Hurstcare Limited

The Hurst Residential Home

Inspection report

124 Hoadswood Road
Hastings
East Sussex
TN34 2BA

Tel: 01424425693

Date of inspection visit:
03 December 2021
06 December 2021

Date of publication:
14 January 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
The Hurst Residential Home is registered to provide accommodation and support for up to 29 people who live with mental health difficulties including depression, anxiety, alcohol dependency and personality disorders. Peoples ages ranged from 40 to 80 years old. Some people also lived with health problems, such as diabetes, brain injury and mobility problems. The service also provides people with short term care (temporary) before they return to live in the community. There were 21 people living at the home during our inspection. The provider for The Hurst Residential Home is also the registered manager.

People's experience of using this service and what we found
Whilst the quality assurance systems have improved, the provider's systems failed to identify that care and treatment was not provided in a safe way. Audits did not always identify and manage risks to people. The provider acknowledged that following a COVID-19 outbreak in June 2021, they haven't been able to sustain improvements. Senior staff had left, and there was a new team of staff who were settling in, and time was needed to embed systems. The registered manager knew the people who live in the home very well, however there was a lack of management support which meant that they dealt with the day to day running of the home, care planning and staff management. He was also on call everyday. The management structure was not robust and did not include any a deputy manager or any senior staff.

An infection prevention control audit was carried out by CQC during the inspection. It was found the provider was not meeting government guidelines for COVID-19. There was a lack of clarity on procedures to be followed and practice to follow in of infection. There had been no COVID-19 person specific risk assessments completed for people or staff during the pandemic.

Care and treatment was not consistently provided in a safe way. Staff had not all received essential training and the specific training necessary to meet people's individual needs. There was also minimal evidence that competency assessments for training that had been undertaken.

Not everyone's specific health needs were identified and planned for to promote their safety and well-being. There were people who had recently arrived at the home who had not been assessed and therefore had no care plans or risk assessments. However, for most people, care plans for were comprehensive, person centred and reflected changes to their health and well-being.

People told us that they were looked after well and enjoyed living at The Hurst. One person said, "I do get the support I need." Another one said, "The foods good, its clean and I feel safe here."
Staff were open and transparent during the inspection. Staff were kind to people and wanted to deliver good care. One staff member said, "I haven't been here long, but I am enjoying it here, interesting job."

Rating at last inspection:
The last rating for this service was Requires Improvement (published 10 January 2020).

Why we inspected:
We undertook this focussed inspection to check on specific concerns we had about peoples' safety and well-being and the management of risk in the service.

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 coronavirus and other infection outbreaks effectively.

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 have identified breaches in relation to safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up:
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

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

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below

The Hurst Residential Home

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 inspection team consisted of two inspectors.

Service and service type
The Hurst Residential Home 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 registered with the Care Quality Commission, the registered manager is also the provider. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was on annual leave at the time of the inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed the information we held about the service and the service provider. We looked at notifications and any safeguarding alerts we had received for this service. We sought feedback from the local authority and professionals who work with the service. Notifications are information about important events the service is required to send us by law.

The provider was 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 used all this information to plan our inspection.

During the inspection
We looked around the service and met with the people who lived there. We used the Short Observational Framework for Inspection (SOFI) during the morning of the first day of our inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
We spoke with five people to understand their views and experiences of the service and we observed how staff supported people. We spoke with the registered manager, and six further staff members. This included care staff and the cook.

We reviewed the care records of four people and a range of other documents. For example, medicine records, four staff recruitment files; staff training records and records relating to the management of the service. We also looked at staff rotas, and records relating to health and safety.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with three health care professionals and completed these discussions on 7 December 2021.

Requires Improvement

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 Requires Improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection
At the last inspection the provider had failed to assess the risk of, prevent, detect and control the spread of infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst improvements were seen, not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- We were not assured that the provider was preventing visitors from catching and spreading infections. The visiting procedure for staff to follow when professionals, contractors or social visitors came to the service had not been updated in line with the latest government guidance. Visitors were not checked for any signs of infection and were not asked suitable health questions to minimise the risk of spreading infections.
- We were somewhat assured that the provider was meeting shielding and social distancing rules. Social distancing was difficult as people had complex care needs that included learning disabilities and mental health illnesses. However, people had not been risk assessed for individual measures to be considered to promote individual safety.
- We were somewhat assured that the provider was admitting people safely to the service. The registered manager and staff confirmed that staff were being tested as per government guidance. This included LFD tests each day. People were willing to be tested and had consented to testing. Some completed their own LFD tests. If admitted with a negative PCR they did not need to isolate, but we were not assured that the guidance re second PCR test was followed for all admissions.
- We were assured that the provider's infection prevention and control policy was now up to date. During our inspection the new November 2021 guidance regarding checking vaccination status was added to the policy.
- We were assured that the provider was using PPE effectively and safely. Staff had all received specific training for COVID-19 and the use of PPE. They were wearing PPE effectively in line with government guidelines. For example, staff wore masks at all times and aprons when providing personal care and cleaning. There was a specific room for staff to put on PPE or remove and dispose of this equipment safely. There were also pedal operated bins in the service to reduce the risk of cross-contamination.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

The provider had failed to assess the risk of, prevent, detect and control the spread of infection. This is a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

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

● The overall cleanliness of the premises had improved significantly.
● Cleaning schedules were in place, just detail of high touch cleaning needed to ensure consistently completed.

