Hurstcare Limited

The Hurst Residential Home

Inspection report

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Date of inspection visit:
13 May 2019
14 May 2019
17 May 2019

Date of publication:
01 July 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

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 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 20 people living at the home during our inspection.

People's experience of using this service:
The provider's governance systems had not identified the shortfalls found at this inspection. There was a lack of clear and accurate records regarding some people's care and support and personal details, such as next of kin and current GP details. The culture of the service was task focused and staff had not always recognised poor practice. For example, the management of behaviours that challenge were not managed safely and effectively. Staff said they had concerns about a lack of teamwork. Feedback from staff and people who lived at The Hurst were not always appropriately acted upon by the provider.

The provider lacked effective quality assurance systems to identify concerns in the service and drive necessary improvement. Audits to improve service delivery had not been done on a regular basis, for example, the daily cleaning check list for the kitchen had not been completed since January 2019. We found concerns about the cleanliness of the kitchen and cooking equipment. This has been referred to the environmental health agency. Immediate requirements from the fire service had not all been actioned and there was no action plan as to how the provider was to action the fire requirements. Environmental audits had not identified the poor maintenance within the home and garden. A fire risk assessment had been completed however, we found areas of potential fire risk in the home that had not been included in this risk assessment.

People's health, safety and well-being was not always protected, because not all people who lived at The Hurst had a care plan and risk assessment that reflected their identified needs, such as diabetes, epilepsy and anxiety.

Risks to people's safety was not always mitigated. Infection control procedures were not being followed to prevent spread of infection. Incidents were not fully investigated and analysed to prevent future occurrences. This meant that people's safety and welfare had not been adequately maintained at all times.

Staffing levels had not always ensured that people's personal care was delivered in line with their assessed needs and preferences. Some staff training was out of date and staff did not always have the skills and expertise required to provide safe care and support. Some staff were unsure of the safeguarding procedures and of how to ensure peoples safety and well being.

Staff were not consistently caring in their approach to the people they supported and people were not

always treated with respect. There was a lack of person-centred care and people were not all offered meaningful activities. People told us they were 'bored' and 'nothing much happens here'.

We have made a recommendation about involving people in discussions about their personal care and seeking advice as necessary.

People were supported to receive their medicines safely and when they needed them. One person said, "Staff make sure I take my tablets and that keeps me well" and "I get my pills and insulin on time." People were supported to have access to healthcare services when they needed them. People told us "The manager takes me in his car" and "The doctor comes and sees me here, much better."

People's dietary needs were assessed, and people were provided with a choice of cooked meals each day. Not all feedback about the food was positive but the majority of people said they enjoyed the meals . There was the opportunity of a fried breakfast three times a week which was enjoyed by people.

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

Some people were enabled to maintain their independence and make their own decisions and choices about what they did each day. People went out into the community and were enabled to make friendships.

Recruitment processes were thorough and ensured that staff were suitable for working with people in a care setting.

The service met the characteristics of inadequate in safe and well-led.

Rating at last inspection:
The service was last rated Requires Improvement (published in May 2018).
At that inspection, improvements had been seen, but needed to be embedded in to practice and sustained over a period of time. There were no breaches of regulation.

Why we inspected:
This was a planned inspection based on the rating at the last inspection.

Enforcement: Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up: Following the inspection we took action to ensure the provider improved the safety in the service. We informed the local authority and clinical commissioning group (CCG) of our concerns.

The overall rating for this registered provider is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our

enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led

Details are in our Well-Led findings below.

Inadequate

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of two inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses care services. In this instance services for older people.

The service is required to have a registered manager:
The registered provider is also the registered manager and is registered with the Care Quality Commission. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

The service type:
The Hurst is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection:
We did not give the provider any notice of this inspection.

What we did:
Before the inspection we reviewed the information, we held about the service and the service provider,

including the previous inspection report. We looked at the action plan provided to CQC following our last inspection. The registered provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications and any safeguarding alerts we had received for this service. Notifications are information about important events the service is required to send us by law.

During the inspection we spoke with:
12 people and observed care and support given to people in the dining room and lounges
Eight members of staff
Four external healthcare professionals.

We also reviewed the following documents:
Eight people's care records
Records of accidents, incidents and complaints
Four staff recruitment files and training records
Audits, quality assurance reports and maintenance records

Inadequate

Is the service safe?

Our findings

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

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. Regulations may or may not have been met.

