Lotus Care 1 Limited

Hurst Nursing Home

Inspection report

1 Mill Road
Worthing
West Sussex
BN11 4JR

Tel: 01903236935
Website: www.lotuscaregroup.com

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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
Hurst Nursing Home is a care home with nursing and is registered to provide accommodation and support for a maximum of 22 people in one adapted building. At the time of the inspection there were 17 people living at the service. People living at the service were older people, some living with long term health conditions or memory loss.

People's experience of using this service and what we found
People did not always receive support in line with health professional guidance, this put them at risk of aspiration such as when food or liquid enters the lungs.
There was not an adequate process for assessing and monitoring the quality of the services provided and that records were accurate and complete. People's care plans and risk assessments lacked important detail to guide staff on how to keep people safe.
Aspects of leadership and governance of the service were not effective in identifying some service shortfalls, such as failing to assess, monitor and mitigate risks relating to the health and safety and welfare of people and medicine administration.

People were relaxed, comfortable and happy in the company of staff and told us they felt safe. People's independence and choice was considered important by staff and their privacy and dignity was promoted. Staff had a caring approach to their work, which was observed at inspection.

People and their relatives had the opportunity to share their views about the service and felt they were listened too. One relative told us, "When I raised an issue it was dealt with and it's been fine since."

Systems were in place to protect people from the risk of abuse and improper treatment and staff knew how to identify potential harm and report concerns.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 22 May 2019).

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels, moving and positioning, lack of hydration and management of the service. A decision was made for us to inspect and examine those risks. This report only covers our findings in relation to Key Questions, Safe and Well-led. The

ratings from the previous comprehensive inspection for the key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Good to Requires improvement. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hurst Nursing Home on our website at www.cqc.org.uk.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this report.

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 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 have identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 17- Good Governance. The provider had failed to ensure there were adequate systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and improve the quality and safety of services provided.
Regulation 12- Safe Care and Treatment. The provider had failed to ensure care and treatment was provided in a safe way. There was a failure to assess and manage risks relating to people's health and do all that was reasonably practicable to mitigate any such risks.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. 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.

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.

Hurst Nursing 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 was carried out by one inspector.

Service and service type
Hurst Nursing 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 did not have a manager registered with the Care Quality Commission. The provider had put interim management arrangements in place, whilst recruiting a permanent manager, who would apply to CQC to become the registered manager of the service. The provider is 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 inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do

well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and three relatives about their experience of the care provided. We spoke with seven members of staff including the provider, manager, registered nurses, care workers and the chef. Due to some people's needs they were unable to tell us about their experiences of the service. We made observations of care to help us understand the experiences of people who could not talk with us.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one professional who regularly visits the service.

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 Good. At this inspection this key question has now deteriorated to Requires improvement. 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.

Assessing risk, safety monitoring and management; Using medicines safely

● People were not safe from the risk of aspiration, one person was receiving nutrition, fluids and medication by a Percutaneous Endoscopic Gastrostomy (PEG.). A PEG is a feeding tube into a person's stomach and is used to provide the person with the nutrients and fluids they need. People who have a PEG are at an increased risk from aspiration especially when lying flat, as fluid can travel up the oesophagus from the stomach and into a person's lungs. We observed one person positioned at an angle between 20 and 25 degrees in bed while receiving nutrition via the PEG. There was information on positioning in the person's care plan which showed the person must be at a 45-degree angle when receiving nutrition. We brought this to the attention of the manager who agreed that staff had not followed the care plan. The manager immediately adjusted the person's position.

●There was no risk assessment in place to alert staff to the risk of aspiration, and no information to inform staff that the PEG needed to be stopped for 30 minutes before moving the person to a lying flat position for personal care. The manager told us the person always received personal care lying flat with the Peg nutrition still flowing. This meant that the PEG feed was not being used safely and placed the person at increased risk of aspiration. This was brought to the provider's attention who told us they would address it immediately.

● Choking risks were not fully considered, for example we observed another person who had requested to have lunch in bed. The person was given lunch while laying almost flat and although staff had suggested they sit up, the risks were not discussed with the person and they were left without staff support to eat a meal in this position. The staff member told us it was known that the person may request food in this position. There was no guidance on how to support the person in the care records or known to the staff member. There was no risk assessment in place.

● Safe processes for medicines management were not always adhered to. For example, as and when required medicine (PRN) did not have a written protocol describing what the medicine was prescribed for or details such as dose instructions, signs or symptoms about when to offer the medicine, interventions to use before medicines offered. When to review the medicine and how long the person should expect to take it. We spoke to two registered nurses who were aware of people's PRN needs, however because the information was not recorded, we could not be assured that new or agency staff would have the same information.

● Risk assessments and care plans for people were generic and not personalised. They lacked detail and personalised information relating to specific health care needs. For example, one person's risk assessment had type 2 diabetes recorded as a risk, but the assessment had not identified what the risks of this condition were or what actions staff needed to take to mitigate the risks. This meant that people could not be assured of receiving appropriate and safe care and treatment to manage their diabetes.