Assessing risk, safety monitoring and management

At the last inspection care and treatment had not always been provided in a safe way. Risk of harm to people had not always been mitigated. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst improvements were seen, not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● As we found at the last inspection, risks to people had not always been assessed and documented prior to and following their arrival at The Hurst Residential Home and therefore their safety had not always been monitored and managed safely.
● Some people had not had their individual needs assessed and documented. For example, for one person, there was no handover letter, and no care plan or risk assessment in place to guide staff how to support them safely, or monitor for changes in their health. Such as management of their diabetes. Staff we spoke with had minimal knowledge of this persons' needs and the reasons for them moving into The Hurst Residential Home.
● Staff were not able to discuss the person needs and of how to support them and therefore there was the potential of harm from uninformed staff when the registered manager was not in the service.
● One radiator in an occupied room was unguarded, and was hot to the touch. This had been highlighted at the previous inspection and remained outstanding. The radiator was immediately turned off and alternative heating provided in the bedroom.

The provider had failed to ensure that care and treatment had been provided in a safe way. Risk of harm to people had not always been mitigated. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was acknowledged by the registered manager and CQC received full care plans and risk assessments for the people identified following the inspection visit.

● Other peoples' care documents and risk assessments were up to date and reflected peoples' health and mental well-being. Staff had a good knowledge of the people who lived at the Hurst Residential Home .
● There were detailed fire risk assessments, which covered all areas in the home. People had laminated Personal Emergency Evacuation Plans (PEEPs) to ensure they were supported in the event of a fire. These were specific to people and their needs.
● Improvements had been made to the premises and outside areas. For example, door guards were in use and no doors had been wedged open.
● Premises risk assessments and health and safety assessments continued to be reviewed on an annual

basis, which included gas, electrical safety and legionella. The risk assessments also included contingency plans in the event of a major incident such as fire, power loss or flood.

Staffing

● There were enough staff at the service to safely support people. Comments from people and staff included, "Always a staff member to help," and "There is usually staff free to take me out." Feedback from staff included. "Four staff and the manager is plenty," and "If we need another staff if someone is poorly and needs to go to hospital, we have another staff member."

● Rota's confirmed staffing levels were consistent and based on people's needs. Following a COVID-19 outbreak in June 2021, staff left, and it has been difficult for the registered manager to recruit new staff. He was fortunate to recruit some care staff and a cook but still has vacancies for maintenance and cleaning.

● From talking to staff, viewing the training programme and meeting people with varied needs, we were assured that staff had the necessary training to meet peoples' needs. All recruitment files had copies of certificates of training completed

● Staff supervisions had been undertaken and staff we spoke with said, "We have supervisions sessions," and "We regularly get together to discuss work and residents."

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe. One person said, "I know who to go to if I have a problem," and "Staff are very supportive." One person sad, "I have complete faith in staff to keep me safe."

● Staff were aware of their responsibilities to safeguard people from abuse and any discrimination. Staff were aware of the signs of abuse and how to report safeguarding concerns. They were confident the registered manager would address any concerns and make the required referrals to the local authority.

● A staff member said, "We have had training the manager talks to us if there are updates and if we need to introduce anything for our residents." Another staff member said, "Training was provided when I came here to work, and I still have some to do."

● There was a safeguarding and whistleblowing policy which set out the types of abuse, how to raise concerns and when to refer to the local authority. Staff confirmed that they had read the policies as part of their induction and training. The policy was displayed in the dining room so people also had access to it. Two people told us that they had read it and showed us where it was.

● Staff received training in equality and diversity awareness to ensure they understood the importance of protecting people from all types of discrimination. There was an equalities statement, which recognised commitment as an employer and provider of services to promote the human rights and inclusion of people and staff who may have experienced discrimination due to their ethnicity, religion, sexual orientation, gender identity or age.

Using medicines safely

● Arrangements had been made to ensure the proper and safe use of medicines. Medicines were stored, administered and disposed of safely. Medicines were ordered in a timely way.

● We asked people if they had any concerns regarding their medicines. One person said, "No concerns at all, very good." Another told us, "If the doctor changes anything, staff will talk me through what's changed, it makes me understand why its been changed." We were also told, "I get my medication everyday."

● All staff who administered medicines had the relevant training and competency checks that ensured medicines were handled safely. We observed staff administering medicines safely to people ensuring that they were offered the medicines, given time to take them in the way that they preferred and signed for once they were taken.

