Shaftesbury Care GRP Limited

Hamilton House

Inspection report

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23 October 2018

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Ratings

Overall rating for this service	Good

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

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, 54 people were living at the home.

The inspection was unannounced and took place on 22 and 23 October 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 April 2018, we identified breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Best practice guidance in the management of diabetes was not always followed and quality assurance systems were not always effective. At this inspection, we found action had been taken and there were no longer any breaches of Regulations.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made. Therefore, this service is now out of Special Measures.

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

Arrangements were in place for the safe management of medicines. People received their medicines as prescribed. The home was clean and hygienic and staff followed best practice guidance to control the risk and spread of infection.

There were enough staff deployed to meet people's needs. Appropriate recruitment procedures were in place and pre-employment checks were completed before staff started working with people.

People's needs were met by staff who were competent, trained and supported in their role. Staff acted in the best interests of people and followed legislation designed to protect people's rights and freedom.

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

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. Staff used supportive techniques to communicate effectively with people.

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. Each person had a care plan that was centred on their needs and reviewed regularly. Staff empowered people to make choices and responded promptly when people's needs changed.

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 felt able to raise concerns.

Staff took account of people's end of life wishes and preferences. They supported people to remain comfortable and pain free.

People and professionals who had regular contact with the home felt it was run well. Staff were organised, motivated and worked well as a team.

There were effective quality assurance systems in place to help ensure the safety and quality of the service.

There was an open culture where people were consulted and positive links had been built with the community.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff understood their safeguarding responsibilities and knew how to identify, prevent and report abuse.

Individual and environmental risks to people were managed effectively.

There were enough staff deployed to meet people's needs. Recruitment practices helped ensure only suitable staff were employed.

Medicines were managed safely and people received their medicines as prescribed.

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

Is the service effective?

Good

The service was effective.

People received effective care from staff who were competent, suitably trained and appropriately supported in their roles.

People's nutritional needs were met.

Staff acted in the best interests of people and followed legislation designed to protect people's rights.

People were supported to access to other health professionals when needed. When people were admitted to hospital, staff ensured key information accompanied the person to help ensure continuity of care.

The environment had been adapted to meet the needs of people living at the home. Staff made appropriate use of technology to support people.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They used appropriate techniques to communicate with people.

Staff explored people's cultural and diversity needs and supported them to follow their faith.

Staff protected people's privacy and respected their dignity.

People were encouraged to be as independent as possible and were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

Care and support were centred on the individual needs of each person. Care plans were reviewed regularly and staff responded promptly when people's needs changed.

People were empowered to make as many choices as possible. They were supported to access a wide range of activities based on their individual interests.

Staff knew how to support people to receive compassionate end of life care that helped ensure their comfort and dignity.

People knew how to raise concerns and there was an appropriate complaints procedure in place.

Is the service well-led?

Good

The service was well-led.

There were effective quality assurance systems to assess, monitor and improve the service.

There was a clear management structure in place. Staff were organised in their work and communicated effectively with one another.

There was an open and transparent culture. People were consulted about the way the service was run.

Positive links had been developed with the community to the benefit of people.

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 22 and 23 October 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 improvement action plan and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 18 people who used the service and eight 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, six care staff, an agency care worker, an activities coordinator, two administrative assistants, 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 16 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 April 2018 when we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and rated the service 'Requires improvement' overall.

Good

Is the service safe?

Our findings

People told us they felt safe at Hamilton House and appeared at ease when interacting with staff. When asked if they felt their relative was safe, a family member told us, "Oh yes, perfectly safe here. She says she's not frightened now."

Staff protected people from the risk of abuse and understood their safeguarding responsibilities. They had received training in safeguarding adults and were confident action would be taken if they raised any concerns. Records confirmed that the registered manager had reported concerns promptly and liaised appropriately with the local safeguarding authority. Staff were aware of people who were prone to behave in a way that put themselves or others at risk of abuse. They described the action they took to protect people and their property from avoidable harm. For example, a staff member told us, "We keep an eye on [one person] and if they become agitated we [support them on a one-to-one basis]."

