Hurstway Limited

Hurstway Care Home

Inspection report

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21 July 2022

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Hurstway Care Home is a nursing home providing personal and nursing care to up to 42 people. The service provides support to older adults including those living with dementia. At the time of our inspection there were 29 people using the service. Hurstway Care Home is a purpose built home consisting of two separate floors. People have their own bedrooms and en-suite bathrooms. They have shared use of lounges, dining areas and a garden.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
Some hazards and health and safety issues around the home had not been identified or addressed. Monitoring of some people's risks around weight loss and skin integrity was not robust. Some gaps in medicines administration records were found and stock counts were not always accurate. Staffing levels were appropriate to people's needs.

Care plans lacked detailed guidance for staff around supporting people with some medical conditions. Some relatives told us they had not been involved in developing or reviewing people's care plans. We saw some improvement in the personalisation of people's rooms, but the home décor was tired and in need of redecoration and repair. People told us they enjoyed the food.

Systems and processes in place to monitor and identify risk were not always effective. In some cases risks had been identified but not addressed in a timely way. Relatives told us communication with staff was not always effective. Staff were positive about the new management team and the changes being introduced.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 10 February 2022) and there was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. This service has been rated requires improvement for the last three consecutive inspections and prior to that was rated inadequate.

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about the management of skin health and the risk of pressure wounds. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the management of skin health and the risk of pressure wounds, so we widened the scope of the inspection to become a focused inspection which included the key questions of Safe, Effective and Well-Led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has remained requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-Led sections of this full report. The provider took action to address the concerns identified during the inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hurstway Care Home 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 monitor the service and will take further action if needed.

We have identified breaches in relation to governance and management of safety and risk in the home at this inspection.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.	**Requires Improvement**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by an inspector and a nurse specialist.

Service and service type
Hurstway Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Hurstway Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. A manager had been recruited but had not yet commenced the registration process.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 06 July 2022 and ended on 28 July 2022. We visited the service on 06 July 2022, 20 July 2022 and 21 July 2022.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people using the service and five of their relatives. We spoke with 13 staff, including the manager, quality assurance manager, nominated individual, carers, senior carers, nurses and housekeeping staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.
We sought information from external professionals working with the staff team. We reviewed a range of documents including eight care plans and other records of care monitoring. We looked at multiple medication administration records. We reviewed policies and procedures and quality assurance checks and documentation. We reviewed three staff files. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement.

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

Using medicines safely; Assessing risk, safety monitoring and management

● We found four recent gaps in people's medication administration records (MAR). Stock counts suggested people had not been given their medicines on these occasions. This meant staff could not be sure people had been given their medicines as prescribed. We also found stock recording was incorrect in some cases. People were at risk of side effects and other possible symptoms from not receiving their medicines when they should. People were at risk of running out of medicine early or having unsafe levels of additional stock in the home.

● The nursing staff had not completed any competency checks to ensure they remained up to date with safe practice. NICE guidance recommends annual competency checks for all staff administering medicines. Not all senior care staff who administered medicines had competency checks. Those who had, were checked for their use of the electronic MAR system, which was not in use at the time of inspection. This meant people were at risk of unsafe medicines administration practices from staff.

● A container of thickener was left out on a kitchen top, which was accessible to anyone walking by. Thickener is added to fluids for some people at risk of choking. It must be locked away when not in use as it poses a significant risk to people if eaten. People were not protected from this risk as the thickener was not stored safely.

● The monitoring of risks to people with pressure wounds and risk of weight loss was not effective. Charts to record fluid consumption, food intake, wound management and repositioning of people who could not move themselves were inconstantly completed. For example, fluid charts did not have totals for each day calculated. This meant staff could not be sure how much people had been drinking and if any action was needed to prevent dehydration. A person identified as at risk of developing a pressure wound had later developed one. It was not clear from monitoring records whether they had received all the support they needed to prevent this wound developing. People were at risk of dehydration and development of pressure wounds due to ineffective monitoring of the identified risks.

● Hazards and risks around the home had not been identified and removed. For example, we found two plastic containers being used as ashtrays next to doors in the garden area. This posed a fire hazard. Most of the wardrobes in the home had been removed from the bracket which fixed them to the wall. This left people at risk of pulling them on top of themselves.

● Some areas of the home were unclean. The upstairs kitchen which was used for basic food preparation contained a wash bowl which was unclean and cupboards which were unclean inside. We also found food and drinks which were not date labelled and not stored correctly to keep them fresh and protected from the risk of rodents.

Systems to ensure safety and safe practice in the home were not robust and left people at risk. This was a breach of regulation 12(1) Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team acted immediately to address the concerns we raised. The manager advised they would investigate each potential missed medication to determine what action needed to be taken. A checklist had been introduced to ensure safer medicines administration but was not being used by staff. The manager described steps they would take to ensure the checklist was followed. All staff administering medicines had completed medicines competency checks by the end of the inspection. The kitchen was deep cleaned during our site visit and wardrobes were all re-fixed to the walls.

