Minster Care Management Limited

Hamshaw Court

Inspection report

Wellstead Street
Hull
Humberside
HU3 3AG

Tel: 01482585099

Date of inspection visit:
27 November 2017
30 November 2017

Date of publication:
08 March 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection of Hamshaw Court took place on 27 and 30 November 2017 and was unannounced on the first day but announced on the second.

Hamshaw Court is a residential care home for up to 45 older people who may be living with dementia and is located down a residential street in Kingston-Upon-Hull. Accommodation is provided in individual flat-lets, each of which has its own bedroom/sitting area, a small kitchenette and an en-suite shower room. Some of the kitchenettes have been altered so that they are no longer functional to prepare or heat up meals, but still offer storage. There are communal rooms to sit in and an enclosed garden. At the time of our inspection there were 39 people using the service.

The provider was required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 the time of the inspection there was a manager that had been registered for the last two years and eight months. However, the registered manager had taken another post and held a second registered manager's certificate without cancelling their registration at Hamshaw Court. They held two separate manager registrations for two different locations belonging to two different providers. They had returned to Hamshaw Court when their new position had not worked out.

At the last comprehensive inspection in September 2016 the service was in breach of Regulations 9, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that inspection the service was rated 'Requires Improvement'. These breaches in regulations were with regard to safe care and treatment, person-centred care and good governance.

The provider put people at risk of harm because staff practice and recording were not in line with how medicines were prescribed and had to be accounted for. Audits used by the registered manager had not identified issues with the safety of the environment, care plans or medicines. The provider had not ensured care plans were up-to-date with regard to managing anxieties, catheter care, pressure care, weighing people and personal hygiene. Therefore people could not be sure they accurately instructed staff on how to meet their needs. We issued two requirement notices and a warning notice to the provider.

At that inspection we asked the provider to take action and make improvements to the recording and practice when administering medicines, the effectiveness of identifying shortfalls with the environment, medicines and care plans when auditing them and with care plan reviews so that people received accurate care and support. The provider sent us an action plan saying when these improvements would be made to comply with the warning notice.

We visited again on 08 February 2017 to assess whether or not the warning notice we issued had been met and found that it had. We found sufficient improvement had been made to ensure the provider met the regulation, as audits had been set up and were being used to identify shortfalls with the environment, care plans and medicines. Action was being taken swiftly to remedy the shortfalls identified.

At this inspection in November 2017 we checked whether the requirement notices were addressed and if the provider was now meeting regulations. We found that they were not. Therefore the service was still rated as 'Requires Improvement'. This is the second consecutive time that the service has been rated as 'Requires Improvement'. There were still issues with the safe management of medicines in regard to recording. People's medicines were not always safely managed, because recording and practice were still poor. This was a continued breach of Regulation 12: Safe care and treatment.

Systems were in place to detect, monitor and report potential or actual safeguarding concerns and staff were appropriately trained in safeguarding adults from abuse and understood their responsibilities in respect of managing safeguarding concerns. However, people were not always safeguarded from neglect due to poor care and failure to follow risk assessments. We have made a recommendation about safeguarding people from harm due to neglect.

Staffing numbers were not always sufficient or appropriately deployed to meet people's needs, as people said that staff were not always around to call on for help. We have made a recommendation about ensuring there are sufficient staff who are effectively deployed based on people's dependencies.

People and their relatives had complaints investigated by the registered manager, but were not always satisfied by the outcomes or the way in which they were treated. We have made a recommendation about seeking advice and guidance from a reputable source on the management and resolution of complaints.

There was a quality assurance system in place, which helped lead to improvements in service delivery, but it was not robust enough to always be effective. We have made a recommendation about ensuring the robustness of the quality assurance audits.

Recruitment practices were safely followed to ensure staff were 'suitable' to care for and support vulnerable people.

The premises were safely maintained and the environment was 'friendly towards' those living with dementia. Equipment was safely used in the service.

People were protected from the risks of infection and disease because suitable infection control management systems and practices were in place.

Staff encouraged people to make choices and decisions wherever possible in order to exercise control over their lives.

People were cared for and supported by qualified and competent staff. Staff received supervisions and annual appraisals of their personal performance, but this was an area where some improvement was required with the frequency of supervisions. Staff respected people's diverse needs.

People's nutrition and hydration needs were met to support their health. The provider appropriately monitored people's health care through observations and care plans and called upon the support of healthcare professionals when required.

