Caspia Care Limited

Hurst Manor Nursing Home

Inspection report

Hurst
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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 18 19 August 2015 and was unannounced. Hurst Manor registered on 17th April 2015, The new provider is Caspia Care Ltd.

Hurst Manor is registered to provide accommodation with nursing or personal care for up to 36 people. At the time of the inspection there were 26 people living at the home. 11 people were living in the Garden unit which provided care and support for people living with dementia. One person was receiving day care. Day care is not a regulated activity and this service was not inspected.

Hurst Manor is situated in the village of Hurst in Somerset. The home was a period building with single storey extensions at the back of the main building. Many of the rooms opened up onto the garden or coutyards .

There was a registered manager in post. The registered manager was also managing another home owned by the provider. A manager had been appointed solely for Hurst Manor and had been in post since June 2015. They were applying to be the registered manager of the home. We also met a peripatetic manager who had been supporting the provider's homes in the area.

Summary of findings

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.

People and relatives told us they felt safe and were happy living in the home. However we found areas that required improvements. Staff had not received relevant training and did not have the skills and knowledge to support people in the Garden unit. Staff were not receiving supervision or appraisal. People's care records lacked information that would support staff to guide them. As part of the provider's quality assurance systems we saw plans of the improvements that needed to be made. Target dates had been set for improvement but these target dates had not been met. People were supported to maintain good health.

People had not been fully consulted or involved in drawing up and reviewing their care plans. The care plans had not been regularly reviewed or updated and some information was out of date. Care plans were locked in the nurse's station; this meant staff did not have information to hand regarding meeting people's needs.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the take at the back of full version of this report.

Summary of findings

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 completely safe

Procedures had not been put in place that identified risk to people regarding their health and safety. People's behaviours were not managed in a way that protected them or others.

Staffing levels were inadequate to support the needs of people.

People were not always receiving their medicines at the times of their prescription which meant they were at risk of their health needs not being met appropriately.

Is the service effective?

Inadequate 

The service was not effective

People's legal rights were not always protected because the provider did not act in line with current legislation and guidance.

People were not always supported by staff with the knowledge, training or skills to carry out their roles effectively.

People were not fully supported at mealtimes and were not involved in the choice of their food and drink.

Is the service caring?

Requires improvement 

The service was always not caring

People's communication needs were not always considered or understood which meant their choices and preferences were not always considered.

Although some people were treated with kindness and compassion, staffing levels prevented staff from being able to give time and listen to people

Is the service responsive?

Requires improvement 

The service was not responsive

People were not involved in their care planning or given information in formats they would be able to understand.

People's care needs had not been regularly reviewed and care plans contained out of date information which meant there was a risk people would not receive the support they needed to meet their needs fully.

People were not supported to lead active lives or be involved in a range of activities within the service.

People were aware of how to complain and who to complain to. There were complaints procedures in place.

Summary of findings

Is the service well-led?

The service was not well led.

The provider did not have effective quality assurance systems that ensured people received a safe service that responded fully to their individual needs.

People did not receive care from staff who were fully supported through supervision or appraisals.

Staffing structures in the home did not support the needs of people or the support needs of staff.

Requires improvement

Hurst Manor Nursing Home

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 act.

The inspection was carried out by two inspectors from adult social care, and took place on 18, 19 August 2015. The first day was unannounced. This was the first inspection since the new provider had taken over the service in April 2015. During the inspection we spoke to three managers, three nurses, six staff members' five relatives and 18 people using the service. We looked at records which related to people's care and the running of the home. These included eight care plans, six staff files, nine medicine records and some of the provider's quality assurance evidence including incident and accident files.

Some of the people living in the Garden unit were unable to fully express themselves; we therefore spent time observing care practices. To help us gain more information about people's experiences we used a Short Observation Framework for inspection (SOFI). A SOFI is an observational tool used to help us collect evidence about the experience of people who use services, especially where people may not be able to fully describe these experiences themselves because of cognitive or other problems. We looked at the care records of the people we had observed through the SOFI.

