Lett's Care Ltd

Hamilton's Residential Home

Inspection report

26 Island Road
Upstreet
Canterbury
Kent
CT3 4DA

Tel: 01227860128

Date of inspection visit:
27 April 2022

Date of publication:
08 June 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Hamilton's Residential Home is a residential care home providing personal care to up to 17 older people, some of who were living with dementia. At the time of our inspection there were 15 people using the service.

People's experience of using this service and what we found
People and their relatives told us they were happy living at Hamilton's Residential Home. However, we found guidance was not in place for staff, to inform them how best to support people with their medical needs. In some cases, care plans were in place, but not followed putting people at risk of not receiving the care they needed. When accidents and incidents occurred, they were documented, but there was no analysis to look for patterns and trends.

Environmental risks such as rips in the flooring which could cause a trip hazard had not been identified by the provider. Medicines were not consistently managed safely; stock counts had not been completed on all medicines to ensure people had received their medicines as prescribed.

The provider and manager completed a series of checks and audits; however, these had not been effective in identifying and addressing issues highlighted in this inspection. Once issues were known the provider was responsive and implemented improvement and changes, for example putting catheter care plans in place, and fixing rips in the flooring.

People and staff told us there were sufficient numbers of staff to meet their needs. People told us they did not have to wait for care, and staff had time to chat with them. Staff understood their responsibilities around safeguarding and had received training. The service was clean.

People told us there was a positive culture within the service. Healthcare professionals and relatives were involved in supporting people to provide joined up care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 14 March 2019).

Why we inspected
This inspection was prompted by a review of the information we held about this service. The inspection was prompted in part due to concerns received about staffing and infection control. A decision was made for us to inspect and examine those risks. You can see what action we have asked the provider to take at the end of this full report. Following the inspection

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. 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 full report.

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

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Hamilton's Residential Home

Detailed findings

Background to this inspection

The 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 Health and Social Care Act 2008.

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
This inspection was carried out by one inspector.

Service and service type
Hamilton's Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Hamilton's Residential Home is a care home without nursing care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with CQC to manage the service. 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.

At the time of our inspection there not a registered manager in post. The previous registered manager deregistered in January 2022. There was a new manager in post who had submitted an application to be

registered with the CQC.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people about their experience of the care provided. We spoke with six staff members including the provider, manager, senior carer and carers.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection We continued to seek clarification from the provider to validate evidence found. We looked at training data. We spoke with four relatives about their experience of the care provided.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Risks to people's health were not always well managed. Staff did not follow care plans to support people to manage diabetes care well. For example, when staff took blood sugar levels and they were outside of the person's normal range, staff did not document any action taken to reduce the blood sugars. Blood sugar levels were not checked again to ensure they had reduced within a safe range.

● Detailed guidance had not been provided to staff to inform them of how best to support people with catheters. A catheter is a tube that is inserted into the bladder, allowing urine to drain freely. Although staff told us they changed the catheter bag frequently there was no documentation to confirm this, and no guidance to inform staff what to do if they had concerns about the person. Following the inspection, the provider sent us evidence that guidance was now in place for staff to follow.

● Some people were at risk of chronic constipation. There was no care plan in place to inform staff what action to take and how to assess if someone was constipated. Staff were not always documenting when people had opened their bowels and could not be assured that action had been taken when people had not opened their bowels.

● Documentation reviewed detailed that some people had lost up to 10kg in a month. Staff told us this was not the case, that weights had not previously been recorded correctly. However, staff had failed to identify that weights had been recorded incorrectly and had failed to contact the dietician or GP in every case when large weight loss was identified.

● Risks to the environment had not been mitigated. Two people had rips in the flooring in their rooms. Staff had failed to identify this as a trip hazard and take action. Following the inspection, the provider sent us evidence that the flooring had been repaired.

Learning lessons when things go wrong

● Accidents and incidents were recorded by staff, however action taken to mitigate the risk of incidents re-occurring was not always documented. Learning on each accident report was not documented to inform staff how to reduce the risk of the incident reoccurring.

● There was no oversight of accidents and incidents to use to identify patterns and trends. Each incident was reviewed in isolation therefore it could not be established if more falls occurred at night for example or to ensure the correct action occurred if someone had more than one fall.

Using medicines safely

● Medicines were not always managed safely. Some people were prescribed 'as and when' medicines such as pain relief or medicines to relieve constipation. There were not always protocols to inform staff why and when people should take these medicines, and how and when to check their effectiveness.

