

Rooks (Care Homes) Limited

Green Hill

Inspection report

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17 November 2017

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Ratings

Overall rating for this service	Inadequate ●
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Is the service safe?	Inadequate ●
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Is the service well-led?	Inadequate ●
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Summary of findings

Overall summary

We inspected Green Hill Care home 17 November 2017. This was an unannounced inspection

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

Green Hill is a care home for up to 30 older people who live with dementia and require support and personal care. At the time of the inspection there were 16 people living in the home. The people who lived at Green Hill also lived with a degree of physical frailty, such as reduced mobility.

There was no registered manager in post. An acting manager has been in post since March 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The acting manager has submitted their application to register and an interview date has been arranged.

In January 2016 the service was placed into administration and a consultancy agency was brought in to run the service to ensure the people who lived there were safe and cared for appropriately and in line with Regulations. Inspections undertaken since January 2016 have been overseen by the consultancy agency.

Since November 2014 we have inspected the service seven times and found continued breaches of Regulation. At a comprehensive inspection in July 2015 the overall rating for this service was Inadequate for the second time and the service was placed into special measures. At this time we took further enforcement action. Seven breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014 were identified. Due to concerns raised about the continued safety of people we undertook a responsive inspection in January 2016 to look at how safe the home was. We found improvement to people's safety had not improved and therefore the rating remained inadequate. We inspected again on 25 and 26 May 2016 to see if improvements had been made. At that inspection we found considerable improvements to people's safety had been made. However some areas required time to become fully embedded into everyday practice and further improvements made to fully meet the breaches. Our inspection in March 2017 found whilst improvements had been made in some areas there were two breaches of regulation because the premises were not clean and well maintained and the quality assurance systems had not identified the shortfalls we found.

We received new concerns in relation to people's safety in November 2017. As a result we undertook a focused inspection on 17 November 2017 to look into those concerns and be assured of people's safety. This report only covers our findings in relation to the key questions of whether the service is safe and well-led. 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.

This inspection found people were placed at risk from unsafe premises because fire doors were not all working consistently and systems to support staff in managing an emergency evacuation were either incorrect or not available. The provider had also failed to inform CQC of on-going issues with fire safety which had the potential to impact on the safety of both staff and people at Green Hill Care Home. The lack of support care plans and risk assessments for people who had behaviours that challenge placed people and staff at risk from harm. Whilst medicines were ordered and stored safely there were improvements needed for the consistent recording of medicines and of the management of PRN medicines. Staffing deployment and staffing levels were insufficient to keep people safe.

We found there was a lack of consistent and strong leadership and provider oversight. We identified areas of record keeping that needed to improve to document more clearly the running of the home. For example, in relation to accident and incident records. There was an audit system in place however this had not identified all the shortfalls we found. Improvements were therefore needed in relation to auditing as a number of areas we identified had not been picked up as part of regular monitoring. This included auditing in relation to environmental and individual risk assessments and maintenance issues.

When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. Staff had a good understanding of Equality, diversity and human rights.

People's individual risks had been assessed and reviewed. Work had continued to ensure people's needs were regularly reviewed with specialist advice sought as required, for example, dietician and GP referrals.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 Care Home was not safe and was not meeting the legal requirement that was previously in breach.

The provider did not demonstrate safe practises with regard to fire safety and the maintenance of emergency equipment.

Risk assessment documentation in relation to the management of behaviours that challenged were not in place.

There were not always enough staff deployed to meet people's needs. Whilst medicines were ordered and stored safely, the management of medicines prescribed on an as required basis were not always safe.

Staff recruitment practices were safe

Is the service well-led?

Inadequate ●

Green Hill was not well-led and was not meeting the legal requirements previously in breach. There was a lack of strong leadership or provider oversight and improvements have not been sustained.

The provider had failed to inform CQC of the malfunctioning of fire equipment and other safety devices where that malfunctioning has lasted for longer than a continuous period of 24 hours.

Quality assurance systems were not robust and record keeping did not always clearly demonstrate the running of the service.

Green Hill

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the home on the 17 November 2017. This was an unannounced inspection. The inspection team consisted of one inspector. This was a focussed inspection to follow up on concerns raised by whistle-blowers that people were at risk from unsafe premises and unsafe care and treatment. 'Whistleblowing' is when a worker reports suspected wrongdoing at work. Officially this is called, 'making a disclosure in the public interest.'

Before our inspection we reviewed all the information we held about the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We also considered information which had been shared with us by the Local Authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We contacted the Local Authority to obtain their views about the care provided by the service. We looked at the action plan supplied by the provider following our last inspection in April 2017.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. During the inspection, we spoke with nine people who lived at the service, the acting manager, five care workers one of whom was an agency care worker and one who was working as a domestic, maintenance person and the relief cook (who was also a care staff member). We looked at all areas of the building, including people's bedrooms, the kitchen, bathrooms and the lounge and dining room.