Staffing and recruitment

● We saw some staff files contained gaps in employment records. These had not been explored with applicants. We also saw an applicant had not completed all sections of their application form. This meant potential carers had not always been asked to fully evidence their employment and education to ensure their suitability for the post. The manager advised they were already aware of missing information in recruitment files. They told us a plan was already in place to obtain any missing documentation and information.

● None of the recruitment files checked contained health questionnaires. Employees are required to obtain this information as part of their assessment of risk and suitability of potential candidates. The manager advised health questionnaires had been issued to the staff team, but had not all been returned.

● DBS checks had been completed for staff. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● People were supported by adequate numbers of staff.

Preventing and controlling infection

● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the upstairs kitchen were unclean and food in it was not being stored safely. New checks were put in place by the manager to address these concerns. The task of cleaning the upstairs kitchen was re-assigned to the housekeeping team. Holes in walls and ceilings were noted across the home, making cleaning difficult. A plan of work to fill and repair all the damaged walls and ceilings was underway during the site visit.

● We were somewhat assured that the provider was using PPE effectively and safely. We found some face masks had been disposed of in the grounds of the home and not in the bins provided. The manager was already aware of this issue and arranged checks of the grounds. The person who had been assigned to complete the checks was not in work during our site visit and the checks had not been re-assigned.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

The manager told us there were no restrictions on people visiting their loved ones at Hurstway Care Home. They were also aware of and supportive of people's rights to receive visitors during an outbreak. This was in

line with current government guidance.

Systems and processes to safeguard people from the risk of abuse

● Staff had completed safeguarding training and were able to describe signs of abuse and what action they would take.

● Safeguarding concerns had been investigated by the manager, who had also liaised with the appropriate health professionals.

● Staff told us they felt confident to tell the manager if they had concerns. They also told us they felt assured appropriate action would be taken if a concern was raised.

Learning lessons when things go wrong

● Although systems had identified issues of concern, actions taken had not always ensured the risk was mitigated. For example, the management team had identified repositioning charts contained gaps. It was not clear whether people had not been repositioned or whether there had been a failure to record the repositioning. Staff were encouraged to record repositioning carefully, but charts did not include how often people needed to be repositioned as a reminder. Checks of repositioning charts failed to identify and address the ongoing gaps in recording of repositioning.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Care plans did not always detail people's needs in relation to their medical conditions. For example, they did not always contain clear guidance for staff on how to support people with their condition.
- We spoke with some staff who could describe in basic terms what they would do to respond to identified medical concerns. However new and agency staff would not have written guidance if they needed it. This meant people were at risk of not receiving the support they needed to prevent or identify a deterioration of their condition. We raised this with the manager who put the necessary guidance in place during the inspection.
- Care plans did not always document evidence they had been prepared in consultation with people. For example, they were frequently not written from the perspective of the person or signed by them. Relatives told us they were not involved in the reviews of people's care. One relative told us; "I have not been involved in reviews or been asked about [my relative's] care." The manager told us they had plans to contact people's relatives and invite them to be involved in future care reviews where appropriate. They also advised they planned to ensure people would be involved in future reviews of their care where possible.
- Assessments of people's care needs had been completed before they were admitted to the home. These included people's wishes around their culture, spiritual and religious beliefs and their sexuality.

Staff support: induction, training, skills and experience

- Staff recruitment was not always robust and could not ensure applicants had the right skills and experience for the role.
- Staff competencies in medicines management had not always been completed to ensure they were following safe practice.
- Staff had completed induction and training to help them develop the skills and knowledge needed for the role.
- Staff told us they felt supported in their role. They described a number of opportunities for training and development which they were pleased to have. These included wound care and supporting people with nutrition and hydration.

Supporting people to eat and drink enough to maintain a balanced diet

- Some people who had been identified as at risk of weight loss or skin integrity issues had been assessed as needing regular monitoring. For example, they needed regular weight checks, and fluid and food monitoring. However, gaps in food intake diaries meant staff could not be sure whether meals had been missed. This put people at risk of losing weight and becoming dehydrated.

● People's fluid monitoring charts and care plans lacked guidance for staff in some cases for what their target fluid consumption was. There was also insufficient guidance for staff on what action to take if people did not drink or eat enough. The management team put an action plan in place during the inspection, with clear fluid targets and actions to take if targets were not met.
● Care plans highlighted who had special dietary requirements. The kitchen team were updated with this information and provided meals in line with their needs.
● Relatives gave mixed views on the meals offered to their relative. One relative told us they had asked for their relative's meat to be cut up for them, but this was still not done. With permission, this concern was passed to the manager to discuss.
● We saw people were not rushed at mealtimes.
● People told us they enjoyed the food offered to them. One person told us; "The food is very good."