This was the first inspection for the current provider. We therefore had no previous records to observe. Before the inspection we had not received any notifications of incidents or accidents or safeguarding alerts.

Requires improvement

Is the service safe?

Our findings

Whilst some people that lived at the home were able to manage their care and support needs safely with staff support, we found aspects of the service to be unsafe.

People informed us they did not feel there were always sufficient staff on duty to deliver care in line with their wishes. People made comments such as. “Regular staff had left, we are unsure who works here all the time as lots of people are from agencies." “I know when to push my call bell and when it is pointless pushing it as it won’t get answered”. “There have been many changes, it used to be good here, but now they seem to be short of staff”. “Staff that are still here are cheerful and helpful but seem to be struggling.” “There is no point ringing your bell at busy times in the home as they don’t come”.

One visitor informed us. “There are not enough staff around to enable people to do things.” Another visitor said. “Sometimes I have to remind staff that my relative needs support. There does not seem enough staff to help anymore. Some days I come in and my relative is still in bed. I have been told there were not enough staff to help get them up. I do know who to complain to if I need to”.

Staff also informed us there were not enough staff on shift to support and give time to people. Throughout the inspection it was noted call bells were ringing for long periods of time. Visitors commented on the bells ringing one visitor told us. "It is clear staff were always busy as the bells rang a lot." People felt unsettled by a number of staff changes. One person said. “People come into my room it worries me as I don’t know many staff anymore. There have been a lot of changes.”

We observed one person repeatedly banging a cup looking for attention from staff. When a member of staff asked them what was wrong, the person asked for some personal care support. The person was informed they would have to wait until other staff came back. At that time of the request there was only one staff member available.

There were registered nurses on duty each day and evening. Nurses supported all people in the home regardless of whether they had been assessed for nursing or residential care. This meant nurses often spent time caring for people who did not have nursing needs. Nurses informed us they were responsible for the care of all the people in the home. A senior care assistant was also on each shift to support the nurses. Nurses informed us senior care assistants worked as part of the care team therefore they were not available to support the nurses.

Staff rotas during the week of the inspection showed two registered nurses employed by the service were working part-time on day duty. One nurse was employed to work on night duty. Other shifts were covered by agency nurses. Six agency nurses were seen on the staff rota for August covering day and night shifts for varying amounts of time. There was no nurse on duty with clinical oversight during the week we inspected the home. Nurses informed us that because there was no continuity of nursing support, messages in the communication book were being missed.

This meant it was difficult to ensure continuity of nursing care.

Concerns about staffing levels and the safety of the service have been passed on to the local authority safeguarding team following this inspection.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated

People’s risks had not always been identified and acted upon. One relative said their family member was at risk of falling. When we looked at the person's care records no risk assessment had been completed, there were no clear guidance on how to reduce the risk of falling. We observed this person was being encouraged by staff to use a walking aid, so were aware of the risk of falls. The person on occasions seemed to be unsure of their surroundings and was encouraged by staff from a distance to sit down. We observed staff telling another person from across a communal room they should stop walking in and out of the building as it was raining and they may fall. No assistance or alternative activity was offered to the person to prevent them going outside again.

Another person had difficulty with fluid intake and needed regular prompting. Staff told us fluids were given with a syringe into the person’s mouth. There was no risk assessments in this person’s care plan relating to the administration of fluids. Using a syringe to administer fluids is not a safe practice and risks the person inhaling fluids.

One person living with dementia was seen to challenge staff with some of their behaviours. Staff seemed unclear how to support this person. A relative expressed concerns

Requires improvement

Is the service safe?

that staff were not managing interactions between people safely and were worried about their own relative. People were anxious due to the person shouting. When we looked at their care plan there were no risk assessments relating to their behaviour or their interactions with other people. There was no evidence of appropriate professionals being involved to support the person or reduce the risks to themselves or other people in the home.