People's mental capacity was appropriately assessed and their rights were protected. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People received care from considerate staff who knew about their current care needs and preferences. People were involved in aspects of their care and their right to express their views was respected. People's privacy, dignity and independence were respected. Consent for care and treatment took place and was respected.

We saw that people were supported according to their person-centred care plans, which reflected their needs and which were regularly reviewed.

There were opportunities to engage in some pastimes and activities if people wished. People maintained family connections and support networks and their communication needs were assessed and met.

Staff appropriately managed people's needs with regard to end of life preferences, wishes and care.

The culture of the service was described by staff as being friendly and supportive. However, this was not the view of relatives and external professionals who had made complaints that they felt were poorly received and addressed.

The registered manager understood their responsibilities with regard to governance. However, they presented a management style, which was inconsistent because we received mixed feedback from people, their relatives and healthcare professionals about how approachable and supportive they were.

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.

People's medication was not always safely managed, because recording and practice were poor.

People were not always protected from the risk of harm. The provider had systems in place to detect, monitor and report potential or actual safeguarding concerns, but people were exposed to the risk of harm from neglect due to appropriate action not being taken following falls, other accidents and illness.

Improvements in staffing numbers and their deployment were needed as people found staff were not always around when they called on them for help. Recruitment practices were safe and the premises were safely maintained.

Is the service effective?

Good

The service was effective.

People's health care was appropriately monitored and supported. Staff worked collaboratively with other health and social care organisations. People received adequate nutrition and hydration to maintain their health and their diverse needs were respected. People were encouraged to make choices, their mental capacity was appropriately assessed and their rights were protected.

Qualified and competent staff were employed. They received infrequent supervisions and appraisals of their performance. The premises were suitable for providing care to older people and the environment was appropriate for those living with dementia.

Is the service caring?

Good

The service was caring.

People received care from staff that were considerate and helpful. People's rights were respected and they were involved in aspects of their care.

The attitude and approach of the staff was friendly, supportive and encouraging.

People's wellbeing, privacy, dignity and independence were monitored and respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their relatives had complaints investigated but were not always satisfied by the outcome. The provider had not taken learning from complaints to improve the care and support people received.

People were supported according to their person-centred care plans, which were regularly reviewed. They had the opportunity to engage in some pastimes and activities to occupy and entertain them.

Communication needs were assessed and met where possible.

Staff appropriately managed end of life preferences, requests and care needs.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a quality assurance system in place, which helped lead to improvements in service delivery, but it was not robust enough to always be effective.

While staff described the culture as positive and the registered manager understood their management responsibilities, the registered manager's management style was inconsistent so that there were mixed views among people and relatives on how supportive and approachable they were.

Hamshaw Court

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.

The inspection of Hamshaw Court took place on 27 and 30 November 2017 and was unannounced on the first day, but announced on the second. One adult social care inspector and a 'bank' inspector carried out the inspection. Two officers of the Hull City Council quality and contract monitoring team also carried out their monitoring check on the 27 November 2017 as they had liaised with us regarding certain concerns that had been raised by relatives, staff and health care professionals over several months. Together we conducted our fact finding inspections.

Other information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also reviewed information from people who had contacted CQC to make their views known about the service. We had also received a 'provider information return' (PIR) from the registered provider. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 12 people that used the service, three relatives and the registered manager. We spoke with six staff that worked at Hamshaw Court. We looked at care files for six people that used the service and at recruitment files and training records for six staff. We viewed records and documentation relating to the running of the service, including the quality assurance and monitoring, medication management and premises safety systems. We also looked at equipment maintenance records and records held in respect of complaints and compliments.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and staff. We looked around the premises and saw communal areas and people's bedrooms, after asking their permission to do so.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in September 2016 the provider was in breach of regulation 12 because they had put people at risk of harm from receiving their medicines unsafely. Staff practice and recording were not in line with how medicines were prescribed and had to be accounted for. There were discrepancies in recordings on medication administration records (MARs). Staff omitted to date opened medicines. Topical medicine charts weren't completed appropriately. Protocols (instructions) for 'as required' medicines did not contain enough information to ensure that such medicines were administered consistently. The impact on people from ineffective medicines management may have prolonged pain and discomfort or exacerbated conditions.