Adapting service, design, decoration to meet people's needs
● One room which was labelled as the quiet room was in use as a COVID-19 testing room. This meant the room was not suitable for people to use. Signage was changed during our site visit to reflect this. Other areas of the home were labelled appropriately to assist people in orientating themselves.
● The décor in many areas of the home needed refreshing. Some people's bedrooms and some areas were poorly maintained with holes in walls and ceilings. Planned work to complete repairs had commenced, but many areas had not been redecorated at the time of our site visit.
● One relative told us how shocked they were when they saw their loved one's bedroom and said; "The room is awful, like a prison cell." The nominated individual gave assurance money was set aside to fully redecorate the home. The management team explained some of the bedrooms identified as in particularly poor repair were top priority and work began on them during the inspection.
● Some work had been done to improve personalisation of people's rooms.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Monitoring of fluid and food intake for people identified as at risk of dehydration, weight loss or skin integrity deterioration was not robust. This meant people were not fully protected from the health risks identified.
● Monitoring of how often people were helped to move to prevent pressure wounds was not always robust. This meant people's identified risk of developing pressure wounds was not monitored effectively.
● People were supported to receive care from other health care professionals such as tissue viability nurses, occupational therapists and the speech and language assessment team.

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 MCA 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 when this is in their best interests and legally authorised under the MCA.

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 and whether appropriate legal authorisations were in place when needed to deprive a person of their liberty.

● We saw staff seeking consent before offering support to people. However, care plans had sometimes been completed without the involvement of the person or their representative. This meant staff could not be sure care plans reflected people's needs and wishes fully and accurately. For example, one relative whose loved one had difficulty communicating their needs had purchased equipment to support their independence. However staff had not shared this information amongst the team and it was not added to the person's care plan. This resulted in the person often not having access to the equipment. With consent this was shared with the manager who told us they would make sure it was added to the person's care plan and staff would all be told about it.
● People had received mental capacity assessments when required. When the outcome of this assessment queried a person's ability to make important decisions for themselves, DoLS authorisations were applied for.
● Staff had received mental capacity training and understood the basic principles of the mental capacity act.
● We saw when a restriction of a person's liberty was required, best interests' decisions were made. For example, to allow staff to use a sensor for a person who was at possible risk of falls in their room.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to ensure adequate systems were in place to improve the safety and quality of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We found further concerns during this inspection and the provider remained in breach of regulation 17.

● The management team had not established effective systems to monitor health and safety in the home. Daily checks of the environment had failed to identify some of the issues found during the inspection. For example, the quiet lounge had been repurposed as a COVID-19 testing room. A sign on the door still labelled the room as a quiet lounge and clinical equipment and waste was stored inside. Daily checks had not identified the risk to people should they enter, believing the room to be a shared lounge for their use.
● Care plans lacked detailed guidance for staff on how to support people with risks associated with identified health conditions. The management team told us they were aware of this issue and were working towards introducing an electronic care record system. This was planned to provide the detailed guidance needed. They had not considered how this risk could be mitigated whilst people waited for the electronic system to be ready. Although we found no evidence people had been harmed, newer staff and agency staff did not have access to written guidance to help manage known risks.
● The management team had identified the risk of staff not recording medicines administered correctly. They had introduced a checking system to prevent and identify errors early. However, the manager had not checked to ensure this checklist was being used. Staff had not always been using this new system and further errors had occurred.
● Changes to the way fluid intake was being monitored had been introduced to support better management of dehydration risk. However, some staff had been confused by the new recording method and fluid totals were still not clear. The manager had not identified this.

The management team had failed to introduce and establish effective systems to ensure safe care. This put people at risk of avoidable harm. This was a breach of 17(1) Good Governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team responded immediately to the concerns raised during the inspection. For example,

the processes for recording and monitoring fluid intake were updated. Prompts for daily and weekly checks of the environment were also updated.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Some care plans had not been developed with the recent involvement of the person themselves or their representative. The manager told us they had plans to contact representatives where possible to involve them in care reviews.

● Staff spoke positively about the new manager and the changes being introduced. One staff member told us; "[The manager] is quite open and nice to speak to." A member of the night staff told us; "[The manager] comes to meet us and makes us feel included."

● Residents meetings had been introduced to seek feedback and encourage people's input into the running of the service.

● Assessments completed for people prior to their admission to the home, gathered information about their culture, religious and spiritual beliefs and sexuality.

● Events had been planned to celebrate people's cultures. Maps and photographs in the lounge areas showed the different parts of the world people had lived in.

Continuous learning and improving care

● Although systems had been developed to review and learn from mistakes and accidents, further work was needed to embed this learning. Further monitoring was needed to provide assurance that new processes were being understood and followed by staff.

● Systems and processes were in place to ensure safeguarding incidents and accidents were monitored and investigated appropriately.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● A duty of candour incident is where an unintended or unexpected incident occurs which results in the death of someone receiving support, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.

● As part of internal investigations when mistakes had been made, the management team had apologised to people. The management team understood their duty of candour responsibilities.

Working in partnership with others

● Staff worked in partnership with other agencies to provide the care people needed. This included support to have dental checks, optical checks, support from podiatrists as well as the local GP surgery.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Systems to ensure safety and safe practice in the home were not robust and left people at risk.

The enforcement action we took:

We issued a notice of decision to impose conditions on the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The management team had failed to introduce and establish effective systems to ensure safe care.

The enforcement action we took:

We issued a notice of decision to impose conditions on the registration.