need anything", "I couldn't get more love and affection than I do here" and "I'm very happy here. All the staff are very kind". Family members echoed these comments. One who told us, "[My relative] is cared for by a group of staff who are extraordinarily caring. There's lots of banter and laughter; they clearly feel a degree of contentment [in their work]. They treat me like a mate; I'm considered part of the family." Another family member said, "[Staff] talk to [my relative] throughout. They have some knack of making her understand what they are going to do. They use touch too. I often see someone holding her hand. That's important to her and they do it tenderly."

'Thank you' cards sent to staff by family members included the following comments: "I have been touched by the concern and sympathy given to me and my family by all the staff", "I want to commend the team allocated to [my relative's] care. I have observed the affection and courtesy she is receiving and realise it's team work, but some go the extra mile which puts our family's mind at rest" and "We formed good relationships with staff. [My relative] was treated with great kindness, everybody was really friendly. The carers were very gentle and caring. Staff were cheerful and compassionate".

We observed positive interactions between people and staff throughout the inspection, with one isolated exception. While supporting a person to eat their meal, a staff member did not engage with the person and was seen to take and eat a chip from the person's plate. We raised this concern with the registered manager, who took immediate and robust action using the provider's disciplinary procedures.

All other interactions demonstrated that staff knew people well and were patient, kind and caring in their approach. For example, when a person who always carried a doll wanted to use the bathroom, the staff member offered to "hold and look after your baby". This freed up the person's hands, so they could use the bathroom safely. When medicines were being administered, nurses took time to explain what they were for and administered them in the way the person preferred. When people were supported to reposition using the hoist, staff explained what was going to happen, using expressions such as: "Just going to connect you to the hoist [person's name]", "We're going up, alright?", "Is that alright for you?" and "Are you comfortable?". Staff made people feel they mattered by celebrating important events, such as birthdays and people received a birthday cake. When they reached 100 years of age they were also given a high tea and a party with their relatives.

Managers told us they explored people's cultural and diversity needs during pre-admission assessments and included people's specific needs in their care plans. This included people's faith needs and whether they had a preference for male or female care staff to support them with personal care. Further information was included in a 'This is me' document which staff completed once the person had settled in to the home.

People were supported to follow their faith. One person told us, "I do a Church service once a month on the

middle and ground floors. It's good for me and hopefully for others. A hymn, prayers and some classical music. We call it 'our reflection'." Staff explained that was a multi-faith service open to everyone living at Hamilton House. In addition, ministers attended weekly to give Holy Communion to people who wished to receive it.

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. For example, arrangements had been put in place to enable one person to look after their own medicines. The person told us, "I self-medicate and have signed the appropriate forms. It suits me. I'm super careful not to leave them lying around." Another person said, "I want to keep my independence. Life is for the living." People's care plans also encouraged staff to promote independence. For example, one described how the person could brush their own teeth if staff handed them the toothbrush with toothpaste on it.

Staff protected people's privacy and respected their dignity. A family member told us, "Staff always knock on the door to come in, they don't just barge in." Another family member said, "All the care staff that work with [my relative] are without fail respectful, cheerful and caring. They are all fabulous. We know them all by name." They added: "What they do is amazing. They are so respectful." We heard staff knocking on doors and calling out for a reply before entering rooms. When providing personal care, staff described how they closed windows and doors and kept the person covered as much as possible. A staff member told us, "We always treat [people] in a dignified way. We always ask first and give choice."

People and relatives told us they were involved in discussing and making decisions about the care and support they received. A family member told us, "They [staff] ring me with any problems and keep me informed." Another family member said, "[My relative] has a care plan and that has been discussed with [the unit manager]. They call me if there are any changes, even things that might seem trivial." Records showed staff had consistently involved family members in decisions about their relatives care, including for example, a discussion about the benefits of moving a person to a new bedroom to reduce the risk of them becoming socially isolated.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, in September 2017, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's care plans did not always reflect their current needs and some people's needs were not met in a personalised way.