At this inspection in November 2017 we found there had been insufficient improvements with the safe management of medicines, with regard to documentation and recording. Controlled drugs (CDs) are medicines required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. The CDs themselves were safely stored and they were stock checked and signed by two staff each time they gave them to people, but on 21st November 2017 only one staff had signed for administering a CD medicine. Staff could not evidence that a safe process had been used to administer CD medicines or that it had actually been given. The management of pain may be via an adhesive pain relief patch, applied to different sites in rotation to ensure absorption of the medication and prevent skin irritation. For people who used patches there were no body map charts to record where they were sited, which did not protect them from the risk of poor absorption or side effects.

We observed a senior carer sign a MAR before taking a person their medicines. The person had then not taken it and so the pre signing of MARs demonstrated poor practice that could have caused confusion later or resulted in the person not receiving their medicines. Staff did not follow the management of medicines policy and procedure with regards to recording when medicines were administered. Individual protocols contained information for 'as required' medicines, but not all of these contained the correct detail. For example, one protocol for eye drops said 'use as directed'. They should be given when eyes were dry and no more than twice in every 24 hour period. Another said 'one or two Paracetamol up to four times daily with a maximum dose of 400mgs in any 24 hour period'. This was incorrect, as the maximum dosage should be 4000mgs in a 24 hour period.

Notifications we received from the provider included information about medicines errors that amounted to seven incidents in the last twelve months. They included errors in medicines management, administration and recording, failure to send medicines with a person that transferred to another service, missed medicines for up to 10 days for one person and a double dose of an anti-depressant for nearly two weeks for another person. We discussed all of this with the registered manager during our visit and while there was no evidence to show that anyone experienced lasting harm from the mismanagement of medicines, there was potential for harm if staff followed some of the incorrectly recorded information or if people experienced other health complications.

This was a continued breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act

2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of the report.

Systems were in place to manage safeguarding incidents and staff were trained in safeguarding people from abuse. Staff demonstrated knowledge of their safeguarding responsibilities and knew how to refer incidents to the local authority, all of which were recorded. Training records evidenced that staff were trained in safeguarding. However, systems had not always worked effectively to safeguard people as we found evidence of people having been neglected regarding their care following accidents or illness. One person's health care needs had not been identified or treatment sought, their increased confusion had not been referred to a dementia specialist for assessment and other health care appointments had not been arranged regarding an injury. This had been the case for several months. Relatives identified that the person's health had deteriorated and made requests for healthcare support. In November 2017 another person had not received the health care they required with regard to nutritional preferences and reducing falls. Both people were referred to the safeguarding team at Hull City Council by external professionals and these investigations were on-going at the time of our inspection.

The provider had accident and incident policies and records in place, as well as risk assessments, and they sought involvement from the 'falls team'. Records showed that accidents and incidents were recorded appropriately. However, we were unsure that people were protected from the risk of harm because there had been so many accidents. The provider reported 25 serious injuries to us in the last 12 months, which was a high figure for the size of the service. We also found a high number of falls recorded in the service during the same time and so we assessed that risk assessments were being inappropriately followed. People's files had blank risk assessment forms, a person that used a wheelchair did not have a risk assessment form in place for this and another person's Malnutrition Universal Screening Tool had not been completed. There was potential risk of harm due to neglect for people that used the service.

We recommend that the provider considers current guidance on safeguarding people from harm due to neglect following accidents and illness and assessing risk.

Despite the findings above people told us they felt safe living at Hamshaw Court. They said, "I feel quite safe here. I lock my door" and "I feel safe here, as I can't get out except into the garden and so no one can get in."

Staffing rosters that we reviewed corresponded with the numbers of staff on duty during our inspection. This included two senior care and four care staff on both days we visited. Shifts were timed according to two seven hour duties during the day and a ten hour duty at night. While the provider's dependency tool showed there were sufficient numbers of staff on duty to meet people's needs and staff confirmed they had just about sufficient time to carry out their responsibilities to meet people's needs, staff also told us they could not spend quality time with people. They said, "We're rushing all the time. We can't take time to talk to people. It shouldn't be like that" and "There are not enough staff. Residents needs are changing and their health is deteriorating, but increased dependency has not led to increased staffing." We heard during the first hour of our visit people constantly ringing for assistance on the 'call system'. One person commented they were assisted up much later than usual.