● Protocols for 'as required' (PRN) medicines such as pain relief medicines were available and described the circumstances and symptoms when the person needed this medicine.

● Medication audits were completed on a monthly basis. The registered manager reviewed and analysed the findings of the audits to ensure they took action that may be required to safeguard people. Medicine givers check the MAR (Medicines Administration Record) on a daily basis, this ensured any discrepancies were picked up and acted on immediately.
● The arrangements for the safe storage of specific medicines was discussed and will be raised with the medicine provider to ensure it is risk assessed in line with current good practice guidance..

Learning lessons when things go wrong
● Any serious accidents were escalated to other organisations such as safeguarding teams and CQC. Staff took appropriate action following incidents and accidents to ensure people's safety and this was recorded.
● Specific details and follow up actions by staff to prevent a re-occurrence were documented. This demonstrated that learning from accidents took place. For some people there were behaviour managing techniques in their care plan for staff to follow . Staff also shared how they managed this safely.

Requires Improvement

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 Requires improvement. At this inspection this key question has remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Continuous learning and improving care

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: continuous learning and improving care.

At our last inspection the provider had had not always operated effective systems and processes to make sure they assessed and monitored the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection systems and processes to assess, monitor and improve the quality and safety of the service provided had improved. However, due to an outbreak of COVID-19 in June 2021 and staff leaving, the improvements had not progressed and been sustained. Therefore, whilst improvements were seen, not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider is also the registered manager and has overall responsibility for the service provision. The management structure has not changed since the last inspection. There is still no deputy manager and no senior care staff. This means that the registered manager has little support and assistance in the day to day running of the service and completion of care documentation
● The registered manger was the only staff member with the experience and knowledge to write care plans. The registered manager told us that he is interviewing new senior care staff member who will then be trained in implementing care plans and risk assessments to ensure documentation is implemented in a timely way.
● The registered manager has assured us that he was still trying to recruit a deputy manager who can work alongside him in embedding changes and improvements into everyday practice.
●The quality monitoring systems in place had ensured the provider had oversight of the service. However, there has been delays in implementing changes required. This had impacted on safe support for people within the service, and infection control procedures. For example, we found government guidelines for COVID-19 were not being adhered to. This has been referred to in depth in the safe section of this report.
● Events, safeguarding concerns, accidents and incidents were well documented until June 2021, however there was no analysis and overview since July 2021 to determine any potential themes and implement mitigating actions. These have been updated since the inspection visit. .
● Care documentation including risk assessments showed review and updates had been undertaken until

July 2021 and not done since. The register manager updated the handover sheet daily with any changes to peoples' care, staff confirmed that they felt informed. However, the lack of information recorded, could impact on admissions to hospital and care pathways.
● The care plan system still contained care plans for people who no longer lived at The Hurst Residential Home. This could lead to confusion for new staff.
● The 'out of hours' service to cover emergencies in the home was well managed. Staff said the registered manager was always available. However, the registered manager lives some distance from the home and therefore would not be able to get there quickly if they needed to attend.

The provider had failed to sustain and operate effective governance systems to assess, monitor and mitigate the risks to people's health, safety and welfare. Some records were not in place, accurate or complete. Feedback from relevant people had not been sought and acted on. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. 2014.

● Handover documents had helped the shift leaders organise the staff to ensure that peoples' needs were consistently met.
●The registered manager shared outcomes of safeguarding's with staff and these were then taken forward as lessons learnt. The registered manager said that all incidents was used as learning and remained motivated to take these lessons forward. This meant opportunities for learning, development and improvement had been taken.

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: Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The rating of the previous inspection was clearly displayed at the home along with the updated registration certificate that showed the condition imposed on the service.
● Feedback from people at this inspection told us that people and staff felt listened to. One staff member said that they found the registered manager approachable and knowledgeable.
● Residents meetings and staff meetings were put on hold due to the pandemic, but small meetings have been continued on a daily basis. People told us if they had questions they would go to the registered manager.
● The registered manager was aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The service had notified us of all significant events which had occurred in line with their legal obligations.

Working in partnership with others
● Since the last inspection the organisation continued to improve partnership working with key organisations to support the care provided and worked to ensure an individual approach to care.
● Feedback from health professionals was mainly positive and indicated that the registered manager and staff team had listened to advice and worked alongside them to improve the service and outcomes for people.
● There was partnership working with other local health and social care professionals, community and voluntary organisations. Feedback from the GP practice was positive. One health professional said, "They do very well with complex problems."
● There were connections with social workers, commissioners and the community mental health team for people who lived at The Hurst Residential Home.

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 safety of service users by assessing the risks to their health and safety and doing all that is practicable to mitigate any such risks. The provider had not appropriately assessed the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated such as Covid19; Regulation 12 12(1)(2)(a)(b) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective systems to assess and quality assure the service. Regulation (17) (1) (2) (a). The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. Regulation 17 (2) (c).