Assessing risk, safety monitoring and management; preventing and controlling infection:
• Pre-admission assessments had been undertaken by the registered manager before people came to live at the Hurst. This process was to ensure that the service and staff could meet peoples' needs. Professional's involvement in these assessments were viewed and this included social workers and GP's.
• However, some people's care plans did not reflect the reason for admission and did not contain risk assessments in relation to their specific care needs. For example, one person who had recently moved in to the Hurst did not have any risk assessments or guidance for staff to follow to support the person with their specific health problems. This meant staff did not have the guidance and information to ensure their safe care. Another person had had oesophageal varices and there was no guidance for staff to monitor or manage a re-occurrence of this condition. There was a risk that this could re-occur because of their choice of life style. This meant that risks to health and well-being had not always been identified or planned for. Staff were not all aware of people's health needs and could not discuss how they ensured people were kept safe and that their mental and physical health was promoted.
• For some people with behaviours that may be challenging, there was a lack of clear documentation of how staff managed people's behaviours in a pro-active way. Some people's behaviours had escalated recently. There were clear contributing factors which staff were aware of but had not documented or managed safely. We observed incidents that were not managed in an appropriate way as they occurred and which had a negative impact both on staff and people that were present in the room.
• Staff had not recorded incidents or completed ABC charts to monitor and manage verbal and physical aggression and self-harm. The Antecedent-Behaviour-Consequence (ABC) Model is an approach that can be used to help people examine behaviours, the triggers of those behaviours, and the impact of those behaviours on negative or maladaptive patterns. This had meant that the risk of behaviours that challenged had not been managed safely
•There was evidence of behaviours that had escalated and that had resulted in harm. Staff told us "There are no boundaries, it's hard to manage." One care plan stated 'do not ignore the behaviour.' We observed on five separate occasions when the person's behaviours had escalated, that staff ignored the behaviour and walked away. This had caused a further outburst.
• There were people who lived with diabetes and not all had a care plan or risk assessment in place to manage and monitor risks to their health. For one person it stated blood sugars should be done twice weekly but there were significant gaps. For example, the blood sugar was taken on 2nd April 2019 and found to be high (18.2 mmols) and no action had been recorded and the next blood sugar record was on the 22 April 2019 where it was recorded as even higher at 21.3 mmols. High blood sugars can cause long term health problems if not rectified, such as, eye complications, weight gain and kidney problems. Following that recording, the blood sugar had been monitored daily until the 30 April 2019 and then twice weekly until the 12 May 2019. During that time, it had reached 24.4 mmols but there was no reference as to what action

had been taken or whether the GP had been informed. During the care tracking process, we identified that this person had refused their medication up to 17 times in one month. There was no evidence documented that this had been discussed with the diabetic community nurses or GP.
• One person with epilepsy did not have a care plan or risk assessment to guide staff in the event of a seizure. Staff told us that there had been seizures but there was no record of the seizures or of the action taken. This meant staff were not recording the information required for doctors to review the person's medication to manage their seizures.
• Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are required to have additional administrative controls. There were systems and policies for the management of Controlled medicines. However, we found a discrepancy with one medicine treated as a CD in that three tablets were missing. We have asked the registered manager to investigate this discrepancy.
• The environment was not clean. This included the kitchen, communal toilets, bathrooms and the lounges. These areas were identified to the provider for action. There were large bags of food produce, such as sugar left open (uncovered) in cupboards and milk was left out in the kitchen without refrigeration. Cupboards and storage units were covered in grease and dirt/dust. Cleaning schedules and temperatures of fridges had not been completed consistently. The last cleaning schedule was completed in September 2018 and the temperature of the fridge was not recorded for four days and temperature on the first day of inspection was 10 degrees Celsius rather than the 4 degrees Celsius recommended. An Environmental Health Officer (EHO) visited in February 2019 and awarded a rating of '5'. We have contacted the EHO to inform them of our concerns in respect of changes to the kitchen environment.
• Staff were observed walking through the kitchen to the outside laundry, with uncovered soiled clothing and bed linen without using appropriate protective equipment. Staff were also observed carrying uncovered soiled laundry around the services at various times during the inspection This placed people at risk from cross infection.
• A recent fire assessment (25 March 2019) had been undertaken by the fire service. This had identified requirements that needed to be rectified to ensure people's safety and these had not been actioned or an action plan put in place to ensure completion. For example, removal of a padlock from a rear gate was an immediate requirement but, it was confirmed by the registered manager and maintenance person that this had not yet been done.

