Minster Care Management Limited

Hamshaw Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Hamshaw Court is a residential care home providing personal care for up to 45 older people, including people living with dementia. At the time of our inspection 34 people were receiving personal care in one adapted building.

People's experience of using this service and what we found
People who lived at Hamshaw Court did not receive a safe and well led service. People's medicines were not well managed. Staff did not ensure correct procedures were followed and people did not receive always their medicines as prescribed. People were placed at risk of harm, including from the risk of fire. The provider had not provided staff with opportunities to practice progressive horizontal evacuation using evacuation equipment nor had all staff completed fire drills.

The provider had failed to carry out inductions with agency staff to ensure they had the required information they needed to support people using the service in a safe and effective manner. Records were also not available regarding the training of agency staff to confirm what skills and knowledge they had completed before starting work at the service.

The leadership, management and governance arrangements did not provide assurance the service was well-led, that people were safe, and their care and support needs could be met. The provider had not ensured that their systems and processes were effective in enabling staff to provide safe and good quality care for people.

Records relating to people's care did not always contain information and guidance to enable staff to provide the safe care and support people required. Risk management was not in place for some people who were at a high risk of skin breakdown and who presented a risk to others from their behaviour. Staff told us they did not have time to read care plans or risk assessments and when they were short staffed, this had an impact on records being completed.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service had a manager in post, but they had not yet made an application to register with the Care Quality Commission. 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.

The management team, which had been appointed following our last inspection had demonstrated some

improvements and this was reflected by people and staff in their comments. Positive feedback was received and observations were made in relation to staff interactions with people using the service, increased staffing levels, the completion of supplementary records and the ambience of the service.

Staff told us they felt the service was improving, but further improvements would need to be made before they would consider placing their relatives at the service.

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 inadequate (published 17 March 2020) and there were multiple breaches of regulation and the service was placed in special measures. Prior to this, the service had been rated requires improvement for the previous four consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected

This inspection was carried out to follow up on action we told the provider to take at the last inspection. We also carried out this focussed inspection, in part, in relation to concerns we received about the management of medicines, neglect, poor care and treatment, poor pressure area care, poor record keeping and the overall management of the service. As a result, we reviewed the key questions of safe and well-led only. This report only covers our findings in relation to those requirements.

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 Hamshaw Court on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safety, management of medicines and other risks, staffing, records and improving the quality of the service at this inspection. After the inspection we wrote to the provider and requested that they provided us with urgent information regarding poor standards of care and record keeping, high use of agency staff and inductions of agency staff, issues relating to infection control and management of medicines and fire safety concerns to ensure people were safe. The provider responded and took action to address some of the areas of concern that we had identified.

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

Follow up
We will continue to monitor information we receive about the service and we will continue to work with partner agencies. We will also request a specific action plan to understand what the provider will do immediately to ensure the service is safe. We will work alongside the provider and the local authority to closely monitor the service. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe section below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Hamshaw Court

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 Care Act 2014.

Inspection team
The inspection was carried out by three inspectors.

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

A manager had been appointed but has not registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and other professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We spoke with five members of staff including, the manager, the area manager, the quality and compliance director, the deputy manager and the nominated individual. We spoke with a further 12 staff members,

fifteen relatives and one person using the service by telephone during the inspection process. 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 reviewed a range of records which included people's care records, monitoring charts and medication records. 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 information, induction records, supervision records, fire safety records, minutes of meetings and quality assurance records. We spoke with the area manager to review the home development plan following the inspection.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Using Medicines safely

At our last inspection the provider had failed to ensure the safe management of medicines. This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Medicines were not always managed safely. The providers medication policy was not always followed by staff.
- There had been ongoing medicines errors and people had always not received their medicines as prescribed.
- Stock levels were not appropriately monitored to ensure people did not run out of their prescribed medicines. Stock levels did not always match records maintained within the service.
- Protocols were not always in place to guide staff on when to use medicines, which were prescribed for use 'as and when required.'
- We observed agency staff administering medicines and were concerned about the timeliness of people receiving their medicines. Records confirmed that they had not all agency staff received an induction or had their competencies assessed to ensure correct administration practices were being followed.