● When staff administered 'as and when' medicines, they did not always document on the medicine administration record (MAR) when these medicines were given, and why in line with guidance. There was no evidence that staff had checked the effectiveness of the medicine.
● Not all medicine stock had been documented on the MAR when a new medicine cycle started. Staff could not complete a reconciliation of all medicines and ensure stock levels were correct.
● Not all creams had been dated when staff opened them in line with best practice guidance.

The registered person failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. The provider failed to ensure the premises were safe for their intended use. The registered person failed to manage medicines safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse
● People told us they were happy at Hamilton's Residential Home and felt safe. One person told us, "Well I like it very much. Everyone is so kind to you." Another person told us, "All the carers are so very kind."
● Staff had received training in safeguarding and knew how, and where to report concerns. One staff told us, "I would report it to my line manager. I would feel confident with [manager]. Or I would go above either to the CQC or the owner."
● The provider understood their responsibilities to safeguard people from the risk of abuse and had worked with the local authority when issues were raised.

Staffing and recruitment
● People told us there were sufficient numbers of staff to meet their needs and keep them safe. One person told us, "Oh yes they come quickly when I call," and another told us, "They have three or four that's not too bad."
● The provider was introducing a dependency tool to use to support them with their decision making around staffing numbers. Previously staffing was determined by people's needs but without a formal tool to support this. When staffing numbers were low due to sickness for example, the provider told us staff covered the vacancies or they would employ agency staff.
● All the staff told us there were enough staff to meet people's needs. Staff told us, "For the amount of residents we have we are ok. If we had more people, we would need more staff."
● All new staff had the relevant checks including full employment history and two references completed. Staff also had a Disclosure and Barring Service (DBS) check completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- People and their relatives told us visiting was supported by staff and that visits occurred regularly.

Requires Improvement

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Governance and auditing systems had not been effective in identifying shortfalls highlighted during this inspection. People were placed at potential risk of harm due to these shortfalls.
- The manager had carried out a health and safety audit in March 2022, however this failed to identify hazards and ensure action had been taken to mitigate them. For example, rips in the flooring in people's bedrooms caused a trip hazard to people. This was addressed following the inspection; the provider sent us evidence that the rips had been mended, however internal auditing systems had not picked this up.
- Medicine audits failed to identify that stock counts had not been carried over, and that guidance was not being followed in relation to topical medicines.
- There was no robust audit system to review care plans. The manager and staff had updated some care plans, however had failed to identify that care plans were not complete or accurate. For example, key guidance was missing from care plans, and the manager was unaware that staff were not following guidance in place in relation to diabetes care.
- Checks and audits completed by the provider failed to identify that weights had not been recorded correctly or accurately for some months.

The registered person failed to ensure systems were in place and were robust enough to assess, monitor and improve the quality and safety of the service. This placed people at risk of harm. 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 their relatives gave positive feedback about the service and staff. One person told us, "Mum seems happy she said they are very nice to her and very kind." Another relative told us, "She is clearly content with the Home and her care."
- Relatives told us that their loved ones were well cared for, and they were treated equally and their rights were respected. One relative said, "The Home is well run and cares for her needs well. The staff treat her well and cover all her needs to my satisfaction." Another relative told us, "The staff engagement and a feel that the community is a family," and, "The Home is well managed and have never needed to complain about anything, so am happy with the Home and provisions."
- Staff told us the culture at the service had improved. One staff told us, "I can't speak highly enough of

[manager]. There has been a lot of improvements and we are getting there." Another staff member told us, "Things are changing for the better. We are all documenting more on [the care planning system]. We are more thorough on everything. Like cleanliness. Infection control. We are more thorough the cleaning is better."

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

● The duty of candour requires providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. We found that the provider had been open and honest, and understood their responsibility to comply with the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People told us they felt involved in the service. People had met the new manager and were all very positive about them.

● Relatives told us they received information to help keep them informed of events at Hamilton's Residential Home. One relative told us, "I receive regular newsletters as to the homes improvements. They communicate with me regarding COVID-19."

● The provider held regular staff meetings where all aspects of the service were discussed. Staff told us they felt involved in the service and could approach the manager or provider at any time.

● Staff and the manager worked with a range of healthcare professionals to provide joined up care to people. Some people had referrals to healthcare professionals when their needs changed, for example the speech and language therapists.

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 registered person failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. The provider failed to ensure the premises were safe for their intended use. The registered person failed to manage medicines safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person failed to ensure systems were in place and were robust enough to assess, monitor and improve the quality and safety of the service.