We were given a list of people living in the home and the rooms they were living in. We found some people were not in the rooms recorded. Other people in the home were not on the list. This meant in the event of an emergency such as fire, people could be at risk of not being evacuated. Also information provided to the fire services would not be inaccurate.

People's medicines were administered by the trained nurses in the home; however people were not getting their prescribed medicines at the right time. We saw medicines which were due at eight am had still not been administered by lunchtime. Nursing staff said they did not have sufficient time to be able to carry out this task in a timely manner. Nursing staff were responsible for the administration of all medicines in the home regardless of whether people had been assessed as needing nursing or residential care.

There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. The home used a blister pack system with printed medication administration records (MAR) We saw medication administration records and noted that medicines entering the home from the pharmacy were recorded when received by one person. We also looked at records relating to medicines that required additional security and recording. These medicines were appropriately stored and clear records were in place. We checked records against stocks held and found them to be correct. When people were given medicines it was in a safe, considerate and respectful way. Medicine administration records (MAR) were mostly signed and accurate although a small number of gaps were seen.

When we reviewed the medicine administration records (MAR) some audit trails were not clear. Some medicines had been stopped. There were no amendments or signatures in place to identify by whose instruction the medicines had been stopped. We found some medicines that were out of date.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Some people felt safe and were happy living in the home. One person informed us that following an illness they stayed in their room as they felt safer doing this. They could look after themselves for most things but knew staff were available if needed. Another person told us. "Staff are dear, sweet and lovely but there is not enough of them". One person told us that it has been difficult to leave their home, but they knew people in the home and felt safer living there.

Some risks to individuals were managed well, people were seen to receive good personal care and those resting in bed seemed safe and well cared for. Staff supported people who were unable to get out of bed with kindness and patience. People, who were at risk of skin damage, received appropriate preventative care. There was no one in the home with skin pressure damage at the time of the inspection. The manager, staff and care records confirmed this.

The risk of abuse to people was reduced because the provider had recruitment procedures in place. They carried out appropriate checks on new staff which included seeking references from previous employers and checking with the Disclosure and Barring Service (DBS.) The DBS checks people's criminal history and their suitability to work with vulnerable people. Staff were not allowed to start work until the checks had been completed. The managers were trying to recruit additional staff including additional activity coordinators to improve people's social opportunities.

New systems were being put in place with regard to health and safety in the home. Regular maintenance checks were being carried out. Records showed fire checks were being carried out weekly. The person responsible for the maintenance of the home said the systems were safe and they had received support to implement them.

There were suitable secure storage facilities for all medicines. This included secure storage for controlled drugs and for medicines which required refrigeration. The home used a blister pack system with printed medication

Requires improvement

Is the service safe?

administration records. Blister packs and most medicines used each day were stored in a medicines trolley that were locked and secured when not in use. We observed the nurse carrying out medicines round.

Inadequate

Is the service effective?

Our findings

People did not always receive effective care. People living with dementia in the Garden unit did not receive care and support appropriate to their needs.

People were not always given adequate support to be able to eat their meals. Staff did not work effectively with each other or with the people they were supporting to ensure people were having a positive experience at meal times. For example, one person was grabbing meals away from others causing people to shout and hit out at each other. People were seen to be distressed by this person's behaviour which included shouting and grabbing the table cloth, people were not eating their meals. Staff cleared away the meals without encouraging people to eat. A person's meal was served without cutlery; staff did not communicate with the person when serving the meal or notice the lack of cutlery. The person was left unsupported to eat their meal until another person at the table offered them their spoon. The person did not eat their meal. Staff removed the meal asking the person "are you not hungry" and "would you like a drink instead". They did not wait for a reply and took the meal away. In another part of the home a person was given a meal of spaghetti bolognaise. They were not offered help to eat the meal. Eventually the full plate of food was removed.

People's care plans did not reflect the experiences that people were having at mealtimes or that meals had not been eaten. People told us that they were offered a choice at meal times, and could choose if they ate in the dining areas or their rooms. A dining room in the main house was laid with appropriate cutlery and tablecloths. However we saw one person using this over the inspection period, most people chose to eat in their rooms.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Meeting nutritional and hydration needs.