The above evidence shows that care and treatment had not always been provided in a safe way. Risk of harm to people had not always been mitigated. This meant that people's safety and welfare had not been adequately maintained at all times. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There was some good examples seen of people's risk assessments which were detailed and updated regularly. These plans set out the risks and control measures to mitigate the risks. For example, people with mobility problems had guidance of how to support people to walk with walking aids to maintain and promote independence.
• 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.
• 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 and recruitment:
• Staffing levels and the deployment had not always enabled staff to provide the level of support people

required or wanted. Whilst staff were busy assisting people with personal care we saw other people sitting around with no interaction with staff or the opportunity to engage in meaningful activities.
• We received mixed comments about staffing numbers from people and staff. One person said, "There's never staff around." Another person said, "The staff seem to always be busy, but I think they do well." Staff comments included, "There have been problems with staffing and staff have left, including the cook so we have to cook as well. We have had new staff starting, but not many have stayed." Our observations highlighted that staffing levels did not allow staff to monitor and manage people's behaviours or ensure they were occupied.
• There were twenty people living in The Hurst. The rota in April 2019 showed three care staff in the morning and reduced to two care staff in the evening and overnight. However, this had decreased to two care staff for all shifts from 4 May 2019. A staffing assessment tool was not being used to assess peoples' needs against staffing deployment. To meet the needs of twenty people meant that staff were stretched to provide any support apart from basic care. One staff said, "We don't always have time to offer a shower." This was confirmed by one person who said they hadn't been able to shower for four days. Care delivery was also impacted on by the lack of a cook. Staff told us that one of them had to do the cooking and that meant they couldn't be with people. The rota did not demonstrate how the staffing levels accommodated the cooking duties. The registered manager was currently recruiting a cook.
• The registered manager was usually in the building from 10 am to six pm and told us he usually administered the lunchtime medicines to allow staff to prepare lunch.
• One member of staff told us "I handed in my notice and left last week, but I was asked to come in today because they had no staff."

Based on the above evidence, the provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet peoples assessed needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were made aware of recent changes to the staff team due to staff resigning. The registered manager informed staff recruitment was on-going.

• There was evidence of continuing robust recruitment procedures. All potential staff were required to complete an application form and attend an interview so that their knowledge, skills and values could be assessed.
• The provider continued to undertake checks on new staff before they started work. This included checking their identity, their eligibility to work in the UK, obtaining at least two references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Learning lessons when things go wrong:
• Incidents were not always documented and recorded as they occurred. Staff told us of incidents that had occurred. However, these had not been recorded and people's risk assessments did not reflect these incidents. For example, one person had hurt themselves deliberately and there was no risk assessment to manage this and prevent a re-occurrence.
• Staff told us of specific incidents where the consumption of alcohol had caused outbursts of anger and swearing and behaviours that could impact on other people's mental health needs. These had not been recorded and there was no plan as how to support people to manage their alcohol consumption, observe triggers and manage these situations safely. Staff could not tell us how much people were drinking and whether it would impact on the medicines they were prescribed. One person told us staff would not give them pain killers when they had been drinking but that they went out and brought their own. Staff knew this but had not assessed the impact or sought advice on how to manage this. There was no evidence that

learning from these incidents had been taken forward.

The lack of established systems to assess, monitor and improve the safety of the people in the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Safeguarding systems and processes:
• 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.
• Not all staff had a good understanding of their responsibilities and how to safeguard people. We spoke with four staff and only two were able to tell us of the actions they should take. Some of this was contributed to by English not being their first language.
• The staff training programme identified that two staff members had not had safeguarding training, and two staff members had not received a training refresher since 2017.
• The registered manager had not ensured that all staff had received appropriate safeguarding training. Training had not always been updated at appropriate intervals to enable them to recognise different types of abuse and the ways they can report concerns. Staff told us of incidents that had occurred and had not been reported to safeguarding. Such as altercation resulting in harm and an incident of self harm. This was an area that required improvement.

The training shortfalls have been reflected under the effective questions.

Any serious accidents were escalated to other organisations such as safeguarding teams and CQC.
• Staff took appropriate action following accidents to ensure people's safety and this was clearly recorded. For example, one person had had a fall, staff looked at the circumstances and ensured the person had assistance with their walking and had a walking aid nearby. This meant staff were able to support the person safely.
• Specific details and follow up actions by staff to prevent a re-occurrence were clearly documented. This demonstrated that learning from accidents took place.

