Hurstway Limited

Hurstway Care Home

Inspection report

142 The Hurstway
Erdington
Birmingham
West Midlands
B23 5XN

Tel: 01213500191

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Hurstway is a care home providing nursing and personal care to older people and people with physical disabilities. The care home is registered to provide support to 42 people. At the time of the inspection 37 people were living at the home. The accommodation is provided over two floors each of which has its own communal areas and a small kitchen.

People's experience of using this service and what we found
Care and treatment was not provided in a safe way. The providers systems failed to identify risks to people or if risks were identified they were not managed effectively.

Systems in place failed to safeguard people from the risk of abuse. Support for staff to carry out their role was not effective. Staff were not always following current government guidance in relation to COVID19 to prevent the risk of infection.

People received their medicines when needed.

There was a lack of provider oversight which meant risks to people's safety had not been responded to appropriately. Systems to monitor the quality and safety of the service were ineffective and placed people at the risk of harm. The systems in place failed to identify the areas for improvement found at this inspection.

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

Rating at last inspection and update
The last rating for this service was Good (Published April 2019).

Why we inspected
The inspection was prompted due to concerns about the service in relation to safeguarding incidents, whistleblowing concerns and concerns that we were not being notified of incidents at the service. A decision was made for us to inspect and examine those risks.

We reviewed the information we held about the service. We only looked at safe and well led during this inspection. We did not look at the key questions of effective, caring and responsive. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to inadequate. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Hurstway on our website at www.cqc.org.uk.

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 will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, safeguarding, staffing, complaints, governance and failure to notify. Immediately after the inspection we wrote to the provider and requested they provided us with urgent information telling us what they were doing regarding safe care, the management of risks, infection control and management oversight.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This means we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Hurstway Care 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.

Inspection team
The inspection was carried out by three inspectors and a specialist advisor who was a nurse. Two inspectors visited the home on the 27 July 2020, whilst the third inspector undertook telephone calls to staff and relatives on the 23 and 24 July 2020.

Service and service type
The Hurstway 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 (CQC) at the time of this inspection. A manager left the week before our inspection and a new manager was appointed who had only been in post for six days when we inspected. They told us they would be applying to be registered with CQC.

Notice of inspection
We gave a short notice period of the inspection because of the risks associated with Covid-19. This meant that we could discuss how to ensure everyone remained safe during the inspection.

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 and Local Clinical Commissioning group who work with the service. We did not ask for a 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.

We carried out telephone interviews with seven staff members, three relatives and two health care professionals on 23 and 24 July 2020

During the inspection
We spoke with six residents during the inspection. We spoke with nine staff members including domestic, care and nursing staff, the maintenance person, the clinical lead and the manager. We spoke with the provider following our inspection and during formal feedback on 06 August 2020.

We reviewed a range of records. This included 10 people's care records and four people's medication records. We looked at two staff files in relation to recruitment. We also looked at records that related to the management and quality assurance of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found and sought assurance and written confirmation about action taken regarding's people's immediate safety.

Inadequate

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 inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- Risk to people had not been appropriately managed. Risks in relation to specific health care needs for two people had been identified, but no risk assessments were in place to guide staff to how they should support people.
- Where people were known to be at risk from self-harm there were no assessment of the potential risk to the person and no risk assessments in place or action taken to help manage or reduce the risks.
- Where guidelines were in place to support people who were at risk when eating and drinking, they were not followed through in practice, placing people at risk of harm. For example, we saw a person who was at risk of choking was given a high-risk food to eat. Guidelines were in place with specific food items not to be given to this person. However, staff were not following these correctly. The person was assessed as needing supervision during meal times because of the risks, but staff failed to do this. We brought this to the immediate attention of the manager
- Staff we spoke with were not able to tell us about all the risks they needed to be aware of when supporting people. One staff member said, "I didn't know the person had epilepsy." Another staff member told us, "I don't know what type of epilepsy it is, but I would tell the nurse if they were unwell."
- Following an accident or incident, there was no system in place to review the incident and to take action to mitigate further risks. For example, a person had three falls in June 2020. Records showed that although a risk assessment was in place for this person, there was no review of each fall or the identification of any trends so that action could be taken to minimize the risk of reoccurrence.
- Staff working at night had not received fire drill training so they would know what to do in the event of a fire emergency. There were outstanding actions on the work place fire risk assessment. However, there was no timescale for these actions to be addressed. Individual escape plans for people were in place, however, they were not person- centred. For example, they did not include people's specific sensory needs information. There was no assessment of risk completed for people who smoked.
- Systems in place to ensure that people were protected from the risk of infection were not robust.
- We saw that personal protective equipment (PPE) used by staff when assisting people with personal care tasks were disposed of in bins with no lids in people's bedrooms.
- We observed staff in the dining room moved between people providing support with eating meals and direct hand contact was made with people. Staff did not wash their hands between supporting people and did not wear disposable gloves.
- The provider's infection control audit completed on 21 July 2020 identified that significant improvements were needed to infection control procedures and rated the service 'Red' and only 50% compliant. The audit also failed to identify the issues we observed during our inspection.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff told us they had access to ample personal protective equipment (PPE).

