Rooks (Care Homes) Limited

Green Hill

Inspection report

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Date of inspection visit:
14 January 2016

Date of publication:
30 March 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**

Summary of findings

Overall summary

Green Hill Care Home provides residential care for up to 30 people who were living with a dementia type illness and who needed support with their personal care. The home has undergone extensive modernisation building over the past two years. An extension provided additional ensuite bedrooms, a sensory room, bar and café and small shops to encourage independence. Accommodation was arranged over two floors and there was a lift to assist people to get to the upper floor. The home has 30 single bedrooms. There were 12 people living at the home at the time of our inspection.

We carried out unannounced inspections of this service in November and December 2014, March 2015, and July 2015. Due to continued breaches of Regulation and unmet warning notices, we served a notice to close the service in August 2015. The service was placed in to special measures and the local authorities placed an embargo on admissions to Green Hill. We received new concerns in relation to people's safety in December 2015. As a result we undertook a focused inspection on 14 January 2016 to look into those concerns and be assured of people's safety. This report only covers our findings in relation to the key question of whether the service is safe. You can read the report from our last comprehensive inspections, by selecting the 'all reports' link for Green Hill Care Home on our website at www.cqc.org.uk

Although people told us that they felt safe in this home, we found areas of care delivery that placed people at risk. There had been a number of people with unexplained bruising and injuries that had not been reported to the local authority safeguarding team for investigation. The injuries had not been reviewed by the manager and there was no plan in place to promote people's safety. The records pertaining to these injuries were not photographed as a means of monitoring, or analysed to see if there was an identified trend. Additional safety measures had not been put in place. For example, one staff member said that she thought some injuries for one person looked like finger marks. We asked if this had been taken forward to the registered manager and was told it had been mentioned. We found no incident record that confirmed this or a referral to safeguarding.

Risk assessments for people were in place, however not all were reflective of people's current needs in respect of nutrition, continence and mobility. We saw people were at risk from trips and falls due to poorly fitting foot wear and lack of additional aids to support people who were unsteady, such as transfer belts. We saw that equipment such as a hoist and stand-aid were used to move people without a moving and handling assessment being undertaken.

There were people who needed nursing care to meet their increased needs. These people had not been referred to the local authority for assessment and review until it was identified during our inspection.

Not all equipment in use for people, such as beds and moving and handling equipment were in good working order. This placed people and staff at risk from injury.

Whilst staffing levels were stable at three care staff during the day and two at night, the deployment of staff

did not ensure that peoples' safety, health and social needs were met consistently. At times people were left unsupervised in the dining area or the communal space. People told us that they were bored. We saw that people were not offered the opportunity to visit the bathroom.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

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

Green Hill was not safe.

Management of people's individual risk assessments to maintain their health, safety and well-being were not in place for everyone and therefore placed people at risk.

There were risks to people from equipment which was not suitable for their needs and poor moving and handling techniques.

There were not enough suitably experienced or qualified staff on duty to meet people's needs consistently and safely. The management hours and emergency cover were not reflected on the duty rota.

Green Hill

Detailed findings

Background to this inspection

We carried out this focussed responsive inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was undertaken in response to concerns raised in respect of risks to the safety of people, and to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 in ensuring people's safety.

The inspection was unannounced. It took place on the 14 January 2016. We spoke with 7 people who lived at Green Hill, two relatives, the registered manager, four care staff, and the cook. We observed care and support in communal areas and looked around the home and people's bedrooms. We reviewed a range of records about people's care and how staff managed the care. These included the care plans for five people. Not everyone we met was able to tell us their experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

The inspection team consisted of two inspectors. Before our inspection, we reviewed the information we held about the home. This included complaints and concerns, notifications of deaths, incidents and accidents that the provider is required to send us by law. We also spoke with the Local Authority.

Inadequate

Is the service safe?

Our findings

People told us they were looked after and felt safe. One person told us, "It's fine though I get bored," This person also told us, "The staff are nice people." One visitor told us, "Seems okay, no complaints." Although people told us they felt safe, we found examples of potentially unsafe care delivery practices.

Before our inspection we received information that there were specific people who had unwitnessed and unexplained bruising and injury. Additional concerns were made in respect of people's safety through poor moving. Concerns were also raised about inexperienced new staff. We looked at these areas to ensure people were safe.