The failure to adequately manage robust medicines systems and practice was an ongoing breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess and manage risks to ensure the health, safety and wellbeing of people. This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risks to people were not properly assessed or managed safely.
- We identified failings relating to fire safety at the service. People remained at risk because the provider

had not provided all staff with the opportunity to practice fire evacuations or use fire evacuation equipment. Not all staff had completed a fire drill. We wrote to the provider and requested that they urgently provided us with information regarding these concerns. The provider responded and took action to address the concerns.

● There was a lack of detailed behaviour risk assessment to support staff with information to identify potential triggers or how they should support or redirect people in different situations. For example, declining personal care and physical aggression.

● One person who had been assessed as being at high risk of skin integrity breakdown had not their risk assessment reviewed since March 2020 where their care records showed their skin was intact. Daily records dated 20 June 2020 showed the person had developed three areas of skin damage.

● Another person's pressure care plan included details of their specialist bed, mattress and bedrails to keep them safe but gave no information about what setting the mattress should be at or who to contact if there was a fault. This was raised with the management team to contact the District Nursing team to check what setting it should be at and detail in care plan.

● A care plan for one person requiring support from two carers for positional changes did not include any use of slide sheets. A bed rail risk assessment review stated this should be checked daily for issues, but records had gaps so we could not be assured that this was always done.

● Accidents and incidents were not fully analysed to identify emerging patterns or trends. Recorded actions did not show what actions had been taken following incidents or accidents to investigate incidents and what measures had been put in place to mitigate further risk. For example, the majority of falls at the service had happened during the night. There was no evidence to show what actions had been considered or taken to reduce these. Further work is needed in relation to the analysis of accidents and incidents to identify trends and to reduce falls and incidents.

Preventing and controlling infection

At our last inspection the provider had failed to assess and manage risks to ensure the health, safety and wellbeing of people. This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Audits completed in relation to the prevention and infection control did not always demonstrate that immediate action had been taken to address the risks identified. For example, a monthly kitchen infection control audit identified vermin droppings, cleaning products being stored next to drinks and cups, the kitchen and kitchen equipment requiring a deep clean and labelled food as out of date. There were no records to show immediate action had been taken to address these issues.

● Equipment used by people using the service to aid their mobility was observed to be very dirty.

● Observations and audits showed people were not always supported to wash their hands prior to having their meal.

● Relatives raised concerns about the cleanliness of the service. One relative told us they did not feel that the service was clean and had made complaints about this, in relation to urine odours. Another told us they felt the service was not clean and had to ask cleaning staff to support with cleaning of their relatives' room.

The failure to prevent and control the risk of infection is a continuing breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Staffing and recruitment
At our last inspection, we recommended the provider review people's dependency levels and staffing levels currently in place and update their practice accordingly. The provider had reviewed and increased staffing levels since our last inspection, but we identified further concerns in relation to staffing which meant the provider was now in breach.

● People were placed at risk because the provider used high numbers of agency staff and had failed to provide inductions for 28 members of agency staff who had worked at the service. Recruitment at the service was ongoing but this meant people were not cared for by a consistent staff team who were familiar with their care and support needs. We wrote to the provider and asked that they urgently provide us with information relating to how they would address these concerns. The provider responded immediately by telling us what action they would take to address the concerns.
● Staff told us they felt staffing levels were better but did not feel the dependency on agency staff was good for people. Relatives told us, "The high staff turnover and reliance on agency staff meant there was a lack of consistency which further confused people with dementia."
● We observed positive interactions between people using the service and staff and the environment was less noisy and appeared calmer.