The provider had failed to ensure care and treatment was provided in a safe way. There was a failure to robustly assess the risks relating to the health and safety of people, doing all that is reasonably practicable to mitigate any such risks and the proper and safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were received, stored, disposed of safely.
● We observed a staff member administering medicines to people, this was completed with care and attention. The staff member was knowledgeable about the medicines they were administering and demonstrated an understanding of the person's needs and preferences. We observed people being asked for their consent before medicines were given.
● Only registered nurses were permitted to administer medicines; the rota confirmed there were always trained staff available to carry out this task.
● Medicines were audited and any issues identified were rectified.
● To ensure the environment for people was kept safe, specialist contractors were commissioned to carry out fire, gas, water, lift, moving positioning equipment and electrical safety checks. There were risk assessments and regular checks in place relating to health and safety. Risk assessments included the number of staff required to operate equipment such as hoists, this was confirmed by staff.

Staffing and recruitment
● People were not always protected by safe recruitment processes. Staff had pre employment checks, which included undertaking appropriate checks with the Disclosure and Baring Service (DBS) and obtaining suitable references but did not include taking a full work history. This meant the provider was unable to be assured gaps in staff work history were explored and risk assessed. This was raised with the provider who assured us this would be addressed immediately.
● There were enough staff on duty. People told us they received care and support in a timely way. Our observations and the records confirmed this.

Systems and processes to safeguard people from the risk of abuse
● The provider and staff understood their responsibilities to safeguard people from abuse. Concerns and allegations were acted on to make sure people were protected from harm.
● Records showed staff had received training in how to recognise and report abuse. Staff had a clear understanding of how to report abuse and felt confident that management would act appropriately.
● People and relatives told us they felt safe and knew who to tell if they didn't. One relative said, "I have no concerns about safety."

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 using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the

current guidance. People had nominated visitors in their room, visiting is booked and the system is flexible.

Learning lessons when things go wrong

● Staff understood the need to record and report issues. One staff told us, " I report to the nurse on duty and manager, I do an incident report and put it in the daily notes."

● Incidents and accidents were recorded and monitored on a monthly audit, with actions taken to reduce the risk of re-occurrence. For example, one person had a fall and changes were made to introduce the use of a sensor mat to mitigate the further risk of a fall.

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 Good. At this inspection this key question has now deteriorated to Requires improvement. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Processes for auditing medicines had failed to identify staff did not have enough guidance to enable them to safely make decisions about when to offer PRN medicines.
- Systems and processes for quality monitoring had failed to identify the lack of detailed health information in people's care records. For example, important information about care following a PEG feed had been omitted from a person's care plan. This meant staff did not have all the information they needed to care for people safely.
- Records were not detailed enough for the provider and manager to monitor the effectiveness of people's support or to ensure safe care. For example, People were not receiving their recommended daily intake of fluids (RDI). For example, one person had an RDI recorded as 1440ml of fluids per day and records over the previous month showed an intake of less than 700ml a day. The manager told us this was poor recording and issues with internet connectivity when using the recording system, however no action had been taken to resolve the issue and ensure people were receiving the correct RDI.
- Risk assessments had not clearly laid out the risks or included guidance about how to mitigate identified risks such as aspiration and choking.
- Processes for quality audit had failed to identify a lack of personalised information within people's care plans and risk assessments. People's preferences and abilities had not been captured. There was a lack of guidance for staff to ensure they provided personalised support in line with people's preferences and needs.

The provider had failed to ensure there were adequate systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and improve the quality and safety of services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At the time of the inspection there was not a manager registered with the care quality commission in post. Arrangements had been made to provide continuity while a recruitment process took place. The head of care, a registered nurse had taken on interim management and the provider was regularly at the service.
- Incident and accident reports were followed up and actions taken, for example, referrals were made to external health professionals where needed.
- Actions taken when a complaint was received were dealt with appropriately and with sensitivity and

included follow up actions for staff to avoid it happening again.

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; Working in partnership with others

● People and their relatives told us they had regular contact with the manager and staff who spoke to them to obtain their views about the service. One person told us. "It's alright here". A relative said "(name) is more settled here."

● People and their relatives told us they had been well supported throughout the COVID-19 pandemic and kept up to date with changes. One relative said, "They set up a video call, which really brightened our day."

● People and staff were able to share ideas or concerns with the management.

●Staff understood their responsibilities and told us that they were listened to and valued. One staff member told us, "We have staff meetings, we are a small friendly team, someone can always answer questions."

● We observed staff talking with people in a friendly, dignified and respectful way. People were encouraged to do things for themselves, but staff stepped in to assist when needed.

● The management team worked with other health and social care professionals to seek guidance and support with health care. One health professional told us "The nursing staff are responsive to changes in their residents and escalate problems appropriately."

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

●Records showed that when incidents had happened, families had been communicated with in a timely way. One relative said, "They keep me up to date."

●People and relatives told us they felt able to speak openly to the manager and care staff.

● The provider and manager were open and transparent throughout the inspection and demonstrated a willingness to improve the service.

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 failed to ensure care and treatment was provided in a safe way. There was a failure to robustly assess the risks relating to the health and safety of people, doing all that is reasonably practicable to mitigate any such risks and the proper safe and management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there were adequate systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and improve the quality and safety of services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.