People and their relatives told us they thought there were insufficient staff around to support people. People said if they used the call bell staff usually took a long time to arrive. One person said, "I can wait an hour and a half sometimes when I ask for assistance to use the toilet." Others said, "There are definitely not enough staff and they are always busy. I sometimes have to wait ages for the toilet", "I don't know if there are enough staff. I see them when I walk around", "There are times when I need a bit more help and I just

shout loudly" and "I'd like to talk one to one with somebody, but staff are so busy with other residents. I hear the bells going all the time. I need help to fill some forms in but they [staff] are busy all the time."

Staff told us they worked well together to achieve outcomes for people that used the service. However, we saw that household duties of were inefficiently managed. For example, beds were poorly made, a breakfast tray was still on the floor of a bedroom at lunch time, in en-suite bathroom the toilet, washbasin and floor were soiled. The person in this bedroom told us it had been like that since they'd had a shower the previous day. These were pointed out to staff at the time and remedied straightaway. We understood that not all bedrooms could be cleaned immediately they were vacated for the day, but improved staff vigilance could have avoided these.

We observed that people sat, walked about or stood in the entrance area a lot of the day with no staff visible to support or spend quality time with them. These examples, testimonies and the number of un-witnessed falls indicated that there may have been insufficient staffing numbers, despite these being based on people's dependency assessments and calculated as sufficient. We discussed with the registered manager and area manager an increase in staffing levels should there be any new admissions to the service, which they agreed to. We recommend the provider reviews people's dependency assessments to ensure staff deployment at certain times of the day is effective at meeting people's needs.

Staff we spoke with understood whistleblowing and said if they reported an issue to the registered manager and it was not resolved, they would not hesitate to escalate concerns to the local safeguarding team or the Care Quality Commission. One staff member said, "I'd rather report something wrongly than do nothing and later find that I was right about the concern." Formal notifications were sent to us regarding incidents, which meant the registered provider was meeting the requirements of their registration.

Maintenance safety certificates were in place for utilities and equipment used in the service, and these were all up-to-date. Contracts of maintenance were in place for ensuring the premises and equipment were regularly maintained. A warning of the risk of oxygen was on the door of the medicines room, the front entrance to the home and on the bedroom door of the person who needed to use it, so that everyone that entered the building were alerted to these risks from a naked flame. Some audits were carried out to ensure fire safety and equipment safety measures were followed. Where checks were made this ensured people's safety.

Staff used various equipment to assist people to move or transfer and we saw that this was used effectively. People were assessed for the use of hoisting equipment and there were risk assessments in place to ensure no one used it incorrectly. Bed safety rails were in place and these had also been risk assessed for safe use. People had a personal emergency evacuation plan (PEEP) in place, so staff knew how to support them out of the building in the event of an emergency or in case of a fire.

There was a recruitment procedure in use which ensured staff were suitable for the job. Staff files we looked at contained documentation for the vetting and screening of candidates. The procedure was supported by consistent recruitment practices around requesting job applications, references and Disclosure and Barring Service (DBS) checks. A DBS check is a legal requirement for anyone applying to work with children or vulnerable adults. It checks if they have a criminal record that would bar them from working with these people. The DBS helps employers make safer recruitment decisions.

Systems in place ensured that prevention and control of infection was appropriately managed. Staff had completed infection control training, followed guidelines for good practice and had personal protective equipment that they required to carry out their roles. We identified that the sluice room had no infection

control waste bin and asked the staff to ensure one was made available in that area. Cleaning staff were employed and did a good job of keeping the premises clean, but several bedrooms had some unpleasant odours. These were discussed with the registered manager who was already aware of them and had plans in place. They were working with cleaning staff to ensure improvements were made and if necessary were using alternative floor coverings for easier maintenance.

Good

Is the service effective?

Our findings

Some people we spoke with felt the staff at Hamshaw Court knew about their needs and that they were appropriately met. Two relatives we spoke with also said that their family members' needs were met. People were accepting of the tasks staff performed for them.

At the time we arrived for the inspection, which was 08:00 we were not confident that all of the staff were embracing 'person-centred' care in their work and being available to people when they needed them. This was because two from six staff (plus the deputy manager) were sitting together in the shift office and as the first shift of the day started at 07:00 they were unlikely to have still been carrying out a handover. We were told that there were four care staff and two senior care staff on duty that day during the morning and when we asked why the 'call system' was ringing so much during our first hour there, staff and the registered manager said that mornings were the busiest time for them and a time when people needed a lot of support. Seven people were already up and dressed waiting for breakfast, when we arrived. Others were still waiting to be assisted.