Using medicines safely:
• Medicines continued to be stored, administered and disposed of safely. People's medication records confirmed they received their medicines as required. There were some gaps, but this had been checked and it was missing signatures rather that a missed dose of medicine. We saw that medicines remained stored securely.
• Staff who administered medicines had had the relevant training and competency checks.
• Staff continued to receive regular medicines competency checks to ensure they administered medicines safely. We asked people if they had any concerns regarding their medicines. One person said, "I have no worries, I get my medicines." A second person told us, "The staff are very good with my pills, I get them on time."
• There were protocols for 'as required' (PRN) medicines such as pain relief medicines, which included recording the effectiveness of the medicine.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience:
• People told us that they felt staff were competent. One person said, "I think staff know what they are doing, they give me my tablets."
• The training programme provided by the registered manager identified that not all staff had been provided with training in essential areas such as safeguarding, fire drills, fire safety, nutrition and infection control. For example, nine of 11 staff had not received infection control training and four staff had not received food hygiene training.
• The lack of training in food hygiene and infection control had impacted on the cleanliness of the service especially the kitchen.
• There was also gaps in service specific training such as managing challenging behaviours. Only two of the eleven care staff employed had received the training.
From our observations and the shortfalls we found in respect of safe care delivery, the lack of staff training had impacted negatively on people's outcomes. This meant that the provider had not ensured there were enough numbers of suitably qualified and competent staff deployed at The Hurst to meet peoples' individual needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• It was acknowledged that staff supervision was behind but actions were being taken by the registered manager to ensure that all supervisions were brought up to date. The supervision records were well completed.
• Staff received an induction and shadowed experienced staff before they worked with people on their own. The organisation used the Care Certificate as part of the induction process to promote good practice. The Care Certificate is an identified minimum set of standards that health and social care workers adhere to in their daily working life.
• Staff competencies had not been undertaken following training, but we received confirmation following the inspection that these were being commenced. This will improve the registered managers overview of staff knowledge and understanding of the training they had received.

Adapting service, design, decoration to meet people's needs:
•The provider had not ensured the service had been properly maintained. Since the last inspection redecoration had taken place in some communal areas including the hallways but these were not fully completed and there were gaps all around the skirting boards which meant that floors were not sealed against spills, risk of cross infection and to support appropriate cleaning to help prevent the risk of cross infection. We received mixed comments about the standard of cleanliness. One person said, "It was

disgusting, the state of the kitchen is shocking and shouldn't be allowed." Another person, "It could be better, the garden is littered with beer cans and cigarette ends, its not safe."
• There was water damage to the top floor ceilings, which had resulted in falling rubble on the stair case. This stairwell was a fire risk as there were boxes of old paperwork and other flammable items.
• Shower and bathrooms had missing floor tiles??; poor sealant and the flooring was not in good condition which posed a cross infection risk.
• The wall tiling in the kitchen was poor and pipe lagging was covered in dust and dirt. The downstairs toilet was very unclean as were the walls and flooring. Furniture was torn and therefore a possible health and safety risk if people ingested the foam and was also a fire risk.
•Some areas of the home did not smell fresh. For example, there was a strong smell of cigarette smoke throughout the home despite it being a smoke free environment. Some bedrooms and communal areas had an unpleasant odour. One chair in the communal lounge had a pool of unidentified fluid on it.
•The provider and staff were aware improvements were required but these had not been addressed in a timely way. There was no plan in place to identify how this was to be prioritised and achieved.
• People's rooms remained personalised and individually decorated to their preferences.
• The garden areas were not safe, there was broken fencing that meant the garden area was not secure and suitable for people as they were littered with empty cans and cigarette butts. There was also accumulated rubbish in a corner of the garden. The driveway had a skip with items in it, but also old fridge/freezers were standing in the driveway.
• Ensuring people live in an environment that is clean and well-maintained helps them to improve and maintain their mental and physical health. Although people told us they were happy with the home the provider had failed to recognise the potential impact the lack of upkeep and refurbishment to the home may have on people.