Other risks to people were also managed safely. All care plans included risk assessments which were relevant to the person and specified actions required to reduce the risk. These included the risk relating to falls, nutrition, swallowing and skin integrity. Staff had been trained to support people to move safely and we observed equipment being used in accordance with best practice guidance. When people experienced falls, staff described how they 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. For example, one person had been given a bed that lowered all the way to the floor, to reduce the likelihood of injury if they fell out of bed.

Environmental risks were 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 given a presentation about fire safety procedures to people, relatives and visitors. Each person had a personal emergency evacuation plan detailing the support they would need if the building needed to be evacuated.

There was a system in place to help ensure that health and safety checks of the premises were completed regularly and that equipment was checked and serviced according to specified timescales. Records showed, however, that two bath hoists had not been checked a month prior to the inspection, as scheduled. Staff were unable to provide an explanation for this, but the registered manager took immediate steps to rectify the situation and ensure checks were not missed in future.

There were enough staff deployed to meet people's needs. The registered manager used a tool to calculate the number of staff needed, based on people's needs and 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.
The provider had a safe recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All the appropriate checks, including references, full employment history and Disclosure and Barring Service (DBS) checks were completed for all the staff. A DBS check will

identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. We identified that one staff member's right to work in the UK had not been checked before they were employed, but this was verified during the inspection.

There were clear processes in place to obtain, store, administer, record and dispose of medicines. Medicines were only administered by staff who had been suitably trained and been assessed as competent by one of the managers. Medicine administration records (MARs) confirmed that people had received their medicines as prescribed. However, we found there was a lack of information in the MAR charts used to record the application of topical creams. Directions to staff were often limited to "as directed" without any further indication of where or when they should be applied. We raised this with the registered manager who undertook to seek clarification from the prescribing doctor and update people's MAR charts accordingly.

There were appropriate systems in place to protect people by the prevention and control of infection. A family member said of the home, "It's always clean and it doesn't smell." Another told us, "[My relative's] bed clothes and room are always clean and tidy." We saw that all areas of the home were clean. Staff had completed infection control training, had access to personal protective equipment (PPE) and wore this whenever appropriate. We observed that they washed their hands before preparing or serving meals to people, as well as before and after delivering personal care. They described how they processed soiled linen, using special bags that could be put straight into the washing machines in the laundry. The laundry was organised in a way that minimised the risk of cross contamination.

Good

Is the service effective?

Our findings

At our last inspection, in April 2018, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff did not always follow evidence-based practice in the management of diabetes. At this inspection we found action had been taken and there was no longer a breach of this Regulation.

People's needs were met by staff who were skilled, competent and suitably trained. A family member told us, "[The care] is as good as it gets. I can go home and relax, knowing [my relative] is well looked after." Another family member said, "Everything is brilliant. The staff are good. [My relative] wasn't well on Saturday and the staff looked after them very well."

Nurses demonstrated an evidence based approach to their practice. For example, they used recognised tools to assess people's nutritional needs and their skin integrity. Where people's skin integrity was compromised, there was usually a clear plan in place to prevent or treat any pressure areas. For one person, who had arrived at the home with a pressure sore, there was a not a specific plan in place to treat this, but staff had, nevertheless, provided appropriate care and the pressure sore had healed. For other people, there were clear wound plans in place and staff used photographs to monitor the progression of the wound. People had also been given special pressure-relieving mattresses. There was a clear process in place to help ensure the mattresses remained at the right setting, according to the person's weight and 'turn charts' confirmed that, where needed, people were supported to reposition regularly. Staff also demonstrated a sound understanding of catheter care, maintaining clear records of the output, when they were last changed and when they were due to be changed again.