The provider had systems in place to ensure staff received the training and learned the skills they required to carry out their roles. The registered manager used a staff training record (matrix) to review when training was required or needed to be updated and there were certificates held in staff files of the courses they had completed, which they confirmed with us. Staff completed the organisation's induction programme, received one-to-one supervision and took part in a staff appraisal scheme, which we evidenced from documentation in staff files and via discussion with staff. Induction followed the guidelines and format of the Care Certificate, which is a set of standards that social care and health workers follow in their daily working life as recommended by Skills for Care, a national provider of accreditation in training. However, the frequency of supervisions for some staff was infrequent, as there were gaps in the records. We informed the registered manager of this and they told us they would address it with senior staff.

Discussion with staff revealed the service provided people with meals they requested to meet their needs. The cook fully understood about diversity of people and respected their religion, culture and dietary preferences. All food was prepared and cooked on the premises. Vegetarian and gluten free options were provided to those people that required them. People made their choices known regarding nutritional needs on admission and in personal reviews of care.

People's nutritional needs were recorded after consulting them about their dietary likes and dislikes, allergies and any medical conditions. Staff sought the advice of a Speech and Language Therapist (SALT) when needed. The kitchen staff ensured three nutritional meals a day were provided, plus snacks and drinks for anyone that requested them and was able to have them. Nutritional risk assessments were in place where people had difficulty swallowing or where they needed support to eat and drink. People were asked about their menu choices each day and these were recorded and then the food of their choice provided to them. People told us they were satisfied with the meals on offer. Two people said about the food provision, "I'm on a diet but I didn't agree to one" and "I get plenty to eat." The registered manager told us one of these people did not have capacity but was on a diet as agreed by their doctor for health and

mobility reasons. One relative said, "My relative is very picky about their food, but alternatives are offered." They said they were given sufficient food of a good quality and that really the issue lay with their relative.

We saw that meal times were very unhurried to the extent that some people were still arriving in the dining room for breakfast at five minutes to ten and being given food of their choice. One person said they were usually assisted to get up earlier and so the cup of tea they were given was the first of the day, which meant they'd had to wait far longer than usual and was thirsty.

Staff told us they thought they worked well with other care professionals that visited the service in providing care and support to people. We did not receive any testimony of this from the professionals we had contact with and that visited the service. Information we had been made aware of included that from other organisations and relatives regarding the service staff not always being effective in their relationships with them. One social worker had expressed concern about how the registered manager related to them and two relatives stated the same. This was discussed with the registered manager and area manager and was taken on board.

Staff told us they learned about people's medical conditions from information obtained on assessment and from speaking to relatives and people themselves. Information was recorded in care files and reviewed when needs changed. Staff handovers were used to share information. Staff told us that people saw their doctor on request and the services of the district nurse, chiropodist, dentist and optician were accessed whenever necessary. Health care records that were held in people's files recorded when they had seen a professional and the reason why. Diary notes recorded when people were assisted with the health care that was suggested for them.

Those people that used the service who were living with dementia had signage and some colour schemes that aided their orientation. Minor areas for improvement within the premises included that two beds did not have a headboard and one en-suite shower was not connected to the water supply so it could not be used. Several people's kitchenette areas had become damaged and so the equipment had been removed. The registered manager told us that no one at the time of the inspection was able to use their kitchen facilities and so these were gradually being taken out.

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 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 interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people were assessed as having no capacity to make their own decisions, the registered manager arranged for best interests decisions to be discussed and agreed. The registered manager also ensured DoLS applications were made and reviews of them carried out. All of this was managed within the requirements of the MCA legislation.

People consented to care and support from staff either by verbally agreeing to it when it was offered or cooperating through their body language and accepting support when staff offered assistance. Some

people signed documents that gave permission for their care plan to be implemented, photographs to be taken or medication to be handled, but those unable to do so were represented by relatives who signed on their behalf.

Good

Is the service caring?

Our findings

Most of the people and the relatives that we spoke with told us that they got on well with and liked the staff and each other. Their comments about staff being caring were varied. They said, "Some [staff] are good, some not. They mostly smile and do the best they can", "I say hello and they say hello back, but they don't say much", "[Name] is a nice carer who wants to help but they don't have time" and "The carers are a mixed bag, some are very good, most are kind." One person said, "The cook has lots of compassion and understanding." One relative said, "Staff cannot do enough for my family member. They are patient and uphold people's dignity without question."

