Hurstcare Limited

The Hurst Residential Home

Inspection report

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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
The Hurst Residential Home is registered to provide accommodation and support for up to 29 people who live with mental health difficulties including depression, anxiety, alcohol dependency and personality disorders. Peoples ages ranged from 40 to 80 years old. Some people also lived with health problems, such as diabetes, brain injury and mobility problems. The service also provides people with short term care (temporary) before they return to live in the community. There were 23 people living at the home during our inspection. The provider for The Hurst Residential Home is also the registered manager.

People's experience of using this service and what we found
The provider's systems failed to identify that care and treatment was not provided in a safe way. Audits did not always identify risks to people and provide a safe environment. Staff practice was not always effectively monitored. The registered manager knew the people who live in the home very well, however there was a lack of management support which meant that the registered manager dealt with the day to day running of the home, medicine management, care planning and staff management. He was also on call everyday. This was a heavy work load for one person and resulted in the shortfalls we found.

An infection prevention control audit was carried out by CQC during the inspection. It was found the provider was not meeting government guidelines for COVID-19. There was a lack of clarity regarding the use of personal protective equipment (PPE) and prevention of infection. There had been no COVID-19person specific risk assessments completed for people or staff during the pandemic.

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

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

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

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

Why we inspected:

We undertook this targeted inspection to check on specific concerns we had about peoples' safety and well-being and the management of risk in the service. We inspected and found there were concerns with infection control, management of people's safety and provider oversight, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Enforcement:
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

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

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

Follow up:
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below

The Hurst Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This was a targeted inspection due to concerns we had about people's safety, staffing levels, delivery of safe care and the governance framework to support people and staff safely.
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 and managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
The Hurst Residential Care 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
W reviewed the information we held about the service and the service provider. We sought feedback from the local authority and healthcare professionals that are involved with the service. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

Due to the COVID-19 pandemic we needed to limit the time we spent at the home. This was to reduce the risk of transmitting any infection. Therefore, we requested some information and discussed how we would safely manage an inspection without announcing the date. We also wanted to clarify the providers infection control procedures to make sure we worked in line with their guidance.

To minimise the time in the service, we asked the provider to send some records for us to review before and after the inspection. This included records relating to the management of the service, audits, training and supervision records and staffing rotas. We received the information in the week following the inspection.

During the inspection
We spoke with five people who used the service. We spoke with six members of staff including the registered manager. We spent a short time in the home. This allowed us to safely look at areas of the home and to meet people, the providers and staff whilst observing social distancing guidelines. It also gave us an opportunity to observe staff interactions with people.

We reviewed a range of records whilst in the home. This included a sample of people's care records, medicine records, and fire risk assessments.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We received feedback following the inspection from two staff members and two health professionals.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

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

Preventing and controlling infection

- We were not assured that the provider was preventing visitors from catching and spreading infections. There was no visiting procedure for staff to follow when professionals, contractors or social visitors came to the service. Visitors were not checked for any signs of infection and were not asked suitable health questions to minimise the risk of spreading infections.
- We were not assured that the provider was meeting shielding and social distancing rules. Social distancing was difficult as people had complex care needs that included learning disabilities and a mental health illnesses. However, people had not been risk assessed for individual measures to be considered to promote individual safety.
- The registered manager knew it would be difficult to introduce zoning and cohorting if there was an outbreak, but had not developed any plan for if there was a positive test result for a person living in the service.
- We were not assured that the provider was admitting people safely to the service. People were not isolated for 14 days after admission in line with government guidelines. People were not risk assessed to consider alternative arrangements if isolation was not possible.
- We were not assured that the provider was using PPE effectively and safely. Staff had not received specific training for COVID-19 and the use of PPE. They were not always wearing PPE effectively or line with government guidelines. For example, staff were not wearing aprons when providing personal care. There were no areas for staff to put on PPE or remove and dispose of this equipment safely. For example, there were no pedal operated bins in the service to reduce the risk of cross-contamination.
- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service had not been COVID-19 risk assessed and an infection control audit had not been completed since the pandemic. Cleaning staff had not received additional training on COVID-19 and cleaning practice had not been changed to reflect increased risks. For example, high touch areas had not been identified for more frequent cleaning.
- We observed staff practice that did not promote good infection control practice. For example, dirty linen was being carried through the service without being placed in suitable bags/ containers. Dirty linen was found on the laundry floor. This raised the risk of cross infection.
- We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. Staff had not been given additional training on infection prevention and control (IPC) and COVID-19 and did not follow best practice to prevent infection outbreaks. For example, staff were wearing jewellery including bracelets. This prevents thorough and effective hand hygiene.