Staff were informed at handover that people were not getting enough fluid and "fluids needed to be pushed". It was unclear on what evidence this directive was made as fluid and food charts did not maintain a balance of what people had eaten or drunk. This meant staff did not monitor their intake to ensure they were receiving an appropriate amount. Charts did not show the amount of fluid or food the person should have been taking.

Some people were prescribed food supplement drinks and other people required their food or drink at a specific consistency to assist with swallowing. One person received their nutritional needs through a percutaneous endoscopic gastrostomy (PEG) feed tube administered by registered nurses. PEG is short for percutaneous endoscopic gastrostomy. When a person is unable to swallow, nutrition can be given through a PEG tube directly into their stomach. We were informed on some occasions the person had to wait for night staff to begin their shift before the feed could be given due to nursing staff not having the training to deliver the feed. The feed was recorded in the care plan to begin at 7pm night staff did not come on shift until 8pm.

People's health needs were not always managed well. GPs came into the home each week and saw people with acute and on-going problems. However, health needs were not always being monitored consistently and information was not being effectively communicated and acted upon. For example a GP had requested urgent bloods but these were still not taken one week later. We were informed this was because, although it had been handed over in the nurse's communication book, an inconsistency of nursing staff had prevented the request being followed.

District nurses or other health care professionals were not involved or supported people with residential needs. A local GP had visited the home and raised concerns. The concerns included Medication errors by staff, bowel charts incorrect or not completed, concerns around administration of medicines and instruction not being followed. Managers were aware of these concerns and were addressing the issues.

We spoke with one person who was distressed. The person had been informed that transport would be arranged to take them to their hospital appointment the previous week. The person was informed on the day of the appointment that there were no staff available to support. The person did get supported to their appointment when staff were called in early on the day. However this did not prevent the person becoming anxious and upset. Communication had been put in the nurse's book when the appointment had been arranged but not acted upon.

Inadequate

Is the service effective?

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Frail people who needed support to eat and drink in their rooms were assisted by staff with kindness. They were given time to eat their meals and were treated with dignity and respect. People's nutritional requirements had been assessed and they received a diet in line with their needs and wishes. Some people needed soft or pureed food. This was based on the main meals offered and was presented in an appetising way. One person was trying to reduce their weight and was able to choose salads and make choices to support their weight loss. People were offered drinks and biscuits throughout the day. One person informed us that a birthday cake had been prepared for them by the chef. Visitors informed us they were treated politely and offered drinks if required.

Staff files showed no evidence that staff had been given effective support, induction, training, supervision or appraisals. One member of staff informed us "I don't have supervision so can't discuss my needs, wellbeing or the stress I feel I am under. I then worry people will think I am bad at my job." Another member of staff informed us that they don't receive any form of supervision or training, but had received some training in previous jobs. Recently appointed staff members told us, they enjoyed working in the home, but had not received much induction or received further on-going training. The manager had a development plan which included a training matrix for staff; the report indicated that at the time of the inspection there were 64 members of staff. The training matrix indicated only two members of staff had received safeguarding training, and five members of staff had received MCA training. Dementia training was not evidence on the matrix. We spoke with managers who informed us that the training matrix was currently being updated. The new manager informed us they would be addressing the development plan related to training. Classroom based training and to train the trainer's dates had been organised.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing

People's consent to care and treatment was not sought in line with legislation. The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves Some people living at the home had limitations relating to their capacity to make decisions. Care plans did not give details of these limitations and the action that should or would be taken. Some staff did not have an understanding of the requirements of the Mental Capacity Act (MCA) and associated Deprivation of Liberty Safeguards (DoLS). We observed staff did not consult with people or explain tasks they were about to do with them. One person was supported with their meal; no discussion took place on what the person would like to eat, or what the person was eating. The meal was given without conversation explaining what was being put into the person's mouth, or choice and time to eat. Throughout the support the member of staff had to leave to support others. No communication informing the person what was happening took place.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. There were some restrictive practices within the home but no application for authorisation had been submitted to the local authority. For example people's freedom of movement on the Garden unit was limited. One person wanted to go outside into the garden but was prevented from doing so due to locked doors.

