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

Hamshaw Court is a care home providing personal care for up to 45 older people who may be living with mental health needs or dementia. The service was supporting 37 people at the time of our inspection.

People's experience of using this service
People were at risk of harm as risks to their health, safety and wellbeing were not effectively identified and managed. There were significant concerns about the quality and safety of the service, which had not been identified or addressed by the registered manager or provider.

Robust systems were not in place to ensure safe management of infection control and effectively reduce the risks of people catching and spreading COVID-19.

Accidents and incidents were not effectively reported, recorded and responded to. This placed people at increased risk of harm.

Arrangements were not in place to support the safe management of medicines. People did not receive their medicines as prescribed. People who relied on staff to administer pain relieving medication did not receive it when they needed it, and were left in pain, or to experience discomfort and distress.

People's needs were not robustly assessed on admission and as a result the service was unable to meet their needs. People's care and support needs were not managed safely or regularly reviewed. Care plans and risk assessments did not always reflect people's needs, risks or provide up-to-date information to guide staff on how to safely support them. This placed people at significant risk of harm.

People were unlawfully deprived of their liberty. The registered manager's lack of knowledge in this area meant appropriate applications to the local authority had not been made. The provider had failed to identify this issue via a robust governance system.

Staff were not always effectively deployed. People and their relatives gave negative feedback about the responsiveness of staff. Agency staff did not receive information about the care and support needs of the people they would be supporting.

The provider failed to demonstrate how they complied with requirements relating to duty of candour.

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

The service was not well-led. There were significant concerns about the quality and safety of the service. The provider had failed to take sufficient and timely action to address safety issues and to make improvements,

which would help keep people safe and improve their quality of life. There was a lack of effective oversight and governance.

For more details, please see the full report which is on the Care Quality Commission's (CQC) website at www.cqc.org.uk.

Rating at last inspection and update
The last rating for this service was requires improvement (published 13 July 2021) and there were two breaches of regulation.

At this inspection not enough improvement had been made and the provider was still in breach of regulations. The service is therefore rated inadequate. This service has been rated requires improvement or inadequate overall for the last five consecutive inspections.

Why we inspected
We undertook this targeted inspection to check on specific concerns we received about people receiving poor care, unsafe management of medicines, poor management of and failures to respond appropriately to risks. A decision was made for us to inspect and examine those risks.

We inspected and found there were concerns with people's care and treatment and poor governance and leadership of the service, so we widened the scope of the inspection to become a focused inspection, which included the key questions of Safe and Well-Led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

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 safe care and treatment, safeguarding service users from abuse and improper treatment, staffing, duty of candour and the provider's governance arrangements.

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 work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'inadequate' and the service is therefore 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 findings 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The first day of inspection was completed by one inspector and an inspection manager. The second day of inspection was completed by an inspection manager.

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.

The service had a manager who is registered with the CQC. The registered manager along with the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Both days of our inspection were 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 professionals who work with the service. We used all this information to plan our inspection.

The provider was not asked to complete a provider information return before 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 took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the administrator, two shift managers, four members of care staff, the deputy manager, the registered manager and two area managers.

We reviewed a range of records. This included six people's care records and 26 people's medication administrations records. We inspected four staff files in relation to their recruitment, induction, training and supervision. A variety of other records relating to the management of the service, including audits and policies and procedures, were also reviewed.

We inspected the environment and spent time observing staff's interactions and infection prevention and control practices.

After the inspection
We continued to seek clarification from the provider to validate the evidence found. We requested and reviewed additional records including care records, audits, training data and other records relating to the management of the service.

We spoke with four people who used the service and six people's relatives about their experience of the care provided. We spoke with the 'nominated individual' by telephone. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with the Local Authority commissioning team and Safeguarding team.

Inadequate

Is the service safe?

Our findings

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

At our last inspection this key question was rated requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection people did not receive their medicines as prescribed placing them at risk of harm. 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 remained in breach of requirements relating to the management of medicines under Regulation 12.

- People did not receive their medicines as prescribed.
- Care records showed people requested their 'as required' medicines when they experienced pain or breathlessness. However, staff did not always administer these medicines to people. This meant people experienced pain and discomfort unnecessarily for long periods of time with no intervention from staff.
- People did not always receive their medicines when they needed them. One person explained to us, "I have to wait for pain relief whilst they [staff] get it." A relative told us, "My family member cries out in pain and I have to chase the staff for it to be brought to them. Sometimes they've waited for over an hour, its awful to see your loved one in pain."
- The provider's governance systems had failed to drive improvements in relation to medicines practices within the service.

The failure to ensure the safe management of medicines is a continued breach or Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- People were not protected against the risks associated with COVID-19.
- Not all people had been supported to access the opportunity to have the COVID-19 vaccination.
- Risk assessments, and information relating to the management of COVID-19 risks, were not developed until the second day of the inspection. This meant when people acquired the infection, there was no guidance for staff to follow when providing care and support to people who had tested positive for COVID-19.