At our last inspection in July 2015, we found that accident and incident records were not all completed in full, nor had action plans been put in place to prevent a reoccurrence. At this inspection, we looked at accidents and incidents records from July 2015 until January 2016. There was no overview or analysis of accidents and incidents in place until requested by the local authority in December 2015. This was confirmed by the registered manager. The audit requested by the local authority identified numbers of incidents and accidents, how many people were involved and identified those who had a history of falls. However, accidents and injuries were still not analysed for the cause of the injury or accident , nor had preventative measures been discussed with health professionals to mitigate risk to people. For example there were 12 accident records of bruising, scratches, an upper arm torn tendon and skin tears for one person over a period of seven months which had not been referred to local authority safeguarding team or to falls team for assistance. We spoke with one member of staff who said "We have wondered about bruising on hands, as it's not nice to think of why." For some people who had fallen but the falls had not been witnessed by staff, there was no record of an investigation, written plan or staff practices put in place to prevent further falls. This meant that the provider had not put preventative measures in place to try to prevent a re-occurrence and protect the person from harm. Therefore the provider could not demonstrate there had been any learning from accidents and incidents.

We observed that some people's ability to safely walk around was affected by poor ill-fitting foot wear. One person was wearing slippers that were too big and therefore the person was shuffling and was unsteady. When we asked staff about the footwear they agreed that the foot wear was inappropriate and did not know why the care staff had used that footwear that morning. We saw this person was wearing different footwear later on. We looked at the person's mobility care plan and saw that footwear was not mentioned. This person had also had nine falls since September 2015. Whilst these had been recorded, there was no analysis of the time, place or possible reasons. We asked one member of staff what the person's care plan said to support them. They said they had not read care plans and therefore did not know. We asked this member of staff if anyone else was at risk of falls and they said they did not know. Staff said to support this person, hip pads were worn and they kept an eye on them and helped them along if they 'looked wobbly'. This did not ensure that risks to the health and safety of this person had been considered fully.

One person's ability to move around had changed considerably over a period of time, more significantly over the past ten days. We were told that they now needed full assistance with moving and were using a

stand aid hoist. A stand-aid is a lifting machine that assists people who are having difficulty getting up into a standing position. It is only safe to use if the person participates, as otherwise it could cause injury to the person's shoulders and they may slip through the sling. One staff member told us, "We have to put their hands on the frame because they have dementia and don't understand what they need to do, it can be a struggle." This person had not been appropriately assessed by a health professional as to whether this equipment was the most appropriate aid to use or if it was a potential risk to their safety as they were not able to participate in the move. A moving and handling assessment tool had not been used.

The service had two hoists. The one used in the communal area was broken and staff had to abandon the move once started and move the person to their bedroom and use another hoist. We also found that the electric nursing bed was not fully working as staff could not raise it to the correct height. Staff had not reported this to the registered manager. This placed people and staff at risk from equipment that was not working. One person had been identified as at risk from pressure damage and had a pressure relieving mattress in place. The pressure mattress setting was incorrect. The guidance for the mattress stated it should be set according to the weight of the person. The mattress was set at 80Kg and the person's last recorded weight was 66.1Kg. The daily check of the mattress had not been undertaken since the 08 January 2016. This meant that the person was at risk of pressure damage from equipment that was not being used appropriately.

We were told by care staff that there were three people who needed to be moved with an electrical hoist, however there were no moving and handling assessments undertaken that ensured the correct equipment was used. Different staff told us of different ways they moved one person. One staff member said they could walk whilst another said "We use the hoist because they can't walk now. These conflicting views placed the person at risk from unsafe care. During our inspection one person was seen struggling to rise from their chair and were unable to get their balance before using a walking frame, staff automatically used their hands to steady and bring the person to a standing position . Staff had not used verbal encouragement or a transfer belt to mitigate the risk of a fall. This placed the person at risk from falls.

Risk assessments did not include sufficient guidance for care staff to provide safe care, and other care plans were not being followed. For example, good skin care involves effective continence management and regular change of position. We saw people were sat in chairs and wheelchairs in communal areas with no change of position or toilet breaks from 11:30 am until 3 pm. One person was assisted from the lounge to the cinema at 2:15pm, their clothing was visibly soaked with urine. Staff had not identified this until we informed the registered manager who asked staff to attend to this person. This increased the risk of skin breakdown through prolonged sitting in one position and not receiving regular continence care. These people were therefore at risk from pressure damage.