Staff had a friendly manner when they approached people, knew about people's needs and preferences and were considerate when they offered support. Staff treated people civilly and listened to establish what they wanted. The service used a 'Map of Life' document to record people's personal story but this was not always completed. When we spoke with staff about people using the service they showed us that although they knew people's current care needs they knew little about their past lives or their histories. Staff we spoke with said they felt that they did not have the time to deliver care to the standard they wanted to.

At the time of our inspection we were told that people with diverse care needs were adequately provided for. We saw that people had opportunities in the service to receive the support they required, were treated by staff in the same way and acknowledged as individuals with particular care and support needs that were to be met according to their wishes and choices. Care plans recorded people's individual daily routines, preferences for activities or meeting up with family members and such as nutritional likes. Staff were aware of these details and responded to them appropriately, whenever possible.

We saw that staff considered people's age, disability, gender, race, religion and belief. Those that followed a religion were free to do so. Religious ministers of various faiths could be called upon to visit people on request. People with mobility needs who used wheelchairs were included in activities that ambulant people undertook and were offered opportunity to join in with events.

People's views were taken into consideration with regard to their personal preferences for daily living, by listening to what they had to say and enabling them to make choices. However, in the dining room staff were fixed on ensuring people received a meal and did not always check that people were satisfied with it. We did observe, however, that one staff noticed a person's breakfast was not what they usually liked and so brought their preferred food to them after asking if that was what they really wanted and was told 'yes'.

People's general well-being was observed by the staff who knew what was likely to upset their mental or physical health. This meant that staff sat with people who experienced low moods or felt emotional. One person spent a little time with a member of staff, but could not be sufficiently comforted. People were supported to engage in some pastimes, like having their nails done or passing the time of day chatting to catering staff, which meant they were occupied for periods of the day, but staff did not manage to engage everyone.

While almost everyone living at Hamshaw Court had relatives or friends to represent them, we were told that advocacy services were available if required. Advocacy services provide independent support and encouragement that is impartial and therefore seeks the person's best interests in advising or representing them. Information was available to people and staff about who to contact should people need an advocate. This was discussed within the organisation where a person had no family or friends using a 'best interest' decision.

People's privacy, dignity and independence were respected, but staff had become too used to people's routines and preferences. For example, on arrival at the service on the first day of the inspection, which was at 08:00, we saw one person walking about without any footwear or tights on and their feet were dirty. Staff explained the person chose to be independent with dressing and that they liked to be 'barefoot'. Their choice of attire was respected too easily by the staff, but later they were seen wearing sandals.

Staff told us they only provided personal care in privacy, knocked on doors before entering bedrooms and bathrooms and ensured doors were closed quickly when entering and exiting, so that people were not seen in undignified situations. We observed staff knocking on doors, but not waiting long enough for a person to respond before entering their bedroom. Staff were reminded to be mindful of these finer distinctions in their actions. We saw written evidence in people's files of the ways in which their personal care was to be provided to ensure people's dignity and privacy.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with had differing views of whether or not their needs were being appropriately met. Some talked about having things done as they requested them, but others stated they were not entirely happy with some aspects of their care. Their comments included, "They look after me fairly well", "Staff are not so good as some of them imply I am lazy, though I try to do as much as I can. I like my door locked when I am out of the room but not all the staff will lock it" and "I have what I need and staff are helpful." One person said they told their relative that they were not happy with something and the relative spoke with the manager to get it resolved.

The provider had a complaint policy and procedure in place and those people with capacity told us they knew how to complain. They said they could make their views known to staff or via their relatives. Complaints had been responded to in a timely way but the reason for complaint had not always been resolved. This left complainants feeling dissatisfied and that their complaint was unresolved. The provider failed to ensure that they had taken learning from complaints and used this to improve the service.

Staff were aware of the complaint procedure and knew how to record them and pass the information to the registered manager. We saw that the service had addressed several complaints throughout the year and complainants had been given some details of explanations. However, not everyone had felt their complaints were satisfied. We received details of some of the complaints that were made about the service. Some relatives were dissatisfied with the way in which their complaints had been handled and felt their family members had not always received the care and support they required.

Examples included that one relative had undertaken to deal with most of their complaints themselves so that their family member received the care, treatment and support they required. They liaised with the relevant health care professionals when staff had not done so. Another relative had complained about the way in which their family member had been cared for, stating the most appropriate health care had not been duly requested. Both these concerns had left complainants feeling dissatisfied with the response from the registered manager and the outcome for their family members.