These issues are a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet:
• There was currently no cook employed. Staff were taking over the kitchen duties until a new cook was employed. The care staff member cooking during our inspection had a good understanding of peoples' nutritional needs. She was able to discuss who required a soft or masheable diet and who needed assistance with their food. People had been provided with plate guards and special cutlery to aid their independence.
• We received mixed feedback in respect of the quality of food. Comments received included, "The food is good, plenty of it" and "Food awful, powdered milk, cooked breakfast Monday, Wednesday and Friday, can't eat anything after 6pm. The bread is frozen, it's cheese or ham sandwiches or pizza at 4pm."
• Despite some negative comments, most people enjoyed the food and ate all the food prepared. People had access to drinks throughout the day and they could help themselves.
• Fluid and food charts were recorded for those at risk of dehydration and malnutrition, and staff therefore had oversight of how much people were eating and drinking. However, these records were not initially available but were later retrieved from the new computer system. More training was immediately arranged so all staff were able to access these records to be able to monitor that people were eating and drinking enough.
• The registered manager had a 'tracker' which noted people's weights and malnutrition scores. These could be traced over time to check whether there were any risks and flag staff to request a dietitian's input.
• People's preferences were considered and planned for. People told they got the food they liked, and they discussed food and menus at resident meetings. We were able to confirm this from the minutes of staff meetings.

Supporting people to live healthier lives, access healthcare services and support; staff working with other agencies to provide consistent, effective, timely care:
• The service continued to work with other agencies and professionals to ensure people received the care they needed. People continued to have multi-disciplinary team meetings to discuss people's needs and wishes. We spoke with one health professional who said, "I'm very impressed with the Hurst, no complaints."
• The service continued to have links with other organisations to access services, such as the diabetic nurse, the mental health team and language therapists (SaLT). Feedback from these professionals included, "They have some complicated clients but manage well," and "They continue to advise us of difficulties and work fairly well with us, staff changes though do present difficulties, as they don't always know the history."
• People were assisted with access to appointments. People told us, "If I have to go to the hospital, the manager takes me" and "If I need to see a doctor, he comes to the home."
• Information was shared with hospitals when people visited. Each person had an information sheet that would accompany the person to hospital. This contained essential information about the person, such as their communication, mobility and medicines.

Ensuring consent to care and treatment in line with law and guidance:
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

• We were told that not everyone currently living at the home had the capacity to make their own decisions about their lives and were subject to a DoLS.
• There was a file kept by the registered manager of all the DoLS submitted and their status. The documentation supported that each Dols application was decision specific for that person. For example, regarding restricted practices such as locked doors. One person had previously had their own key, but this had been re-assessed as their condition had changed and a decision specific DoLs referral made. This person still went out, but with health professionals or staff.
• Some staff had received training in the MCA and DoLS. They understood consent, the principles of decision-making, mental capacity and deprivation of people's liberty. One staff member told us, "Some people can no longer make some decisions and we need to support them in the safest way, we have best interest meetings with the family, G.P and involve advocates if necessary."
• One person had a tracker to keep them safe. This had been discussed at a best interest meeting and as the person had capacity and made the decision to have the tracker.
• However, one person told us, "Staff search my handbag for food and I discussed with staff and they confirmed this would not happen again. The person said she was 'happy to show staff their bag as long as she was there.' This had been addressed by the second day of the inspection.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity:
• Peoples feedback was mixed in respect of how they felt supported. Some people said, "The staff are kind, I get what I need" and "The staff are pretty good, but new faces confuse me." We were also told, "Staff don't care, they spend time on their phones, never help as much as they should."
• People were not always respected by the staff that supported them. We saw that staff sometimes ignored people when they asked for something such as a drink or responded 'you've just had one' with no further discussion, explanation or diversional technique.
• Whilst some people who lived at the service had complex needs, staff ignoring people or refusing their request led to further confrontation and distressed behaviours. For example, when one person was ignored, they raised their voice and started swearing and slamming doors, before going to their room and turning their music up to its loudest volume. Their care plan stated do not ignore but try to de-escalate the situation by listening and diversion techniques. Staff did not listen and did not try any diversional techniques. Staff on one occasion walked away when the person was in the middle of talking.
• Our observations showed that staff did not always interact with people. One staff member was very good with people and knew them well. We saw positive interactions with good natured banter and the staff member was helpful to people. Other staff were more task orientated and there was little positive interaction seen. People were left isolated apart from specific times such as meal times. People told us, "It's boring, I feel alone here, no-one to talk too" and "Well it's bed and food, nothing else really, but I'm safe here."
• Peoples dignity was not always protected as people had complex personal hygiene needs and were known to refuse support help with managing their personal hygiene However, one experienced care staff member said, "It is about approach, I can always manage to encourage and prompt people because I go back and try again but not everyone will do that, I do tell them." These personal hygiene issues had not been managed in a respectful way.

We recommend that the service seek advice and guidance from a reputable source, about supporting people to manage their personal hygiene in a way that suits them.