At this inspection, we found improvement had been made and there was no longer a breach of this regulation. There were however improvements required to ensure care plans were completed appropriately.

Assessments of people's needs were completed by one of the managers, before people moved to the home. This information was then used to develop an appropriate care plan in consultation with the person and their relatives, where appropriate. Care plans contained sufficient information to enable staff to provide appropriate care to people and were reviewed regularly. Although the care plans were comprehensive, we found some contained conflicting or duplicated information making them difficult for staff to navigate. For example, one person had a percutaneous endoscopic gastrostomy (PEG). This is a tube that allows food and medicines to be given directly into the stomach. The person's care plan contained guidance notes for two types of PEG, the most recent of which were for the type of PEG that the person did not have. This posed a risk that they would receive inappropriate support to maintain it. In another person's care plan, there was conflicting information about the consistency of drinks the person should be offered. These issues were discussed with the registered manager and by the end of the inspection the conflicting information had been removed.

Staff demonstrated a good awareness of the individual support needs of people living at the home, including those living with dementia. They knew which people preferred baths in the morning and which people preferred them in the evening; they knew the support each person needed with their continence and the level of encouragement they needed to maintain their personal care. However, not all staff were aware that a person with hearing loss heard better with one ear than the other and rarely approached the person from the side where their hearing was best. This made it more difficult for staff to communicate with the person, who was also blind. Staff did know, though, that the person responded positively to touch and we saw them using this consistently.

Staff kept records of the care and support they provided to people and these confirmed that people's needs had been met consistently. For example, they included 'turn charts' for people who needed support to reposition regularly and monitoring charts of the fluid input and output of people with catheters to check they were working properly. From discussions with staff, it was clear they were able to recognise changes in people as they occurred and were committed to delivering the best care possible.

Staff were responsive to people's changing needs. A family member told us, "We couldn't ask for a more responsive home for [my relative] to be in. They [staff] notice things and respond, even the smallest things." Another family member said, "[My relative] has deteriorated over the last month. If [they] need anything, staff are here very quickly. [My relative] is well looked after." One person had taken to sleeping most of the

day. Rather than waking the person during the normal medicines round, staff had started offering the person their medicines when they woke up, as they were not time-critical medicines. This showed flexibility and a demonstrated a person-centred approach to providing care. Records showed that another person had become unusually agitated, so staff had started keeping monitoring charts in an effort to identify the triggers for this. They had also referred the person to their GP, as their body language indicated they might be experiencing pain.

Irrespective of their role, all staff responded promptly to people's requests for support. For example, when a person called out from their room, an administrator who heard them attended to ask what support the person needed. This was immediately followed by a housekeeper who was nearby; they offered to put the radio or the television on for the person and the person then settled. On another occasion, a person complained about an item of clothing being uncomfortable and a housekeeper made an adjustment to make the person comfortable.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death. This was confirmed by a letter from the family member of a person who had recently died at the home. It said, "The [end of life] nursing care was excellent. Everything was carefully explained to us and this helped us immensely to understand what was going on." A 'thank you' card from another family member stated; "The end of life care [my relative] is receiving is exemplary. We have been comforted by how well she is being looked after." A further 'thank you' card talked about how the person "always looked comfortable, was looked after and valued" during their final days. Staff had received some training in end of life care and were about to start an extended training programme in end of life care being delivered by staff from a local hospice. The hospice staff were already being used for ad hoc advice and this was sought for one person when nurses were unsure how to administer a particular medicine to a person receiving end of life care. People's end of life wishes were discussed with them and their families and recorded in their care plans. This helped ensure staff would know what was important to the person at this stage in their life and who they wished to be consulted. The home had a syringe driver and could access additional syringe drivers from community nurses if needed. A syringe driver is a device used to administer symptom control medicines to people in a continuous way at the end of their lives and we saw anticipatory medicines, to be used in the syringe driver, were in place for two people in case they needed them.