We reviewed the records of the home, which included quality assurance audits, staff training schedules and policies and procedures. We looked at three care plans and the risk assessments included within these, along with other relevant documentation to support our findings. We also 'pathway tracked' five people

living at Green Hill Care Home. This meant we followed a person's life and the provision of care through the home and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Is the service safe?

Our findings

At our last inspection in April 2017 we found a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to ensure that the premises were clean and well-maintained. An action plan was submitted by the provider that detailed how they would meet the legal requirements by February 2018.

At this inspection we found some improvements in areas where we had previously identified shortfalls; however we found a continued breach of regulation and new areas of concern.

People told us they felt safe living at Green Hill. One person told us, "I'm safe here." Another person said, "As well as can be expected." There were people who were unable to share their views of the safety of the home but our observations told us people were comfortable with staff.

Before this inspection we received concerns that fire doors were faulty and the issues with fire safety were placing people and staff at risk. On our arrival it was confirmed there were problems with two external fire doors and the front door. We were informed a locksmith was due that afternoon to deal with the front door. Due to our concerns we contacted the East Sussex Fire and Rescue Service safety officers for on-site advice. They attended the inspection to advise the service on any immediate actions needed. It was agreed that a full fire safety audit was to take place by East Sussex Fire and Rescue Service the following week. The identified doors were fixed on the day of the inspection but a wiring issue was identified and needed further work.

At our last inspection we identified issues with the fire doors. From looking at documentation provided and talking to staff there had been intermittent faults and issues with fire doors, both internal and external since March 2017. It was unclear from talking to the maintenance person and the acting manager about the status of outstanding work to ensure electrical fire systems were safe and working effectively. Following the inspection we received further anonymous concerns that regarding heating, fire doors, electrics and water temperatures. We have referred these concerns back to the service to fully investigate.

A Fire Safety report dated March 2016 identified areas of moderate risk that needed to be actioned by the provider. There was no documental evidence these areas had been actioned. A Fire Safety Report was due in March 2017 and had not yet been undertaken. Personal emergency evacuation plans were not available for everyone. There was no suitable evacuation equipment such as evacuation ski sledge or evacuation chair to safely move a non mobile person down stairs. Emergency exits had not been kept clear from obstruction. This had the potential to cause a delay in an emergency situation.

The management of people's medicines were not always safe. Identification photographs of five people were missing from the medicine administration records (MAR) sheets. Photographs are used specifically as a safety tool for staff (new and agency) for identifying people who can't identify themselves and thus reduce the risk of medicine errors. The front pages of three people's MAR records were missing. These pages contained information important to the safety of each person, such as allergies, date of birth, swallowing

problems and how the person preferred to take their medicine.

The management of medicines prescribed 'as required' (PRN) was not always safe. PRN medicines were not all supported by a protocol that informed staff of what the medicine was to be used for, indications for use and possible side effects for staff to be aware of. Two people were prescribed medicine for agitation. There was no advice about what action staff should take to reduce the agitation before giving the medicine. One person had been given the medicine recently and there was no reflection if the medicine was effective.

The overall cleanliness of the premises had improved since the last inspection. However there were areas of the premises that had strong unpleasant odours and were not clean. For example a ground floor bathroom needed attention as there was unclean equipment left in the room. Staff told us they rinsed/cleaned commodes in the baths but there was no policy or procedure of how staff should clean the bath to prevent cross infection or a cleaning schedule that supported this use. In another room a catheter bag and tubing was left in the room with the end of tubing uncovered and touching the floor. This had the potential to cause a urinary tract infection. There were a number of unnamed hoist slings found with the hoist equipment. There was no evidence available these were checked for cleanliness or for their condition since the 07 July 2017.

There were people who presented with behaviours that challenged. The acting manager said two people who had recently come to live at Green Hill were assessed as high dependency due to their behaviours that challenged. Risk assessments and care plans to guide staff in managing these behaviours were not in place. There was no reference within care documentation to using distraction techniques or advice about what worked well to assist the person to calm. Staff had not reflected on possible triggers that had led to incidents. There were no incident reports or analysis of incidences that had occurred and this left people and staff at risk of harm. Staff gave us examples of when behaviours that challenged had occurred and these were not reported on. Staff had not received training in the management of behaviours that challenge or in de-escalation techniques.