• The registered manager acknowledged that staff would benefit from leadership from senior care staff, but staff changes had meant that there were currently no senior care staff and no leadership on the floor.
• Friendships had developed between people, they greeted each other by name and asked how they were." People called out to each other and one person told us, "I sit here with my friends, don't talk much but its company."
• Equality and diversity continued to be promoted and responded to well. People told us that their religious

needs were respected. One person said, "I have told them about my religious wishes." We saw staff supported people to wear clothes of their choosing. One person said, "The staff let me wear what I want, I choose what I want to wear, they help me with my jewellery and precious bits."

Supporting people to express their views and be involved in making decisions about their care:
• People told us they were involved in reviews and planning their care. One person told us, "I see the doctor regularly and staff explain changes to my pills or need further tests."
• Records confirmed regular meetings were held with people to discuss care. We were also aware that not everybody wanted to discuss care or treatment plans and this had been recorded.
• We saw evidence in people's care plans of multi-disciplinary meetings being held and that people were involved in these meetings to discuss their needs and make decisions about the care.
• We asked people if they were involved in planning their move to the service, one person told us, "I don't think I was given a choice but I like it here."

Respecting and promoting people's privacy, dignity and independence:
• People's right to privacy and confidentiality remained respected. One person told us, "Staff respect my privacy and at the same time they knock on my door and ask if I am okay." A visiting professional commented, "I've never had any concerns about the staff, they respect people's privacy when I visit."
• Staff encouraged people to be as independent as possible. People told us "Staff encourage me to walk and I do go out and about, I like my independence and here I can do what I want. I do want I want really." A second person said, "Staff are helpful, I do need help with washing."
• Staff offered people clothes protectors before meals and told them what they were doing. When someone required a change of clothing, they spoke with the person quietly and accompanied the person to the bathroom.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were not always met. Regulations may or may not have been met.

At the last inspection on the 21 and 27 March 2018, we asked the provider to take action to make improvements to ensure peoples individual needs and preferences were planned for. This inspection found that improvements were still needed to ensure that people's care reflected their identified needs.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• Supporting people to take part in a variety of activities helps them to maintain good mental and physical health. Consideration had not been given to the individual needs of people who lived at The Hurst.
• Since the previous inspection, care plans had been updated to show what activities people enjoyed. For example, some people enjoyed colouring and painting and others enjoyed music. However, there was no guidance about how to support people, or whether people needed support, to maintain these activities and interests. Daily notes did not include specific details of activities people had engaged in during the day, which may also have provided guidance for staff.
• Whilst some people were able to occupy themselves during the day, others were less able. As there were a number of new staff working at the home, this lack of guidance meant the provider could not be sure people received the person-centred care and support they needed and would chose.
• Staff told us group activities had previously been discussed with people and there was a weekly activity plan. However, people had lost interest in these and only one person participated in an art/colouring session during the inspection.
•There were people who wanted to do everyday activities such as making their own drinks and sandwiches, but this had not been facilitated. The registered manager said that this was something they were considering introducing.
• Staff had not received guidance in how to support people with meaningful activities to enhance their life. Activities that may make supported living in the future possible for some people had not been explored. For example, people had not been encouraged to tidy up after themselves, (ashtrays and bins in the garden), do their laundry or make their own bed.
• People's needs assessments included information about their background, preferences and interests. This however was not yet completed for all people living at The Hurst, and some people's information needed to be developed and some peoples needed, to be updated.
• One person had recently come to live at The Hurst and the care plan was minimal and contained no information of the circumstances that had led to the person leaving home and moving to the service. There was very little information of their life, what was important to them and how to support them to settle in. The care plan did not mention specific mental health illnesses the person lived with and there was no guidance for staff to follow as how to manage these disorders.
• One person had recently (within last six months) lost their life partner and there was no reference to this within their care plan or an update to their next of kin details. This could have caused distress if mentioned to the person and confusion and a new staff member tried to contact their listed next of kin.

• Some people's health needs had not updated to reflect changes. For example, one person's wound on their foot had healed but their care plan still stated there was a wound. Another person had not been taking their prescribed medicine. but this had not been factored in to their mental health care plan for staff to monitor and be aware of the implications this may have to their mental well-being. There were other discrepancies found in care plans that could impact on the care delivery for individuals. These were discussed with the registered manager.
• Another person had very high blood sugars recorded from 13 April 2019 until 14 May 2019 and the GP visited whilst the inspection was in progress. There had been a delay in seeking advice from the GP. The recordings for this person was three times a day and the blood sugar booklet showed that this had been inconsistent. We saw that the before breakfast blood sugars had not been recorded seven times during the period of 13 April 2019 and 14 May 2019. This had not ensured that the risk to this persons' health needs had been responded to.