We spoke with staff to establish if they were aware of the process to be followed under the MCA particularly with people they were supporting who lacked capacity. Staff seemed unaware of the implications of people's rights regarding restriction of movement or the act itself. We asked one member of staff about supporting people behind locked doors who did not have capacity. We were informed if they wanted to go out then they would let them. This was not practical as these people would not have been safe.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent.

At a handover meeting the nurse provided an update on people's needs and care. They informed staff who would need additional support with fluid or hourly checks. They

Inadequate

Is the service effective?

did not discuss any disturbances at meal times or how to support people within the Garden unit if people were getting distressed. Staff were informed about other professionals, such as the GP visiting the home that day. Staff were delegated to work in different areas of the home including the senior carer. Staff were seen to be working well as a team. Domestic and housekeeping staff had good interactions with people and were communicating well and helping each other thought out the day.

People had the support of professional hairdresser. Two people were seen enjoying the conversation with the hairdresser whilst having their hair done. A vicar visits the home on a regular basis to offer support for people's religious needs.

The home is a Georgian Manor house which had been adapted with modern single storey extensions to meet people needs. The main reception area leads straight into a large lounge were people could watch TV together or sit with relatives. Information was available for all to see for example the forthcoming fete and raffle. People's rooms were personalised. Rooms on the ground floor were attractive and well furnished. Most people looked out onto the grounds or gardens which were secure. People on the upper floor had access via a lift. The rooms on the upper floor were in need of updating and refurbishment. The manager informed us that there were plans on place to refurbish parts of the home.

Requires improvement

Is the service caring?

Our findings

Staff talked kindly to people and we saw examples of gentle and considerate care. However, people slept in chairs or looked around the room with little interaction from the busy staff team.

We observed through the SOFI observation in the Garden unit, staff did not always show concern for people's wellbeing in a caring and meaningful way. For example one person was distressed wondering in and out of the lounge into the rain and back into the lounge, the staff did not listen to the concerns of the person who was looking for something or someone. Staff told them to come in as it was raining and they may slip. A person sat alone throughout the day staring into space. When a member of staff did speak with them, they reacted by smiling and listening. Interaction from the staff was for a small period of time because they were busy. One person was standing in a doorway seemingly unsure of their surroundings unsure where to go, the person was helped to set up a jigsaw puzzle. They did not receive sufficient support to make this a meaningful experience as other people kept moving pieces of the jigsaw. One person was offered a cup of tea, they informed the staff they liked a special tea not ordinary tea. This conversation was ignored and the person given a standard cup of tea.

We observed there had been a memory tree on the wall in the Garden unit showing people and their past lives, the pictures were missing from the tree with just a few sentences left saying what few of the people used to do. There were no other objects of reference. One person informed us that many staff has left recently and that there were many changes. One person said, "staff now don't know us."

During the day loud messages for staff were delivered over a tannoy system, which seemed to startle and upset people. One relative informed us that their relative always thought that there was someone at the door. The manager was aware that the tannoy system was upsetting for people and was reviewing its use. Communication was seen on some occasions to be inappropriate for example, one member of staff informed us when asked how a person was "that they just talk rubbish, talk rubbish back to them".

We spoke to a number of people and their relatives who informed us that they had not been consulted over the change of provider. One relative informed us. "There have been a lot of staff who have worked here a long time who have left. We are not told people are leaving or what changes are happening in the home this is upsetting for our relatives and a worry for us". People told us they did not know or had not met the new provider.