Accidents were recorded and a monthly overview was collated by the acting manager for analysis. However we found four accidents discussed with us had not been recorded either on an accident form or included in the overview. For example a person had been found with bruising and a skin tear on the 27 September 2017 and there was no accident report completed. There was no evidence to demonstrate that there were lessons learnt from incidents.

The above issues meant the provider had not ensured people received safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that the maintenance of the home had not been managed in a timely manner. This inspection found that improvements had been made, however there was still work to be done to ensure a safe and well maintained environment. Whilst our concerns about fire safety and checking of fire systems had been identified, they had not been taken forward in a timely manner. Fire risk assessments had not been updated to reflect the issues with fire exits. There were discrepancies found in the testing of water temperatures, hot water temperatures had not been signed off as work completed. We found that a radiator in the communal quiet lounge was very hot to touch and could be a scalding hazard. Two radiator covers in people's bedrooms were broken and hot water pipes were exposed and placed people at risk from scalds and burns. Not all portable electrical equipment had been tested and included in the environmental risk assessment. As a result of the issues identified above, the provider had not ensured that the premises and equipment were maintained to an appropriate standard for the people who lived there and therefore placed people at risk of harm. This is a continued breach of Regulation 15 of the Health and Social Care Act 2008

At our last inspection we identified staff deployment was an area that required improvement. This inspection found staffing levels had not changed. There were three care staff on duty during the day with the acting manager whose role was supernumerary. There were two care staff on at night. There was also a cook and a housekeeper on in the mornings. However the staffing levels had not been increased despite some peoples' high needs being identified. During our inspection staff told us it was difficult to give care in the mornings as two staff members were needed for assisting two people on the first floor, which left one staff member to ensure the other 14 people were safe. Staff told us either the housekeeper or cook would assist and the acting manager would also help out as needed. However the cook and housekeeper had their own roles to perform.

We were also told that the afternoons and evenings were difficult because there was no cook, no housekeeper and the acting manager left at five. During the early evening it was noticeable from our SOFI that people were active and walking around the communal areas. Whilst the afternoon staff served suppers and undertook kitchen duties they were unable to engage in a meaningful way and motivate people to enjoy participation in an activity of their choice. This meant that staff could not provide meaningful activities and individualised care such as continence care. This was confirmed by our observations.

At present two people with high needs needed two staff for their personal care and behaviours that challenge and therefore two staff at night would not be able to meet peoples' needs safely and monitor the other people on the ground floor. Staff had not yet had training to manage behaviours that challenged despite the acting manager accepting people with these problems in to the home. The manager told us that she was involved in supporting people and worked alongside the staff to ensure people were safe when needed. Staff told us that they felt the staffing levels were not sufficient for the 16 people who lived in the home to keep them safe.

There was no formal staffing assessment tool used to assess peoples changing needs. There were not enough suitably trained and experienced staff to ensure people's needs were consistently met and this is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. Records confirmed staff had received safeguarding training as part of their essential training and this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. On talking to staff it was apparent they had not considered the issues regarding fire safety to be a safeguarding despite the fact people were at risk. This is an area that requires improvement.

With the exception of the two care plans mentioned previously, care plans contained risk assessments completed for all identified needs. These included falls, moving and handling, incontinence, skin integrity, medicines, dietary and fluid intake. We saw examples where people's appetite had decreased. Care staff sought advice from the GP and specialist dietetic advisors. This had been transferred in to care plans and the risk assessments updated. People received fortified food and were weighed regularly; this meant that their health was being monitored and their well-being promoted.

The provider had appropriate arrangements in place for the safe receipt and disposal of medicines. Medication policies to guide staff were available. There were a number of people who had been assessed as requiring covert medicines. There were instructions from the GP as to crush medicines and administer with/in food and drinks for some people and this had been signed by the GP, pharmacist and discussed at a

best interest meeting.

Records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector.

Is the service well-led?

Our findings

At our last inspection in April 2017, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have effective systems in place to monitor the quality of care provided and make improvements.

An action plan was submitted by the provider that detailed how they would meet the legal requirements. At this inspection we found whilst some improvements had been made the provider had not made sufficient improvement to meet the Breach of Regulation 17.

There was no registered manager in post. There had been no registered manager at Green Hill Care Home since January 2016 when the service went into administration. The service has been managed by the consultancy agency Cornerstone. Since January 2016 there have been three home managers, two of whom did not apply to register with CQC. This has had a negative impact on the smooth running of the home and of sustaining improvements. The manager informed us she had received confirmation of an imminent interview. This was confirmed by the CQC registration team.