A wide range of activities was provided to people based on their individual interests. This was coordinated by activities coordinators, but all staff took part in an initiative called 'Three o'clock stop'. At three o'clock each afternoon, every staff member stopped what they were doing and spent time interacting with people. This included managers, nurses, care staff, ancillary staff and administrative staff. Each person was supported to do whatever they wished to do. Some took part in arranged group activities, such as quizzes; some interacted on a one-to-one basis by talking about current affairs; and others used the time to reminisce. This was an example of innovative practice to promote people's well-being.

Other activities included visits by animals, such as a pat dog, and donkeys from a local sanctuary.
Young chicks had recently hatched and were being cared for in the activities room. These were taken round the home for people to see and interact with. In addition, staff organised regular trips to local attractions, including visits to local coffee houses and shops. One person told us, "It's lovely to get out." A family member told us, "They do a lot of activities and stimulation. The [staff] who do the activities are fantastic. They are constantly trying to think of things to do to stimulate [people]."

Staff promoted choice and respected people's autonomy by empowering them to make as many of their own decisions as possible. One person told us they could get up and go to bed whenever they wished. Another person said, "I choose to stay in bed as I don't like the hoist." Throughout the inspection, we heard

staff offering people choice, using questions such as: "Would you like to get up yet?" "Would you like the curtains drawing?" and "What music would you like to listen to?" A staff member showed us picture menus that they used to help people understand their food choices.

There was a complaints procedure in place and people told us they felt able to raise concerns. One person told us, "[Staff] bother if you're not happy about things, whereas before no one cared." A family member told us, "[The registered manager] and [the deputy manager] could not have been more accommodating. I spoke to [the registered manager] about a small thing who said to put it in writing and I got a full written reply. Things are investigated." Another family member said, "If I mention anything [to staff], like [my relative's] nails are dirty, it's done straight away. I don't have any reason to complain, but if I did I'd see [the registered manager or the deputy manager]." We viewed records of recent complaints. These had been investigated thoroughly and responded to promptly, in accordance with the provider's policy. The registered manager described how they used complaints to help identify learning and to improve the service.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, in September 2017, we identified breaches of Regulations 17 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Quality assurance systems were not effective, staff did not always act in an open and transparent way when people came to harm and CQC was not always notified of significant events where required.

At this inspection, we found improvements had been made and there were no longer a breach of Regulation 20. However, further improvement was required. A duty of candour policy had been developed to help ensure staff acted in an open and transparent way when people came to harm, but this was not always followed. Whilst family members were given information verbally about incidents and accidents, we identified two occasions when this had not been followed up in writing as required. We raised this with the registered manager and by the end of the inspection they had introduced a new process to help ensure this was done consistently in future.

Quality assurance systems had been developed to assess, monitor and improve the service, but were not fully effective yet. They were based on a comprehensive range of audits conducted by senior staff and managers, including medicine management, infection control, staff training and care planning. In addition, an extensive quality assurance audit was completed in January 2018 by the provider's regional manager. However, the audits had not identified the areas of improvement we found during our inspection. These related to: recruitment practices, the management of medicines, the support given to people with diabetes, the recording of best interest decisions and conflicting information in people's care plans. The registered manager acknowledged that these issues should have been picked up by the auditing processes. This demonstrated that further time was needed to develop and fully embed the quality assurance systems in practice.

Since the service was registered in 2011, it has been in continual breach of regulations. Following our last inspection, it was rated Inadequate in two key questions and overall, resulting in it being placed in Special Measures. The registered manager acknowledged that further work was needed to improve standards overall and had developed a 'service improvement plan' to help achieve this.

The provider's failure to operate fully effective systems to assess, monitor and improve the service was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Apart from this breach of regulation, we found the registered manager, who had been appointed shortly after our last inspection had made significant improvements to some processes and procedures, making them more robust. This was confirmed in feedback from a family member that said: "There has recently been a new manager and deputy. Since then, procedures have been tightened up with very positive effect." Where audits had identified areas for improvement, we saw action had been taken. For example, audits had identified significant gaps in staff training and a lack of daily mattress checks and we found both of these

issues had been addressed. Other audits had led to improved infection control procedures, such as the one-way system that had been implemented in the laundry. To monitor the standard of care delivery, managers spent time working alongside and observing staff in their work. This included regular, unannounced, visits during the night to monitor the performance of night staff.