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
●Systems in place for the oversight of safeguarding incidents failed to ensure that, following an incident, investigations were completed, lessons were learnt, and preventative actions taken.
●There had been an incident where another healthcare professional had raised concerns about a person care and the provider was asked by the local authority to investigate these concerns under safeguarding procedures. There was no evidence the investigation was completed, or action taken to prevent reoccurrence.
●An incident between two people living at the service took place, which placed a person at risk of harm. Again, the provider was asked to complete an internal investigation. The investigation was not completed and therefore no reassurance was given that such an incident would not be repeated. There was no evidence that learning, or safety measures were put in place to prevent reoccurrence.
●Staff told us that they had reported concerns about a person's wellbeing to the manager (who had since left). The manager failed to recognise this as a potential risk to the persons safety and failed to take any preventive action.
●There was no system in place for the sharing of information with the staff team following allegations of abuse or incidents that put people at risk of harm.
●Where incidents had occurred between people living at the service, risk assessments and care plans failed to provide information about how to safely manage the behaviour and did not include information about triggers or distraction techniques.
●Training records showed a number of staff had not completed safeguarding training.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
●We observed mid-morning in the three communal lounges that some people were still eating their breakfast, some people had spilt their drinks on the floor and some people were requesting support with their personal care. We saw there were no staff available in these areas to respond to people's care needs. We saw that staff were available in other areas of the home and we spoke with the manager about our concerns about how staff were deployed across the service.
●Staff told us all the recruitment checks were completed before they commenced work at the service. There was no evidence of an induction in the staff files viewed and no written induction for agency staff, this was confirmed by the manager when we asked to see these records. It was confirmed to us that agency staff had covered recent shifts.
●We saw that there was no written system in place to ensure that qualified nurses had their registration numbers checked as required to ensure they were safe to practice and continue to meet professional standards.
●Staff told us they did not receive supervision or appraisal and nursing staff had not received clinical supervision. This was confirmed by the records we looked at and meant staff did not receive the appropriate support to carry out their duties effectively.
●Some staff told us they felt they were unable to meet the needs of some of the people recently admitted to the service. A staff member told us, "(Person's name) needs support that we can't give". Another staff member told us, "People with more challenging needs have been admitted and we can't meet their needs.".

●Staff told us they had completed some training. The training matrix that was shared with us showed significant gaps in staff training.

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

Using medicines safely

●Staff had not had their practice observed to ensure they remained competent in the safe administration of medicines.

●Medicines were managed safely. We saw medicines had been stored safely and records indicated people had received their medicine as required.

●When people required medicines to be administered on an 'as and when required' basis there was guidance in place for staff to follow so they would know when to give the medicine. The medicine records we checked showed this guidance was being followed and records were kept.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person- centred, open, inclusive and empowering, which achieves good outcomes for people