Green Hill was not well-led because there was a lack of strong leadership or provider oversight and improvements have not been sustained. A care consultancy agency provided managerial oversight and support for the manager. However records of supervision stated that the manager needed further development of managing staff. This development and support had not been provided. Staff told us the manager was not always approachable. Quality assurance systems were not robust and record keeping did not always clearly demonstrate the running of the service. Although there were systems to assess the quality of the service provided in the home we found these were not consistently effective as some areas were slow to progress. We found continued shortfalls had not been fully actioned. Such as outstanding fire safety issues from March 2017 and maintenance shortfalls.

We identified some issues with the management of medicines: for example lack of guidance in relation to PRN medicines and a number of signature omissions. Medicine audits had been undertaken but not all were completed in full with actions taken. For example one person had been refusing their medication but it was not clear what actions staff had taken in respect of this. The medicine audit for 31 October 2017 stated signature gaps were found, however it did not state how many gaps, whether it was a signature gap or a missed medicine and was there an impact of the omission. The action taken stated 'spoke to staff'. There was no further action taken such as training or competency assessments. The audit also stated everyone had a photograph and PRN protocols. However we found five photographs missing and people without a PRN protocol. Therefore the audits lacked correct oversight. The environmental audits were not clear as they did not correspond with the maintenance book and the areas identified by the maintenance person. Issues with electrical and plumbing systems had not progressed or been fully actioned. We are still receiving information of fire doors not opening, heating problems and water temperatures too high. Health and safety audits were completed but we found discrepancies as the fire audits did not reflect the issues we found, there was also no fire evacuation plan in the fire file and this had not been identified by staff.

The manager had performed an overview audit of when people had accidents and falls. We were given the audits for July, August, September and October 2017. The audits were not accurate and did not contain accidents and injuries we had information about. We tracked one person's skin tear which staff described but there was no accident form completed and it was not included in the overview. The manager acknowledged not all accidents were recorded and would investigate why this had occurred. The audit did not include review of factors such as what time of day the accident or incident occurred to assess if people sustained injuries more commonly at certain times of the day. The manager had not audited where people had sustained minor injuries such as bruising. Due to these factors the provider and manager could not identify common themes or trends and use such information to reduce risk to people.

At the last inspection staff numbers and deployment was an area requiring improvement. This inspection found staffing levels had not been reviewed and increased despite it being identified people's dependency levels had increased and they had people with a high level of needs due to behaviours that challenge. The lack of a dedicated staff member to provide meaningful activities meant people were not receiving stimulation and people were bored. Our SOFI told us whilst staff were kind to people, they did not have time to interact positively with people. Feedback from staff and visitors told us staffing levels were not always sufficient and this had been brought to the management team's attention, but no action had been taken. There was a lack of direction to ensure people were enabled and supported to enjoy everyday life and do what they wished to do on a daily basis. There was no audit or feedback forum in respect of lifestyle choices or of how people's social and mental well-being was being consistently assessed and improved. For example, daily notes lacked on-going monitoring of how people were feeling. One person had been refusing support with personal care and their anti-depressant medicine, and this had not been cross referenced in to their care with strategies to encourage motivation and self-worth.

The lack of management strategies to manage behaviours that challenge and lack of training in this area placed both people and staff at risk of harm. This meant staff were not effectively monitoring people's health and well-being. The provider had failed to have effective systems and processes in place to assess and monitor the quality of the services provided and ensure records were accurate and complete. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager demonstrated an understanding around what needed to be reported. However they had failed to inform the Care Quality Commission (CQC) of malfunctioning of fire safety devices in Green Hill where the malfunctioning has lasted for longer than a continuous period of 24 hours. This was a Breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was mixed feedback in respect of the culture at Green Hill. We were told the management was fair, open and approachable by some staff and visitors, however we were also told by staff and health professionals that the management team were not always approachable, did not always listen and failed to make contact about people's health and mental well-being.

Systems were in place to obtain the views of staff. Staff meetings were being held on a regular basis. Staff told us these were an opportunity to discuss any issues relating to individuals as well as general working practices and training requirements. Minutes of the previous staff meeting verified this. Staff commented they found the forum of staff meetings helpful and felt confident in raising any concerns. However from talking to staff it was noted they didn't feel confident in raising concerns about the problems they had with fire doors and environment. One staff member said, "We realise now we should have acted when things don't work, as it put residents and us at risk."

There were notices on staff notice boards to guide staff on who to contact if they were concerned about anything and detailed the whistle blowing policy. 'Whistleblowing' is when a worker reports suspected wrongdoing at work.

Systems were in place to obtain the views of people. Regular resident and visitor meetings had been held. These provided people with the forum to discuss any concerns, queries or make any suggestions. However two visitors said not all suggestions have been taken forward yet. Relatives said "Lots of different staff over the past two years, that's difficult for people with dementia, hopefully things are settling." Another visitor said, "Not perfect but getting there."