● We were not assured that the provider's infection prevention and control policy was up to date. It had not been reviewed since 2013 and did not take account of government guidelines relating to the COVID-19 pandemic.

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

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

Assessing risk, safety monitoring and management

● Not all areas were safe and well-maintained. In particular, the rear courtyard of the property. We were told this was used predominately by staff. The side gate had recently broken. This meant people and strangers could access the courtyard of the service. There was a crumbling unsafe wall which has yet to be rebuilt, buckets with bleach in were left unattended and a broken glass window with sharp edges. This was immediately brought to the maintenance persons' attention and action taken.

● There was a very hot radiator that was uncovered in one person's bedroom. This was dealt with immediately by staff/the registered manager turning off the radiator until a cover could be fitted. Alternative heating was sourced.

● Fire doors were found propped open with fire extinguishers. One fire door was propped open with a wooden door wedge. This may impact on safe fire evacuations and containment of the spread of fire.

● Risks to people had not always been assessed following their arrival at the Hurst and therefore their safety had not always been monitored and managed safely.

● Three people who had come to live in the service in the last two months had not had their individual needs assessed and documented. For example, one person lived with diabetes and there was no care plan or risk assessment in place to guide on staff to support them safely or monitor for changes in their health. For another, there was no guidance on how to manage behaviours that may challenge or the reasons for taking anti-convulsion medicines.

● Whilst there was minimal impact to people at the time of the inspection due to the knowledge the registered manager, there was the potential of harm from new and inexperienced staff, when the registered manager was not in the service.

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

This was acknowledged by the registered manager and CQC received full care plans and risk assessments for all three people within 48 hours.

● Other peoples' care documents and risk assessments were up to date and reflected peoples' health and mental well-being.

● 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

● There were enough staff at the service to safely support people Comments from people and staff included, "There are enough staff," and "I don't have any problems, staff help me when I need it." Feedback from staff included. "I love working here, there have been staff changes, but we have enough good staff."

● Rota's confirmed staffing levels were consistent and based on people's needs.

● From talking to staff, viewing the training programme and meeting people with varied needs, we were not assured that staff had the necessary training to meet peoples' needs. However, we received a training plan that would ensure that staff had the necessary training in the near future.

● Staff supervisions had been undertaken and staff we spoke with said, "It gives us an opportunity to discuss our job," and "This is my first job in care, I feel supported and supervision is part of the support I get."

●The registered manager explained that there had been a high turnover of staff during the pandemic and this had impacted on the training. There were new staff that had completed an induction and then will proceed to the training programme which includes service specific training. This was an area that requires improvement.

Systems and processes to safeguard people from the risk of abuse

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

● A staff member said, "We have had training and we discuss safeguarding procedures at team meetings, the manager updates us of any local changes." Another staff member said, "We have a safeguarding folder that contains guidance if we need it." People told us they felt safe. One person said, "I have had meetings with a social worker and everything here is good."

● There was a safeguarding and whistleblowing policy which set out the types of abuse, how to raise concerns and when to refer to the local authority. Staff confirmed that they had read the policies as part of their induction and training.

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

Using medicines safely

● Medicines continued to be stored, administered and disposed of safely. People's medication records confirmed they received their medicines as prescribed. 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 to take pills and I get them when needed." A second person told us, "I have pills that I need and I never miss them."