People and their relatives told us they had seen tangible improvements in the service since our last inspection. Comments included: "Since the new manager has been here there has been a dramatic improvement. They are open and approachable. There are questionnaires and they are more than happy to speak to us", "I think [the registered manager] and [deputy manager] have made a huge difference" and "Since the new manager has been here, it's been a lot better. The staff are happier and more friendly and speak to you".

There was a clear management structure in place consisting of the home's registered manager, the deputy manager, heads of units, registered nurses and senior care staff. Each had clear roles and responsibilities and the management team worked well together. In addition, an 'on call' rota was in place to enable staff to access management advice out of hours.

The registered manager told us they felt supported by the provider's regional manager who visited regularly and was always available on the phone. They also had a strong support network of other registered managers and professionals from whom they could seek advice, guidance and support when needed.

Staff were organised in their work and told us they felt engaged in the way the service was run. They said managers operated an "open door" and were "visible and approachable". Other comments from staff included: "Morale has got a lot better. You can approach the managers; they are always around on the floor", "The whole mood [of the home] has changed. There's a lot more going on. Now staff are happy, the residents are too. They pick up on the atmosphere" and "Things are a lot better. The managers are brilliant. They handle situations in a professional way and with a lot of privacy. They maintain confidentiality".

Arrangements were in place to help staff communicate effectively with one another. These included management meetings; staff meetings; meetings with particular groups of staff, for example nurses, housekeepers and kitchen staff. The main staff meetings were held at 2:00pm and 7:00pm on the same day. Staff said this flexibility meant a lot more of them were able to attend and benefit from the discussions. A staff member told us, "I feel listened to now, definitely."

In addition, a 'flash meeting' was held every day at 10:30 with the heads of each department and the nurse in charge on each floor. This covered key areas, such as staff availability, critical care issues, planned events and maintenance. Any identified actions were recorded and followed up.

The registered manager told us the values of the home were based on meeting people's individual needs in a caring and compassionate way. They had communicated this vision during staff meetings and individual discussions with staff. When we spoke with staff, they showed they understood these values. For example, comments from staff members included: "It's all about the residents; we are here for them" and "The way I work is all about putting the person first".

Managers actively monitored the culture of the staff team and had worked hard to foster a positive, compassionate culture focused on the needs of people living at Hamilton House. Their success was demonstrated by staff reaction when one of their colleagues acted inappropriately while supporting a person to eat. They all expressed disappointment that a colleague had behaved in such a way towards a person in their care and felt "let down". This showed they had a clear understanding of what was and was

not acceptable and demonstrated positive peer pressure, causing the staff member to apologise to their colleagues.

People were consulted in a range of ways about the way the service was run. These included regular "residents meetings", yearly questionnaire surveys and individual discussions with people and their relatives. In addition, we saw a comments box had been installed in the hallway to enable people to provide feedback anonymously if they wished. Action had been taken in relation to some of the issues raised in the survey; for example, people had requested changes to the menu and we saw these had been implemented.

People described an open and transparent culture. They and their families had been kept informed about the concerns identified at our last inspection and the measures being put in place to drive improvement. The provider notified CQC of all significant events and the home's previous inspection rating was displayed prominently in the entrance hall. In addition, the results of the latest survey of people and their relatives were displayed on the notice board. Links with the community had been developed to the benefit of people. These included links with a learning disability centre that supported people with activities; a volunteer who helped people with baking each week; and links to local church groups.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way that they could understand. It is now the law for the NHS and adult social care services to comply with the AIS. A 'Service user guide' had been provided to people in their bedrooms. The registered manager told us they could provide this in large print format on request and staff were happy to read it to people if needed. Information about the Mental Capacity Act was available to people in an easy-read format, supported by photographs. A staff member told us they also used visual aids, such as picture menus, to help people understand their food choices. This showed the home had started to adapt the communication tools they used to help people understand information and make choices.