Comprehensive care plans had been developed to support people living with diabetes. Although advice in one of the care plans did not follow best practice guidance, all other care plans did and the nurses we spoke with were clear about the action to take when someone experienced hypoglycaemia (dangerously low blood sugar levels). Records confirmed staff had followed advice from GPs and clinical nurse specialists in diabetes.

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. A small proportion of this training was overdue, but the registered manager assured us this would be completed in the near future.

Nurses were supported to undertake training that met the continued professional development (CPD) needs of their registration; for example, they had received additional training in diabetes and training had been planned to update them in the use of syringe drivers. These are devices used to administer medicines in a controlled way. Some care staff were being trained to take blood samples from people; this would speed up the diagnosis of any underlying health issues when people became unwell and enable treatment to be

started more quickly.

The deputy manager was leading the delivery of additional dementia awareness training to enhance staff understanding of the condition and the support people needed as a consequence. Staff described how they had used this knowledge to good effect; for example, a staff member told us, "When supporting [people living with dementia] I always introduce myself and explain why I am there. I never say, 'Do you remember…?' because they probably can't and it would upset them." Another staff member told us, "[One person] can be unpredictable and it's difficult to meet her needs. She loves her dolls and we will use those to distract her."

Staff told us they felt supported in their work and were able to approach managers with any concerns. For example, one staff member told us, "The bosses are very approachable. I feel appreciated." Other staff told us they had asked to increase or decrease their working hours and their requests had always been accommodated. Staff were also supported by 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 training or development needs. Staff described the sessions as "constructive" and "supportive". In addition, each staff member received an annual appraisal to assess their performance over the past year. The registered manager told us of plans to add time-specific objectives to staff appraisals to help staff achieve their full potential.

People's nutrition and hydration needs were met and people were satisfied with the quality of the meals. A family member told us, "The food's really good. [My relative] will ask for it at unusual times as her hours are muddled up. Staff understand and respect that. If she wants chips, she gets them any time of the day." Another family member said of the food, "It's lovely, especially the fish and chips on a Friday."

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. These included low-sugar options for people living with diabetes. 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 fortified people's meals with additional calories or referred people to dieticians. When people needed support to eat, this was provided in a dignified way on a one-to-one basis. Photographs of meals were available to help people choose their meals in advance. Coloured plates and plate guards were also used where required and supported people to eat independently.

Staff protected people's rights by following 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 made on their behalf must be in their best interests and as least restrictive as possible. Most of the people living at the home lacked capacity to make some or all decisions relating to their care needs. Where this was the case, staff had assessed the person's capacity using an appropriate tool, consulted with people close to the person and made best interest decisions on their behalf. We heard staff seeking verbal consent from people before providing care and staff described how they always acted in the best interests of the people they were supporting.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Some DoLS authorisations had been made and others were awaiting assessment by the local authority.

Staff knew which people were subject to DoLS and were following the necessary requirements; for example, 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.

Staff worked collaboratively with other healthcare providers to help ensure the delivery of effective care and support. For example, they had worked with mental health specialists to establish a supportive medicine regime for a person with mental health needs. A family member told us, "[Staff] pushed and pushed once for [my relative] to be seen [by a doctor] and they got her seen. I was impressed." 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.

The home had been designed and built to support the needs of people living there. 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. There was level access to the building and to a garden on the ground floor. Since the last inspection, flooring in one of the lounges had been replaced to make it more suitable for people living with dementia and family members said this had made it feel more "homely".

Staff made appropriate use of technology to support people. For example, movement alert equipment was used to alert staff of the need to support people when they moved to unsafe positions. Special pressure-relieving mattresses had been installed to support people at risk of pressure injuries. An electronic call bell system allowed people to call for assistance when needed and we were told this would be upgraded to allow data to be analysed.

Good

Is the service caring?