The failure to ensure good infection prevention and control systems were in place put people at increased risk of harm. This was a 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; Learning lessons when things go wrong
● People were placed at significant risk of receiving inappropriate or unsafe care.
● Risk assessments and care plans were not completed for all people who had been admitted to the service since our last inspection in June 2021.
● People with a range of care needs, including people in receipt of end of life care, had 'short stay' care plans. These did not contain up-to-date information about their needs, risks or provide staff with sufficient guidance on how to safely support them.
● Where risk screening tools had been used, these were not always completed correctly.
● Care plans created by the registered manager did not contain adequate guidance for staff to safely support people. For example, one person was deemed a high risk of choking. Their care plan contained no guidance to ensure staff supported the person safely whilst eating their meals.
● A robust system was not in place to ensure accidents and incidents were appropriately recorded and managed.
● Accidents and incidents were not responded to with appropriate actions to prevent reoccurrence and to ensure people were safe. For example, where people had fallen, there was a lack of action taken following these incidents.
● There was no information to show any analysis had been completed to identify trends or themes and therefore no evidence of lessons learned.

The failure to adequately assess and manage risks put people at an increased risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were unlawfully deprived of their liberty.
● The registered manager had not made applications to the local authority to lawfully deprive people of their liberty. This resulted in fourteen people being unlawfully deprived of their liberty.
● The registered manager did not have sufficient skill or knowledge in this area. They told us they had not made applications to the local authority, because they did not think the applications would be successful.

The failure to ensure appropriate applications were made to lawfully deprive people of their liberty 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.

Staffing and recruitment
● Not all staff knew and understood people's care and support needs.
● The provider used agency staff to provide care for people who required support from one member of staff at all times. However, the provider had failed to ensure the members of agency staff were fully aware of the needs of the people they were supporting.
● Inductions for agency staff did not include any information or reference to supporting people. The registered manager told us they thought staff would inform agency staff about people's needs.
● People gave mostly negative feedback about staffing, and how long they waited for staff to support them. Comments included, "Everyone [staff] always says, 'I'm busy' and then they don't come" and "You don't know where you are with staff. Lots of agency staff now; I don't know anyone."
● Relatives told us there were not enough staff on duty to meet people's needs. One relative explained to us, "Staff are either too busy, or don't know what the needs of my family member are. They [family member] don't get the level of personal care that they should. My family member spends a lot of time alone and has deteriorated since moving into Hamshaw Court."

The failure to make sure sufficient numbers of competent and skilled staff were deployed was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 requires improvement. At this inspection this key question has deteriorated to inadequate. 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 our last inspection the service was not consistently and effectively led. People were at risk of receiving poor quality care, because robust quality assurance systems were not in place. This was a breach of Regulation 17 (Good governance) 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 17.

● Since our first inspection in January 2016, when ratings were introduced, we have only rated this service as 'inadequate' or one that 'requires improvement.' The service has a history of breaching regulations and failing to sustain improvement. This showed a systematic failure in the provider's organisation and leadership of the service.
● People were at risk of harm, because the service was not well-led.
● The provider had failed to ensure the registered manager had the knowledge, skills and competence to fulfil their role. For example, in relation to deprivation of liberty safeguards, care planning and risk assessment.
● There was a continued failing to ensure the safe management of medicines. People experienced poor standards of care as a result of ineffective oversight and leadership at the service.
● There was a failing to ensure risks associated with people's care needs were identified through a thorough assessment. Care planning failed to ensure people's needs were safely met. For example, people who had lived at the service for more than four weeks did not have care plans in place as required in the provider's policy guidance.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People gave mixed feedback about their experience of care at the service. Their comments included, "I don't exactly know who the manager is", "I would give it 4 out 10; it's poor" and "It's clean and they feed you well."
● Relatives gave mostly negative feedback about the service. Their comments included, "I've never been

included in my relative's care." "Communication is poor; we find out when things have happened after the fact; the staff don't call us despite us asking them to", and "They [staff] aren't as responsive as they could be; the registered manager just doesn't get back to you."

● People did not receive high quality, person-centred care. There was a clear lack of effective oversight from the provider which impacted on the outcomes for people. The provider and registered manager had not completed thorough checks on people's care and the quality of their daily experiences to satisfy themselves the service was good.

● There was limited evidence to show people's views or experience of using the service were considered in the way the service was run.

The failure to assess, monitor and mitigate risks and take adequate steps to improve the quality and safety of the service was a continued breach of 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

● We asked the provider to provide information to demonstrate they had met the requirements regarding duty of candour. They did not provide CQC with any information regarding this.

The failure to act in an open and transparent way when things go wrong is a breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others

● There was not a culture of continuous learning. Effective systems were not in place to enable the service to improve.

● Further development of partnership working with key organisations including the local authority and safeguarding teams was required to ensure good outcomes for people.

● The widespread issues and concerns identified during this inspection did not support people to achieve good outcomes or improve their quality of life.