The provider had not ensured that peoples' care and treatment was appropriate to their needs or reflected their needs and preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns:
• There were processes, forms and policies for recording and investigating complaints.
• People told us they knew how to make a complaint. One person said, "I know how to make a complaint; I would go to the manager." A second person told us, "I complain and nothing happens."
• We saw formal complaints and concerns were logged and responded as per the organisational policies. For example, one complaint was received, investigated and responded to with a full explanation of the investigation. Actions taken had ensured the issue was resolved and not occur again.
• However people's verbal complaints had not been recorded and not resolved in the way people wanted. We discussed this with the registered manager who acknowledged this could have been managed more effectively and recorded within the care documentation with actions taken to resolve their issues.

• All organisations that provide adult social care are legally required to follow the Accessible Information Standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements.
• Whilst staff had not received any specific training on the accessible standards, there was guidance in care plans about people's communication needs. For example, one person's speech was difficult to understand due to a brain injury and there was guidance for staff to recognise gestures and certain words. There was guidance for staff to listen to what the person had to say, this is what we observed.
• Notice boards contained information about activities, menus and complaint procedure.
• People's communication and sensory needs were assessed, recorded and shared with relevant others.
• There were specific details in people's care plans about their abilities, needs and preferred methods of communication. Menus were displayed on board and changed daily. There was a colourful pictorial monthly menu that people could use to choose their meal.
• People's communication and sensory needs were assessed, recorded and shared with relevant others.

End of life care and support:
• As far as possible, people were supported to remain at the home until the end of their lives.
• Care plans showed that people's end of life wishes had been discussed with them. These were sensitively written, they were detailed and included information about people's feelings about dying. Some people became distressed and there was information not to discuss further at this time.

• There was no one at this time receiving end of life care. However, one staff member was able to discuss the importance of recognising pain and how to contact district nurses and the hospice team for advice.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At the last inspection on the 21 and 27 March 2018, we asked the provider to take action to make improvements to the quality assurance systems. At this inspection, we found initial steps had been taken to drive improvement; however, these improvements had not been sustained or embedded. Therefore, this question has changed to Inadequate.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: continuous learning and improving care;
• The provider was also the registered manager and had overall responsibility for the home. He did not currently have a deputy or senior team leaders to lead the service when he was off duty or on leave . This had led to a service with no clear leadership. We were made aware of the difficulties there had been due to ill health and the fact that the registered manager lived Middlesex. This meant that out of hours service emergencies were difficult to manage and had led to issues within the service and staff. There were no senior staff available to be called on if an emergency should occur. The registered manager is aware that the effective running of the service had slipped and was endeavouring to recruit experienced senior staff.
• There was a handover at each shift change. Whilst staff were updated about changes to people's needs, or any changes at the home, this however was not recorded. Handover sheets whilst available were not used. Staff told us if they had been off for a few days they would have to read each person's daily notes to catch up with any changes but admitted this did not always happen. This meant staff were not always aware of changes to people's health needs or events that had happened whilst they were off duty. When we discussed incidents with staff that had occurred they were not always aware of them.
• The quality assurance system was not robust and did not identify all the shortfalls we found. Many audits had not been undertaken since September 2018. Where improvements had been required by outside professionals, such as the fire service, there was no information about whether these had been made or not. Cleaning audits and schedules had not been completed.
• The improvements we saw at the last inspection in March 2018 had not been sustained or continued. For example, improvements to the environment had not been completed as bathrooms were half tiled, which now created an infection control risk. There was no oversight to show what improvements to the environment had taken place during the past year, what was still required and when and how this would be addressed.
• It had not been identified through the auditing and monitoring process the shortfalls we found in relation to risk assessments and care plans. There was evidence that these shortfalls in diabetes management had an impact on people's health and well-being. For example, high blood sugars and weight gain. Other care plans lacked details of health issues which if not monitored could impact on their health.
• Shortfalls in relation to training had not ensured that staff had the knowledge and expertise to support the

people who lived at the Hurst. Staff were unable to clearly tell us of the how they monitored peoples specific health needs and kept them safe, especially when they were out in the community. For example, one person had been found by the police in a vulnerable state by the roadside and did not have any identification, mobile phone or their tracker on. Staff had not realised the person was out and they could not give the police any details of why the person was disorientated and vague and the persons details of health and social contacts were incorrect when police enquiries were made.