Our findings

People consistently told us they were treated in a kind and compassionate way by staff. One person said of the staff "They are lovely. We have many a laugh." Another said, "They are so lovely to me. The love I have had since [the loss of my cat] has been wonderful. I've sat and cried, not for who I've lost but for the staff's kindness." The person added: "When [my other cat] was sad, because he'd lost his mate, they brought him little pots of salmon." A family member told us, "The staff are lovely. [My relative] is treated well." Another family member described staff as "very good, caring people".

We observed positive interactions between staff and people living at Hamilton House. For example, while supporting them to eat, they engaged with people and gave supportive prompts. While doing some paperwork, a staff member sat with a person who was cuddling and interacting with a doll; the staff member chatted with the person in a very natural way and had a conversation about the doll's name. When another person spilt their drink at lunchtime, a staff member calmly cleared it up, brought the person a fresh drink and sat with them to help them drink it.

A new initiative had started, since the last inspection, whereby a staff member made themselves available to give people hugs if they wanted one. The person wore a bright T-shirt with the words 'Hug-a-day' written on it to advertise the initiative. This empowered people to feel they could ask for a hug and helped promote the caring ethos of the service to people and other staff alike.

Another new initiative was a remembrance service for the relatives of people who had passed away at Hamilton House. The registered manager told us they had been overwhelmed by the response to the first service, held in August 2018, which over 40 family members had attended. The event included a short, non-religious, service and a choir followed by light refreshments, during which attendees could reflect about their loved ones and reminisce about the time they had spent at Hamilton House. The registered manager told us they planned to hold two remembrance services each year in the future, one of which would be close to Christmas as this was often an emotional time for relatives.

Staff used appropriate techniques to communicate effectively with people according to their individual needs. For example, when speaking with people with hearing loss, they faced the person and spoke clearly; when communicating with people living with dementia, they used short, simple phrases and gave the person time to process the information. When a person became anxious and confused, we observed a staff member bent down to the person's eye level, held their hand and spoke to them gently, asking what they wanted to do and where they wanted to go.

All information displayed in the home was in an accessible format. For example, all posters were at least A3 size and used large fonts to advertise meetings and report on the outcomes. Key comments from the previous CQC report had been reproduced in large speech bubbles on multi-coloured paper in one of the corridors to catch people's attention.

Managers 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 preferred male or female staff to support them with personal care. Further information was included in a 'This is me' document of another document entitled "The life and times of [person's name]". These documents gave staff an insight into the person's interests, background and relationships that were important to them. When we spoke with staff, we found they had a good understanding of people's histories and gave examples of how they used the information to support people. For example, they had provided a desk to recreate the previous work environment of one person, together with relevant text books for them to read. Staff told us this had reduced the person's anxiety levels and helped them to settle at the home. Another person enjoyed sorting out buttons and had been given a box with different buttons in open compartments for them to interact with.

People were supported to follow their faith. A local minister of religion attended every month to conduct a brief service. We saw four people attended a service on the first day of our inspection. Other ministers attended each month to give Holy Communion to people who wished to receive it. In addition, one person ran a 'reflections service' for a small group of people.

Staff protected people's privacy. When providing personal care, staff described how they closed curtains and doors and kept the person covered as much as possible. A family member told us, "I came in one day and saw [staff] close the curtains and they asked me go [while they delivered personal care]. They protect [my relative's] privacy well." Staff were observed to knock on doors and call out for a reply before entering bedrooms and doors were closed whilst care was given. In addition, privacy signs were used on people's doors, such as: "If my door is closed you cannot come in. Knock and wait to be invited." and "Care in progress. Please knock and wait."

Staff respected people's dignity. Three staff members had recently been appointed 'dignity champions'. We were told their role was to "advocate for residents and pull up staff behaving in an undignified way". A family member told us they had seen this in action; they said, "[When visiting one day], I heard a junior staff member saying that a resident was 'kicking off' and one of the [dignity champions] picked her up on it and said, 'You don't talk about people like that'."