- The management of safety, risk and governance had not been effective. We identified serious concerns about people's safety during the inspection.
- There was a governance system in place, but this had not been operated effectively and had failed to identify the significant concerns we found during the inspection.
- Systems in place failed to ensure that the home operated a robust pre admission process and failed to ensure thorough pre- admission assessments were completed. For example, we saw preadmission assessments were incomplete and lacked detail about people's care needs. The provider admitted people outside of the 'service user band' (a service user band is people the provider told us they have the skills and knowledge to meet the needs of) they were registered for and failed to apply to the CQC in a timely way to add mental health service user band to their registration. The provider failed to ensure staff had the required training and skills to meet the needs of people with mental health needs.
- Systems in place to assess and monitor risks in relation to falls, accidents or incidents failed to record actions to mitigate risks and prevent reoccurrence. There was no system in place for the analysis of falls.
- Audits had failed to identify that accurate records relating to people's care were not being maintained and to ensure staff had access to consistent and accurate information about people's support needs. For example, risk assessments were not always completed. Where people required observation checks or a record of their food and drink to be kept because they were at risk of low weight, these records were not being maintained as in accordance with their care plan.
- Systems in place for the management of effective infection control had failed to identify that staff were not following government guidelines regarding the use of PPE.
- Systems in place failed to identify that eating and drinking guidelines were not being understood by staff and followed in practice.
- Systems in place for the oversight of safeguarding and complaints management were ineffective and failed to identify the risk of potential abuse and poor care and where preventive measures were needed.
- The service had failed to have a registered manager for twelve months.

The lack of governance systems and poor oversight meant people were receiving poor quality care and were placed at risk. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider had not notified CQC of all events which had occurred within the service as they are legally required to do.
Prior to our inspection the manager (who had now left) told us they had not sent notification to CQC as required and would review their records and send the notifications to us, we did not receive these. During our inspection we saw that notifications in relation to a death of a person and DoLS outcomes had not been sent.

This is a breach of regulation 18 (Notification of other incidents) Care Quality Commission (Registration) Regulations 2009. At the time of writing this report we are waiting on legal advice regarding this breach of the regulations

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;
●Some relatives told us they had raised some complaints about their relative's care. This included concerns regarding poor care and activities. We also contacted the home in May 2020 to discuss with the manager at the time about concerns raised by a relative and we were told these had been dealt with through the homes complaint procedures. However, the homes records failed to show any of these concerns had been recorded in the complaints records and dealt with through the homes complaints procedure.
●The providers complaints records showed three complaints had been received in the last 12 months. However, the records showed that only one had been responded to in line with the providers own complaints policy and procedure.

This is a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We spoke with the manager and provider during and after the inspection site visit. A manager had recently left the service the week before our inspection and a new manager was appointed who had only been in post for six days when we inspected. They told us they had identified issues and will continue to take action to make the improvements needed at the service to meet the regulations and to keep people safe. The provider told us they had appointed a consultancy team to help drive the improvements needed at the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●Staff told us things had deteriorated in the home over the last 12 months. There had been three different managers during this time. Staff told us that communication needed to be improved and staff meetings and staff supervision were infrequent.
●Staff told us they were concerned about meeting the needs of some of the people who had recently come to live at the service because they had not received the training to meet their needs. This included training in mental health.
●There were no regular staff meetings taking place to gather staff views and to keep them informed about the service and there had been no recent relative or staff surveys.
●Relatives we spoke with on the telephone as part of this inspection told us they were satisfied with their family members care. They told us they knew how to complain if they needed to. One relative told us they had raised a concern and it was responded to by the manager at the time. However, we did not see a record of this when we looked at the complaint records.
●Our records showed that relatives had raised concerns about their family members care with the local authority and with us prior to this inspection.

●We found that staff were helpful and kind but lacked direction and support. The manager told us that in the few days she has been working at the service staff were responding well to the changes and improvements being made.

Working in partnership with others;
●The service worked in partnership with other professionals and agencies, such as community health services and social workers. A health care professional told us that the nursing staff acted on their advice and they had no concerns.
●Since our inspection we have contacted commissioners and additional support has been offered to the service to help drive the improvements needed and this has been well received by the new manager. For example, the manager and clinical lead are attending a webinar on infection prevention and control and support from another team is helping with the development of risk assessments.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of other incidents which they are required to do so

The enforcement action we took:

FPN

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that where risks to service users were identified, risk management plans were not put in place to manage the risks.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure that systems for the oversight of safeguarding were effective and failed to ensure that following an incident investigation were completed, lessons were learnt, and preventative actions taken.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure that arrangements for the management of complaints were effective.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that the governance system in place was managed effectively and had failed to identify the significant concerns.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that staff received appropriate support to carry out their duties.

The enforcement action we took:

Impose a condition