We looked at specific care plans of people whose health had deteriorated. The care plans did not fully reflect the changes to their health, such as needing assistance with eating and drinking and weight loss. There was no guidance as how staff could promote independence with appropriate cutlery, crockery and verbal encouragement. One person who was unable to eat without assistance was seen being assisted by a care staff member standing behind them on their right side whilst the person sat looking forward. There was no eye contact between the person and staff member and the staff member could not be assured that they had finished swallowing before putting more food in the person's mouth. There was no verbal interaction from the staff member whilst they assisted the person to eat and drink. This was noted by a senior care staff member but they did not intervene. This placed the person at risk from choking.

One person whose needs had increased significantly had not been referred for a re-assessment to ensure their needs were met. Following our inspection we asked social services to do an urgent review and this

person will be moving to a care home with nursing in the near future. The staff had failed to identify that this person's needs had deteriorated to the point where they needed additional care that they were unable to provide. This put the person at risk of harm because their needs were not being fully met.

The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. This is a continued breach of Regulation 12 (1) (2) (a) (b) (e) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in July 2015, we found that the provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet people's needs. This inspection found that there were 12 people who lived at Green Hill. Whilst there were three members of staff on duty, staff deployment meant staff were not always meeting people's individual needs, such as promoting continence, ensuring their safety from potential falls and ensuring that they had meaningful activities to occupy their time. At times during our inspection there were three people sitting in the dining part of the communal area with no staff supervision or any occupation to engage with. We had to ask for staff assistance in the afternoon as two people were trying to raise another person out of their wheelchair unnoticed by staff. One of these people told us, "I am very bored."

Staff told us that training was provided and was good. One staff member who joined the care team two months ago told us that she had undertaken a two day induction and was really pleased now to be a senior care staff member. We found however there had been a lack of supervision for her to undertake that role and lack of competency checks to ensure this staff member was experienced and suitably qualified to lead the staff team. The staff member told us that this was their first job supporting people with dementia.

Staff told us that they had received training in moving and handling, prevention of falls, safeguarding, nutrition and incontinence. Despite the training we found that staff practices whilst delivering care For example one staff member said they had concerns about a member of staff not moving people safely at night and placing people at risk, but had not raised this as a possible safeguarding concern. This showed that although this member of staff had been trained they had not used this knowledge to protect people.

We talked to staff about how they kept people safe when they were unsteady and found that not all were aware of specific aids to assist them when a person was unsteady, such as a handling/transfer belt that is worn by the person and allows staff to steady them without having to bodily handle the person. Another staff member said they used the stand aid to raise a person who could no longer stand. However the 'Code of Practice for Using Hoists to Move People' (The Management of Health and Safety at Work Regulations 1999) states that a stand-aid is to assist a person who can stand (weight bear) to a standing position. The use of a stand aid hoist for a person that cannot stand places the person at risk of being dragged to a standing position by the belt, and of falling. We had observed unsafe manual handling practices during the inspection which showed that staff were not putting training into practice. We therefore could not be assured that all staff had the knowledge to move people safely.

Staff had received support from the Local Authority 'In Reach' dementia team and training in dementia care. The registered manager had assessed the environment of the home and looked at areas that could be improved to assist people living with dementia, such as signage, so people could navigate their way around the home. However some signage seen could be misleading for people and cause confusion. There was a signpost outside the cinema room that said cinema (with mileage) pointing towards a corridor and a locked door. Staff informed us that people would realise and they didn't feel it was a problem. However for one person who was told to go to the cinema to watch a western, it was confusing as they turned to go towards

the door and were led back to the cinema by a staff member. We also found some clocks in the communal area that were difficult to read and not helpful to people living with dementia. One person said, "I think it's a clock but I'm not sure because it's very confusing." Therefore despite staff training they were not applying this to support people who were living with dementia.

We looked at the staff rota that detailed who was on duty on a daily basis covering 24 hours a day. However the manager's hours were not evident and there was no on call system in place to inform staff of whom to contact in an emergency. This had not ensured that staff knew how to contact in the event of an emergency. One staff said "I think I would ring the manager who lives upstairs." However there was no formal procedure so all staff had clear lines of accountability and reporting.

The examples above show that staff with the appropriate skills, knowledge or competency to care for people safely were not employed or deployed in the service. This is a continued breach of Regulation 18 (1) (2) (a) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. 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 the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs. Staff had not received appropriate training, professional development and supervision