● Some people had been prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example, if they were experiencing pain. There were detailed protocols in place to inform staff why these medicines may be needed. People who were prescribed medicine for anxiety had a protocol to guide staff in offering verbal reassurance before giving them medicine, this had helped prevent unnecessary use of the medicine.

Learning lessons when things go wrong

● Any serious accidents were escalated to other organisations such as safeguarding teams and CQC. Staff took appropriate action following incidents and accidents to ensure people's safety and this was

recorded.

● Specific details and follow up actions by staff to prevent a re-occurrence were documented. This demonstrated that learning from accidents took place. For example, one person likes to wear shoes that are too large, and so shuffles. This has caused trips, and there was clearly recorded with guidance for staff to monitor and assist when mobilising.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has remained the same.

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

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

At our last inspection the provider had made improvements, however this inspection found that some areas of improvement had not been sustained.

- The provider is also the registered manager and has overall responsibility for the service provision. The management structure has changed since the last inspection. There is no longer a deputy manager and the loss of senior care staff has meant that the registered manager has little support and assistance in the day to day running of the service. This has led to the shortfalls we found.
- The reason for the lack of documentation for three people was that only the registered manager has the experience and knowledge to write care plans. The registered manager told us that a new senior care staff member will be trained in implementing care plans and risk assessments to ensure documentation is implemented in a timely way.
- The quality monitoring systems in place had not ensured the provider had oversight of the service. This had impacted on safe support for people within the service, training and competencies and infection control procedures. For example, systems to monitor staff practice had not identified staff were not complying with government guidance in relation to PPE. We found concerns with regard to government guidelines for COVID-19 not being adhered to. This has been referred to in depth in the safe section of this report.
- Some areas of essential maintenance and renewel had re-commenced in September 2020, but not all completed due to the second lockdown in November 2020. These will be re-started in December 2020. However, there were some areas of essential maintenance that had been overlooked. This has been referred to in depth in the safe section of this report.
- Events, safeguarding concerns, accidents and incidents were well documented, however there was no analysis and overview since January 2020 to determine any potential themes and implement mitigating actions.

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

Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. 2014.

● The 'out of hours' service emergencies were managed well and staff said the registered manager was always available.
● Handover documents had helped the shift leaders organise the staff to ensure that peoples' needs were consistently met.
●The registered manager shared outcomes of safeguarding's with staff and these were then taken forward as lessons learnt. The registered manager said that all incidents was used as learning and remained motivated to take these lessons forward. This meant opportunities for learning, development and improvement had been taken.
● The use of technology had been used to improve and develop the service. Staff were now confident in the system which staff were now using to create care plans and record care delivery.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong: Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The rating of the previous inspection was clearly displayed at the home along with the updated registration certificate that showed the condition imposed on the service.
● Feedback from people at this inspection told us that people and staff felt listened to. One person said, "I think we are a good team because we talk and share ideas." Another said, "It's a good place to work, I've learnt a lot since I've been here." One staff member said, "I love working here, I know we still have to improve, but staff have come and gone, so it's not been easy."
● Residents meetings and staff meetings were put on hold due to the pandemic, but small meetings have been continued on a daily basis. People told us if they had questions they would go to the registered manager.
● The 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.

Working in partnership with others
● Since the last inspection the organisation continued to improve partnership working with key organisations to support the care provided and worked to ensure an individual approach to care.
● Feedback from health professionals was mainly positive and indicated that the registered manager and staff team had listened to advice and worked alongside them to improve the service and outcomes for people.
● There was partnership working with other local health and social care professionals, community and voluntary organisations. Feedback from the GP and district nurses has been requested but not yet received.
● There were connections with social workers, commissioners and the community mental health team for people who lived at The Hurst Residential Home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to their health and safety and doing all that is practicable to mitigate any such risks. The provider had not appropriately assessed the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated such as Covid19; Regulation 12 12(1)(2)(a)(b) (h)

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