In other areas of the home although staff were busy, they showed a kind and caring approach to people they were supporting and their visitors. People and their relatives told us that staff were kind, caring and friendly. Experienced regular staff knew the people they were supporting .Some people were able to choose how to spend their time. We observed people choosing to spend time together in each other's rooms and others watching a DVD in the large lounge area. We saw people were assisted in their rooms were treated with kindness and dignity was respected.

We witnessed many acts of kindness throughout the home from staff, for example, one lady who was refusing to drink was encouraged with timely, prompts, gentle persuasion and laughter to have her drink. This took lots of time and encouragement from the staff member, the support was effective and the lady finished her drink.

People had their own rooms which had been personalised with their own possessions including furniture. People who were not able to leave their rooms independently had their doors open enabling them to see what was going on in the home. Many residents choose to remain in their rooms and did not use the communal lounges. Staff respected people's privacy by closing doors when supporting people with personal care. Staff always knocked on doors before entering people's rooms. One person told us "I don't come out of my room now but the staff are lovely and will always get me things from the shop if I ask them".

Requires improvement

Is the service responsive?

Our findings

People's care plans were out of date and showed poor recording which meant there was a risk and people's needs were not always being responded to appropriately. During the inspection we observed one person was distressed and agitated. We noted, the incident had not been recorded, daily records did not give an accurate account of the behaviours or the effect the behaviours had on other people. There were no behaviour support plans available to support the person or guidance for staff on how to reduce this person's distress and reduce the impact on others.

People were not involved in their care planning or in decisions about their care or risks associated with their care. One visitor informed us that as their relative now lacked capacity they were supposed to be involved in day to day decisions. We were informed the person relatives care plans were not available to see and they were not consulted over their relatives care and support. One relative informed us. "I used to look at my relatives care plan to see what they had been doing as they can no longer tell me. Staff used to tell me what they had been doing that doesn't happen anymore. We had a review when my relative moved in which was over a year ago but nothing since". Another relative informed us." We know there is a new manager but don't know what is happening. It would be nice to be informed. I am concerned about my relative due to the behaviour of another resident, I don't think staff know how to deal with the person".

Care plans did not contain sufficient detailed information about people's needs and wishes. Care plans were locked in the nurse's station, therefore not accessible for staff to use or update. In the care plans viewed there were no recorded evidence of reviews. Staff informed us that they had concerns over the lack of information in the care plans and had raised this with managers. We observed that staff mainly relied on verbal communication about people's needs and preferences rather than having access to the care plans.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

One person informed us that there was a particular member of staff that they did not like supporting them but felt there was nothing they could do about it and did not like to complain, they explained that they would not feel that there would be an alternative carer due to the many changes in the team.

A resident's meeting had recently been held at the home. Relatives informed us that they had also attended the meeting but had not heard or seen any of the outcomes. A visitor informed us that they would like to be involved in some gardening in the home. They informed us they had volunteered to get involved. Visitors who had met the new manager were hopeful that activities around the home were going to improve. One person informed us. "The home used to have the use of a mini bus, that is shared between other homes now so we don't get out anymore unless we go out with family". Another visitor told us. "We used to have some nice days out it would be nice if this could happen again, there is a new manager so hopefully this can happen". Relatives came in and out of the home as they pleased and were always greeted warmly by staff. A visitor informed us "I come here three or four times a week; staff are always polite and kind". One person told us. " I like living here the staff are wonderful"

Some people were able to move around the home, and therefore were seen enjoying each other's company. We met people with similar interest who had not met each other, because they were choosing to stay in their rooms. The activity programme did not seem to involve all people or try to encourage people to meet one and other. One relative informed us. "Staff are very caring and there is a new manager so we are hoping that changes will be made and people will have more things to do." One visitor said "I feel guilty that my relative has nothing to do. I try to come here regularly so I can make sure that they are kept busy". Another visitor informed us. "There is an activity programme but it is not varied enough, I would be happy to volunteer and support some activities if asked".

The National Institute for clinical excellence (NICE) provides evidence and guidelines for care homes which relate to the importance of meaningful activity for people's mental and physical wellbeing. We did not see activities being offered in the Garden unit.