Staff encouraged people to be as independent as possible by offering choices and encouraging people to do as much as they could for themselves. A family member told us, "[Staff] are always encouraging [my relative] to walk with their wheeler, to keep her mobile." A staff member said, "We encourage people to make choices, invite them to wash their hands and face and to brush their own hair and teeth. At lunch, we offer to cut up people's food, but we'd never do it without asking first."

People and relatives told us they were involved in discussing and making decisions about the care and support they received. For example, a family member said, "We are very involved with the nurses; we speak on a regular basis and always speak with the carers." They added: "We had a call when we were away to inform us that [our relative] had had a fall. On our return, we met with management to discuss using bed raised sides. It wasn't forced on us, it was discussed and suggested, and as a family we agreed." Records confirmed that staff consistently involved family members in decisions about their relatives' care, including during care reviews and updated them promptly with any changes in their relatives' condition.

Good

Is the service responsive?

Our findings

People told us they received personalised care from staff who understood their individual care and support needs. A family member told us, "The change [in my relative since being admitted] has been remarkable. All the monitoring seems to have stabilised them. You get a feel the place is right."

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 comprehensive information to enable staff to provide personalised care and were reviewed regularly.

Staff demonstrated a good awareness of the individual support needs of people living at the home. They knew how each person preferred to receive care and support. They knew which people needed to be repositioned regularly and the equipment they needed to use to do this safely; they understood the support each person needed with their continence and the level of encouragement they needed to maintain their personal care. They recognised that some people's needs varied considerably from day to day and could assess and accommodate the level of support each person needed at a particular time.

Staff kept records of the care and support they provided for 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.

Irrespective of their role, all staff responded promptly to people's requests for support. For example, when a person called out from their room, the nearest staff member responded and if a nurse or care staff member was needed, one was then found. Adjustments were made when people's needs changed. For example, when a person's swallowing became compromised, staff immediately moved the person to a softer diet while awaiting an assessment by a speech and language therapist. Another person could behave in an inappropriate way towards staff; all staff understood how to respond when this happened and we observed them doing this consistently, in line with the guidance in the person's care plan. A further person was prone to becoming agitated and records showed staff had used prescribed sedatives sparingly, but effectively, to reduce the person's levels of agitation.

People were empowered to make as many choices as possible. A family member said of the staff, "They respect [my relative's] wishes to want to stay in bed." We heard staff offering a choice of tv or radio to one person who was sat alone in the communal lounge; the person chose to sit in silence and staff respected this. Staff offered meal choices in a way people could understand, using supportive photographs of meals to help people decide. After taking one person's order, the staff member asked them, "Would you like some pickle in a separate bowl and some beetroot?" The person told us, "They [staff] know me and have little bits I can cope with. They are very good." Staff also gave people the choice of wearing a clothes protector or not and respected people's decisions.

People could access a wide range of activities based on their individual interests. These were organised by three activities coordinators and recorded in people's 'social activity care plans'. They included trips to local attractions and coffee shops, arts and crafts, singing, baking, quizzes and sessions of reminiscence. For example, we observed activities staff using pictures of actors and actresses to help someone remember and talk about old films. A family member told us, "The activity staff are great, we feel comfortable to leave [our relative] with them." In addition, staff took part in an initiative called 'Three o'clock stop' when they could. At three o'clock each afternoon staff stopped what they were doing and spent time interacting with people. This included managers, nurses, care staff and ancillary staff. Each person was supported to do whatever they wished. Some took part in group activities and others interacted on a one-to-one basis. For example, we overheard a staff member engaging with a person about the town where they had lived for many years. The staff member had visited the town recently and brought back postcards for the person. These prompted them to reminisce, which they described as "a real joy". Another person had a horse, which they had not seen since moving to the home and staff had arranged for it to visit the person at the home.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death. A person living at the home said of the staff, "They do amazing end of life care. I think it is their forte." This was confirmed by letters from the family members of people who had recently died at the home. Comments included: "The level of care and compassion has been all that we could have wished for"; "Thank you for the care, kindness and compassion you showed [my relative] during the time she was with you, especially in the weeks leading up to her passing away"; and "Thank you for making [my relative's] final days so peaceful and comfortable".