Complaints ranged from health issues not being appropriately identified and treated, injuries following accidents not being appropriately treated, food being inappropriate to meet nutritional needs, possessions or clothing going missing and people not always being given the support they required. A complaint log also showed the range of complaint issues and stated how these had been looked into. When discussed with the registered manager issues were explained or accounts were related to us that only defended the actions or omissions of the staff and the service in general. There were no solutions or declarations to amend practice and improve the care and support that people received.

We recommend that the provider seeks advice and guidance from a reputable source, about the management of and learning from complaints.

People were assessed regarding their individual needs, using the organisation's own assessment process,

which covered several areas of care. They were then provided with a care plan which reflected those needs, some of which people presented to us on the inspection. Care plans were person-centred and provided information for staff on how best to meet people's needs. For example, one care plan showed how a person mobilised and how their health issues impacted on their daily life. One described a person's dietary preferences. Others showed details of what was important to people. Senior staff, who had approximately seven or eight people each assigned to them, were responsible for reviewing care plans and risk assessments every month and when people's needs changed. However, the quality of information about people that was held in their care files regarding their preferences and needs was inconsistent. Some records were complete and detailed and others were incomplete or missing. For example, one person did not have a 'Map of Life' completed. Their diary notes mentioned that a GP had been requested but there was no information to show the outcome of the consultation and there was no record of the visit on the 'professional visitors' form. A staff member later confirmed the person had seen their GP. A second person did not have a 'Map of Life' document in place. These omissions were discussed with the registered manager who looked into why the documents were incomplete. They stated they would ensure all staff were spoken to about completing records and documents.

Some activities were held in-house with an activities coordinator and were based on people's preferences identified in the information obtained from them in questionnaires. We were told by staff that people sometimes joined in with craft sessions, quizzes and themed events and also occupied themselves with the hairdresser or chiropodist. There were items in place for simple pastimes, including board games, floor games, magazines, newspapers and puzzle or reference books. Some photographs around the service evidenced where people had been and what they had joined in with over the last few months.

Staff knew about enabling people to make choices wherever possible. They chose where they sat, who with, and who they socialised with. Some chose when they got out of or went to bed, what they wore each day and whether or not they went out or joined in with the activities provided.

People's individual communication needs were assessed as part of the pre-assessment. Communication aids/methods were used, where possible, to enable people to make their views known, but most people at Hamshaw Court communicated verbally. A few that were unable to verbalise their wishes used body language and gestures to make their choices and decisions known. The registered manager was aware of the Accessible Information Standard but had yet to formalise the standard's assessment process.

We asked how people were cared for at the end of their life and found that staff sought appropriate healthcare support to enable people to have a comfortable, pain-free and dignified death. All care and end of life arrangements were recorded within people's care plans. Staff said end of life care plans were introduced when appropriate after discussions with the people's GPs and relatives. Some had 'do not attempt cardiopulmonary resuscitation' documents in place to be protected from any unnecessary and unpleasant treatment. Those that did not had their right to life protected and respected by the health and social care services they used. Positional changes were frequent, fluids given regularly, lighting was kept low and family members were kept informed. One staff member said they were prepared to stay back after their shift if a person needed someone with them at the end, as they had already done so once.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection the provider was in breach of regulation 17: Good governance. They had not ensured effective audits had identified issues with the safety of the environment, care plans or medicines. The provider had set up a centralised auditing system so an overall view of how the service was performing could be made. Although care plans, medicines and environmental audits were carried out no action was taken to rectify the issues identified. Updating of risk assessments and essential information in people's care plans was not done. There was a lack of recording of when medicines had been started, non-application of topical creams and lack of protocols for medicines which were to be given 'as and when required'. Bedrooms which had been refurbished as part of the on-going programme had not been finished off properly before people had moved into them. The provider continued to be in breach of the regulation on good governance and so we issued a warning notice. However, we found they met the requirements of the regulation when we visited again in February 2017.