The home has a complaints procedure but had not received any complaints since the new provider had been in place. People and their relatives said they would make

Requires improvement

Is the service responsive?

complaints if they had to. One relative informed us that they had complained in the past and actions had been taken, they were confident if they had to complain people would listen.

We recommend: The provider seeks obtains guidance such as The National Institute for clinical excellence (NICE) regarding meaningful activities to help people's wellbeing.

Requires improvement

Is the service well-led?

Our findings

Although the home had a registered manager they were also the registered manager for another service run by the same provider. This mean their time at the home was limited.

The provider of the home was Caspia Care Ltd who had been running the service since April 2015. A new manager had been appointed for Hurst Manor and had taken up their position in June 2015. They were applying to the Care Quality Commission (CQC) to be the registered manager of the home.

The managers told us that they knew there were changes needed in the home and that they were addressing these changes. The new manager was hoping to become visible around the home so that people knew who she was and she could support the team. One member of staff informed us. “The new manager seems nice and has been helping us on the floor when we have been short on staff”. The new manager informed us that they wanted Hurst Manor to be as a family home and people who lived there to be happy and well cared for. However, people were not supported by staff who had received training to meet people’s needs effectively. Staff also told us that they felt they lacked support from managers to do their jobs effectively

The provider had a quality assurance system which was not operating effectively. The quality assurance system included regular audits of key aspects of the service. This included staff training, the home development plan, and clinical governance, to do list. The providers quality and performance is reviewed by regional managers six monthly. However, this system had not identified the issues we found during the inspection. In addition, the targets set on the quality assurance systems were out of date and had not been met. Managers were confident that these issued would be addressed. We were informed that the home’s development plan would have new targets set and that these targets would be met.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 14. Good Governance.

Our observations concluded that fundamental changes needed to take place within the home. There were no clear vision for the service and staff did not know the vision of the service. There was a lack of leadership with the senior carer being part of the allocated shift. Staff informed us that the deputy manager had provided most of the leadership but was now leaving. There was a lack of regular staff meetings and formal one to one supervisions. Supervisions are an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. Staff informed us that they felt there was no structure of staffing, one member of staff informed us, “ It is task led, especially in the dementia unit our seniors work alongside us as carers”. Staff informed us. " It is a nice place to work and the team was good, it just feels busy all the time, it nice when we support people in their rooms because we can have a chat”.

There were no clear structures in place to manage the nursing care in the home in times that ensured people medicines were given to them in times prescribed by their GP. Nursing staff informed us that they felt unsupported, and tasks took them to long therefore making them feel that they were providing poor care. The nurses informed us that they felt that they were “left to get on with it”. Drug rounds were seen to take taking too long due to nurses providing medication support to all people living in the home regardless if they needed nursing support, therefore the morning medicines were still being administered at lunchtime putting people at risk of not receiving their medicines in that prescribed time. There was a senior carer on shift however the senior carer is also part of the allocation of staff so no clear lead to care staff.

There were inconsistencies in recording of people care plans and medication charts. Poor meal time experiences for some people. Insufficient support and supervision for people. Staff were unaware of the vision and values of the home. The home had a statement of purpose which was held at the provider’s main office, therefore not available for staff to see and read.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the Regulation was not being met. People who use the service had risks to their welfare. Risk assessments relating to people using the service were not completed and reviewed regularly by people with the qualifications, skills, competence and experience to do so. Regulation 12 (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met. People who used the service did not have adequate support to eat and drink to meet their nutrition and hydration needs. Regulation 14 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met. There were not sufficient numbers of suitably skilled, competent and experienced staff to make sure they could meet the needs of people using the service. Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	How the regulation was not met. Systems and processes such as regular audits of the service to assess, monitor and improve the quality and safety of the service were not effective or in place. Regulation 17 (2)(a)
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met. Where a person lacks mental capacity to make an informed decision, or give consent, staff did not act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation **11(1)**