Most staff were highly experienced in providing end of life care and records confirmed they had worked with doctors and community nurses to support people and their families in a compassionate way, ensuring any symptoms were managed appropriately. In addition, they had started the 'six steps' programme. This is an extended training programme in end of life care, which was being delivered by staff from a local hospice.

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.

There was a complaints procedure in place and people told us they felt able to raise concerns. A family member told us, "We can't complain about the level of communication. [The registered manager] and [deputy manager] always have open doors and we go in and chat." 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.

Good

Is the service well-led?

Our findings

At our last inspection, in April 2018, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as quality assurance systems were not fully effective. At this inspection, we found action had been taken and there was no longer a breach of this regulation.

People who could express a view told us they were happy living at Hamilton House, felt it was well-led and said they would recommend it to others. One person told us things were "generally better" since the last inspection and added: "If you mention that something needs doing, it gets done a lot quicker now." Family members echoed these comments. Their comments included: "The manager is very good, I can go to her with anything"; "Overall I feel lucky that [my relative] is here" and "[The registered manager] and [deputy manager] are very approachable, you can always talk to them. I like that [the registered manager] comes in at weekends." A social care professional told us, "The manager is helpful and easy to communicate with, as is her deputy. The changes [they] have implemented have really turned the home around. They have really worked hard and continue to do so."

There were effective quality assurance systems in place to assess, monitor and improve the service. These were based on a comprehensive range of audits conducted by senior staff and managers; they included the environment, medicine management, infection control, staff training and care planning. In addition, an extensive quality assurance audit had been completed by the provider's regional manager. Any issues identified during audits were rectified promptly; for example, faulty kitchen equipment had been replaced and hard to open windows had been eased. Managers made unannounced visits during the night to check staff were following safe working practices. These checks had also identified and addressed areas for improvement, such as tables being set too early for breakfast, which could confuse people living with dementia who awoke in the night.

There was a clear management structure in place consisting of the provider's regional manager, the home's registered manager, a deputy manager, heads of department, 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.

Staff were organised in their work and told us they felt valued and engaged in the way the service was run. A staff member told us managers were, "visible on the ground, approachable and supportive and had worked hard at improving the service for everyone". Other comments from staff included: "We all work as a team, like we cover [shifts] for each other"; "They are the best managers we've ever had, staff want to work here now" and "There's good morale and teamwork". A person confirmed this and said, "The core staff now are very bonded."

Arrangements were in place to enable staff to communicate effectively with one another. These included management meetings and staff meetings. 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.

People were consulted in a range of ways about the way the service was run. These included regular "residents' meetings", one of which took place during the inspection. Eight people were involved and they were encouraged to provide feedback. Questionnaire surveys and individual discussions with people and their relatives were also conducted regularly. Action had been taken in relation to issues raised in the survey; for example, the menus had been changed, more trips had been organised in the home's minibus and the staffing levels on one of the floors had been reviewed. A family member told us, "The place is well run and I feel [managers] listen. I suggested they needed a dishwasher to free staff up and it's now in place, so the time taken washing up is now spent with residents. They update me with the outcomes from the surveys and [the registered manager's] door is always open."

There was an open and transparent culture. The provider notified CQC of all significant events and the home's previous inspection rating was displayed prominently in the entrance hall and on their website. A family member told us, "We were aware the last CQC report wasn't favourable. We spoke to [the registered manager] who was very honest and said they are working with CQC to move forwards." There was a duty of candour policy in place to help ensure staff acted in an open and transparent way when people came to harm and records showed this had been followed consistently.

Positive links had been developed with the community to the benefit of people. These included two volunteers who helped with activity provision and a local football club that operated a dementia coffee morning once a month and undertook decorating at the home as part of a community initiative. In addition, school and pre-school groups visited regularly to interact with people, which we were told people particularly enjoyed.