• We were aware that a requirement made by the fire service in March 2019 was that staff needed to do practice fire evacuations. However, when this was undertaken in April 2019, it was not successful, but no further training had been provided or further practice sessions organised.

• There were areas within the environment that were identified as a fire risk, this included an attic room containing old mattresses, a stairwell which stored combustible materials . Whilst we did not see anyone smoking in the service, some people told us they did, and staff knew that they did. There was no evidence that this knowledge had been discussed or risk assessments done, to reduce risk of fire. This information was passed on to the provider to take immediate action.

• Accidents whilst recorded did not show what actions had been taken to prevent a reoccurrence. There was no analysis and no overview of safeguarding referrals, incidents and accidents. Therefore, repeated incidents were not identified as a potential safeguarding. Senior care staff were not always aware of actions or outcomes after incidents and safeguarding's had occurred.

• Environmental risk assessments had been completed. However, these had not considered risks outside. The garden area was not secure, and this meant that people could leave the premises without signing out or in. This meant people could beat risk in the community without staff knowing.

• There was no overview of complaints that had been received. This meant themes and trends across people's individual care and the home were not identified.

• We were aware that the local authority had been offering support and guidance, but this had not been taken forward to address the issues within the home. This meant opportunities for learning, development and improvement had been missed.

• The use of technology can be used to improve and develop services. There was a new computer system which staff were now using to create care plans and record care delivery. However, not all staff were yet confident with the system which meant that some records had been archived prematurely. These records were found and the settings changed to ensure that this did not occur again.

• The registered manager said in the PIR that people had been encouraged to have input into their care and the environment through one to one discussion with staff. However, there was no record of these conversations or evidence of how people's feedback had been used to improve and develop the home.

• There had been no formal feedback from people, relatives, visiting professionals or staff. We were told people did not participate in formal feedback. For example, staff meetings had stopped because staff did not attend.

The above examples, demonstrate that the provider's quality assurance framework was not robust and the provider had failed to maintain accurate, complete and contemporaneous records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

• The rating of the previous inspection was not displayed at the home. The provider told us he was not aware this was a requirement. This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, the provider told us they had printed copies of the last report and they gave them to people. The provider had rectified this by the second day of the inspection and it was displayed in the entrance hall.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: planning and promoting person-centred, high-quality care and support with openness; and

how the provider understands and acts on their duty of candour responsibility:
• People did not always feel that their concerns or grumbles were answered or taken seriously by the management team. One person said they had raised concerns to the registered manager but had not received any information or feedback. We raised this with the registered manager who said he had raised a safeguarding. This had not been explained to the person who felt nothing had been done and the relationship with the person had been affected.
• Some staff told us that they did not feel listened to and that there was no team work due to staff changes. One staff member said, "I feel I work alone, it's been really difficult." They told us this had been raised with the registered manager, but things had not improved. The registered manager acknowledged that staffing was an issue.
• The provider 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.
•All staff were keen to emphasise the service would advocate for people if required. For example, in respect of ensuring medicine reviews took place. This meant people were only on the medicines currently required as opposed to taking those which were no longer relevant or the best for the person.

Working in partnership with others:
• Since the last inspection the organisation had worked hard to improve partnership working with key organisations to support the care provided and worked to ensure an individual approach to care. However, there has been negative feedback from the local authority following recent safeguarding investigation. This included a lack of team working to improve outcomes for people and the lack of training to underpin care delivery.
• There was partnership working with other local health and social care professionals, community and voluntary organisations. One voluntary organisation came weekly to take someone out to the town which was looked forward to and enjoyed. Comments received included, "Always very pleasant" and "Staff listen and are knowledgeable about the people they support."
• There were connections with social workers, commissioners and the community team for people who lived with mental capacity.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people received support that met their needs and reflected their preferences. Regulation 9 (1)(a)(b)(c)

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 reasonably practicable to mitigate any such risks. The provider had not ensured systems were in place to protect people from the risk of infection. THe provider had not ensured the proper and safe management of medicines; Regulation 12 (1) (2) (a) (b) (g) (h) HSCA RA Regulations 2014 Safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the home was properly maintained. Regulation 15(1)(b)(e)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assured appropriate systems and processes were in place to fully assess, monitor and improve the quality and safety of the service provided. Regulation 17(1)(2)(a)(b)(c)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing the provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet peoples assessed needs. The provider had not ensured all staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (1) (2) (a)