At this inspection in November 2017 we found that the registered manager may have understood their governance responsibilities, but had not fully ensured that quality performance and risk were monitored and mitigated. They continued to carry out audits on service delivery, which also included checks on catering and the dining experience, safeguarding events, complaints, budgets and occupation, but their findings did not reflect what we had found. For example the medicines audit completed in November 2017 claimed that staff performed at 90% accuracy for meeting the requirements of the audit, but there were many medicine errors throughout 2017 that, although identified, had not been learnt from and so mistakes were still happening. Audits on care plans and risk assessments had not always identified that risk assessments and information forms were poorly completed. People's files had blank risk assessment forms, a person that used a wheelchair did not have a risk assessment form in place for this and another person's Malnutrition Universal Screening Tool had not been completed. The quality monitoring systems were not used effectively.

The registered manager issued satisfaction surveys to people that used the service, relatives and health care professionals. For example, the last satisfaction survey issued to any of these groups of people was to service users and staff in March 2017 and to relatives in October 2017. Those from people that used the service that were returned in March numbered seven and mainly complained about activities being a failure. The activities coordinator had been on leave of absence but reviewed what was on offer on their return and some improvement was experienced in group sessions. We also observed them sitting with some people on a one-to-one basis. The surveys returned from staff and relatives were generally positive from staff but not so positive from relatives.

Meetings were held for people that used the service, relatives and staff to obtain their views of service delivery; for service users the last recorded meeting was June 2017 and staff had met in March, June and September 2017. There was also a shift handover system at which people's needs were discussed and monitored. Further analysis of all of the information gathered should help the provider to identify trends and concerns so that improvements can be made.

We recommend that the provider seeks advice and guidance from a reputable source on the most effective quality assurance systems.

The provider was required to have a registered manager. The person we saw on the two days of the inspection had been registered for two years and eight months. However, their practice had resulted in some poor administration of their registrations between December 2015 and May 2016, which we mentioned earlier in the summary of this report. They had failed to de-register their position at Hamshaw Court when they registered for another provider for a five month period. When this position proved unsuitable they had returned to Hamshaw Court under their old registration.

The registered manager described their management style as open, responsive and delegating. Our questions were openly discussed, there were explanations given for issues raised and staff were given responsibilities to make changes to documentation, practice and the support people received. However, the management style of the registered manager had also been described in the last six months by health and social care professionals, relatives and staff as the opposite to this. Staff told us that, "The registered manager is very firm but also fair" and "They sometimes show favouritism and don't always maintain confidentiality."

Over the last 16 months the Commission received information relating to the registered manager's approach and attitude from eight different people, concerned about the way in which they had been treated and spoken to. We addressed similar issues at the last comprehensive inspection in September 2016. We also received 25 other pieces of information in that time stating complaints, concerns and allegations of inadequate care. Since our inspection visit and before this report was completed we received other information of concern about people's safety for which Hull City Council safeguarding adult's team had requested explanations. In connection with this a relative stated they felt intimidated whenever they visited the service.

People we spoke with felt the service had a satisfactory atmosphere where they could have some fun with each other and the staff. They accepted the way the service was run and expressed no desire to have any control over this. They told us they had met the registered manager at least once and had seen them around in the service. One person said they had found the registered manager helpful.

Visitors to the service that we spoke with on the two days we inspected Hamshaw Court told us they found that things ran smoothly enough. Relatives said, "I don't really need to speak to the manager, as the staff are helpful enough and all of the senior staff are approachable" and "I go directly to the manager to discuss any areas of my family member's care."

The registered manager and provider understood their responsibility to submit notifications to the Care Quality Commission (CQC) and so the service fulfilled its registration responsibilities in this regard.

Staff we spoke with described the culture of the service as, "Friendly" and "Supportive" and said that it "Promoted independence." Staff encouraged people to maintain links with the local community, where possible, through religious affiliation, visits from schools in the area and by using the shops, services and businesses along the nearby main road. Relatives played an important role in helping people to keep in touch with the community by supporting them out to shops and cafes, the cinema/theatre or walks. One person had attended Remembrance Day services with family. Another regularly used the local newsagent, while a third person told us they often went shopping with their daughter. However, other people told us they didn't get out into the community enough and were restricted to using the garden areas of Hamshaw Court.

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 provider had not ensured the proper and safe management of medicines because they had failed to record when a controlled drugs was given, failed to put detail in protocols, failed to give a person their medicines for 10 days, given a person double doses of medicines for 2 weeks, signed before giving a person their medicines and did not use body maps to record where pain patches were sited. All of this did not ensure people received safe care and treatment with regard to medicines managment. This was a continued breach of regulation 12 (1)(2)(g)