At this inspection, we found that improvements had not been made to ensure small numbers of consistent agency staff were used to provide continuity of care. A failure to provide sufficient numbers of suitably qualified, competent, skilled and experienced persons and deploy them to meet the needs of people using the service and keep them safe at all times is a breach of Regulation 18 (Staffing). of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this full report.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure systems and processes were established and operated effectively to investigate, immediately upon becoming aware of any allegation or evidence of abuse. This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● Safeguarding reporting systems in the service ensured that prompt information sharing took place. Staff received safeguarding training and policies and procedures were accessible.
● Staff understood where people required support to reduce the risk of avoidable harm and told us they would not tolerate abuse of any kind. Care plans contained basic explanations of the control measures for staff to follow to keep people safe.
● We received mixed responses from relatives when we asked them if they felt their relative was safe at the service.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At this inspection, we found the provider had begun to take steps to make improvements to the management of safety, risk and governance of the service. However, the improvements made had not yet been fully embedded and further improvement was still needed.
- There was a governance system in operation to monitor the health, safety and welfare of people who used the service. However, this had not been effective and had failed in identifying all of the concerns we identified at this inspection. These related to fire safety, staffing, management of medicines and management of risk.
- The provider had not ensured that governance systems around the management of medicines were effective and robust.
- Risk management was poor. Governance systems were not effective and failed to identify shortfalls within people's care records which put them at increased risk.
- The lack of inductions for agency staff had not been identified through the provider's governance system. This meant there was a failure to identify and mitigate risks associated with people receiving unsafe or inappropriate care from staff who did not know their needs.
- The provider had failed to ensure all records and documentation were accurate and up to date, ensuring that a full and complete, contemporaneous record of people's care was in place. For example, detailed information for staff to follow when people at high risk of skin breakdown regularly declined personal care. Twenty care plans had been reviewed and updated, a further fourteen had yet to be updated onto the new system introduced in October 2019.
- Requests for information to be sent to us during and following our inspection, we did not always receive information that we had asked for in a timely manner. Following our inspection, we wrote to the provider to ask that they provide us with all of the information we had requested and ask the provider what action they would take in relation to the serious concerns we identified.

A failure to ensure systems were effective, in place and robust enough to demonstrate the service was effectively managed is a continued breach of the regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others

- A culture of high quality, person-centred care which valued and respected people's rights was not embedded within the service. This was evident by the breaches of regulation identified during this

inspection.
● The provider did not demonstrate that they had learnt lessons when issues were identified. Improvements to the recording of accidents and incidents had been made, but this did not contribute to the prevention of further incidents or support a proactive approach.
● The management team worked in partnership with commissioners, health and social care professionals. Professionals told us they felt that some improvements had been made but these had not always been sustained.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider did not have robust systems in place to ensure people received person centred care. Care records did not contain information about people's basic preferences for example, their preferred routines, preferences of food, how they liked to spend their time. The shortfalls in the delivery of person-centred care highlighted during the inspection had not been identified by governance systems.
● There were basic communication shortfalls, which impacted on care delivery. For example, staff told us they did not have time to read care plans or risk assessments.
● Feedback from people and their relatives about the quality of the care provided was consistently negative. This included their relatives not having their basic care needs met including not having the opportunity to bathe regularly or have their teeth cleaned. Relatives told us they were not always consulted about their family members care.

A failure to embed robust quality assurance systems and operate effectively the systems for maintaining accurate records is a continued breach of Regulation 17 Good governance of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● A new senior management team had been employed by the provided and introduced to the service at the beginning of the COVID 19 lockdown. Some relatives we spoke with told us they had received a letter of introduction to the new manager and were aware of the changes. Relatives also told us they had not all been informed about being unable to visit the service during lockdown.
● The provider had not promoted the importance of working in an inclusive way. Systems were not in place to engage people, their relatives or staff in the running of the service. There was no evidence of arrangements in place for gathering people's and relatives' views about the quality of service provided.
● Staff told us morale in the service was improving. They felt communication needed to be improved further as not all essential information they needed to know about was shared. Staff turnover continued and in order to maintain safe staffing levels, the use of numbers of agency staff was high, rather than a small consistent group to provide consistency of care concerned staff and relatives.
● Staff meetings at all levels were held regularly.
● Not all relatives felt they were listened to and told us requests for return calls were not always made in a timely way. Requests for updates and information about their family member could not always be provided by the staff on duty.

A failure to seek and act on feedback from relevant persons and other persons on the services provided, including the quality of the experience of people in receiving a service is a continued breach of the regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provider had been responsive to issues and concerns raised by visiting professionals and had made safeguarding referrals when issues were raised.

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 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure small numbers of consistent agency staff were used to provide continuity of care to people using the service. The provider had failed to implement a robust system for the induction of agency staff to the service.