

# Minster Care Management Limited

# Hamshaw Court

## Inspection report

Wellstead Street  
Hull  
Humberside  
HU3 3AG

Tel: 01482585099

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03 March 2021

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## Ratings

Overall rating for this service	Inspected but not rated
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Is the service safe?	Inspected but not rated
Is the service well-led?	Inspected but not rated

# Summary of findings

## Overall summary

### About the service

Hamshaw Court is a residential care home providing personal care to 27 people aged 65 and over, some of whom may be living with dementia, at the time of the inspection. The service can support up to 45 people.

### People's experience of using this service and what we found

Although the person we received a concern about was not at risk of harm, the information used to guide Hamshaw Court staff and agency staff needed review so care and support was consistent.

More oversight was required in relation to ensuring a consistent agency staff team and recording the 1-1 support they delivered. There was also a need to improve communication and support systems between Hamshaw Court staff and agency staff.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection

The last rating for this service was inadequate (published 24 December 2020).

### Why we inspected

We undertook this targeted inspection to check on a specific concern we had about the care delivered to a person, which it was alleged placed them at risk of neglect. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

We found no evidence during this inspection that the person was at immediate risk of harm from this concern. Please see the safe and well-led sections of this report.

CQC have introduced targeted inspections to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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.

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](http://www.cqc.org.uk).

### Follow up

We will continue to monitor information we receive about the service until we 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 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 of the publication date of the last inspection report 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?**

At our last inspection, we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

**Inspected but not rated**

### **Is the service well-led?**

At our last inspection, we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

**Inspected but not rated**

# Hamshaw Court

## Detailed findings

### Background to this inspection

#### The inspection

This was a targeted inspection to check on a specific concern we had about the care delivered to a person, which it was alleged placed them at risk of neglect.

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 inspection team consisted of two 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. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

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

#### Notice of inspection

This inspection was unannounced.

#### What we did before the inspection

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 took this into account when we inspected the service and made the judgements in this report.

We liaised with the local safeguarding team.

We used all this information to plan our inspection.

#### During the inspection

We spoke briefly with three people who used the service about their experience of the care provided. We spoke with six members of staff including the registered manager, a senior care worker, two agency care workers, a laundry assistant and a domestic worker. We also spoke with the deputy manager of the agency that supplies care workers and a visiting community nurse.

We reviewed a range of records. This included three people's care records and a selection of people's supplementary records such as 1-1 support, accidents, nutritional/hydration intake and positional changes. A variety of records relating to the management of the service, including policies and procedures and quality monitoring were reviewed.

#### After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at action plans and further information sent to us from the provider. We liaised with the local safeguarding team.

# 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. This meant people were not safe and were at risk of avoidable harm. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about. This was regarding a whistle blowing allegation about a specific person's care needs.

We will assess all the key question at the next comprehensive inspection of the service.

### Assessing risk, safety monitoring and management

- The person at the centre of the concern had complex care needs and some risks had been identified and documented in daily records, and staff were aware of them. The person had 1-1 support in place.
- The care plan guidance for agency staff, to enable them to safely monitor and manage the person's needs required review to ensure it contained complete and up-to-date information. This would ensure agency staff worked in a consistent way.
- The person was not at risk of harm and their care and safety needs were monitored.

Following the inspection, the registered manager updated the risk assessments and care plan to ensure they provided more relevant and up-to-date information to guide agency staff.

### Staffing and recruitment

- The 1-1 support for a specific person was contracted from an agency. There had been a change of agencies in February 2021, which had impacted on the provision of a consistent, and small, 1-1 support team for the person.
- The induction for agency staff needed review to ensure they read care plans and 1-1 handover notes before supporting the person.

Following the inspection, the registered manager met with the agency manager and agreed a more consistent, 1-1 care support team for the person.

### Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

# 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 the last inspection, this key question was rated as 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. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about. This was regarding a whistle blowing allegation about a specific person's care needs.

We will assess all the key question at the next comprehensive inspection of the service.

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

- Record keeping of 1-1 support had not been monitored effectively. Some recording was inappropriate and there were shortfalls in the content of a care plan to guide staff when they supported a person with complex needs. This had not been identified in audits.
- Communication systems between staff within the service and agency staff required review to ensure there were mechanisms in place to support their 1-1 role.
- There had been some confusion regarding oversight of agency staff. The provider had an exclusivity contract with the agency but, without their knowledge, this had not always been upheld and agency staff worked at different services creating a potential risk during the pandemic.

Following the inspection, the provider took action to address these concerns.