Rooks (Care Homes) Limited

Green Hill

Inspection report

Greenhill Care Home
Crowhurst
Battle
East Sussex
TN33 9DB
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

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. The extension was to provide additional ensuite bedrooms, a sensory room, bar and café and small shops to encourage independence. Accommodation is arranged over two floors and there is a lift to assist people to get to the upper floor. The home has 30 single bedrooms. There were 22 people living at the home at the time of our inspection.

We carried out an unannounced comprehensive inspection of this service on 10 and 13 November and 3 December 2014. After that inspection we received new information concerns in relation to people's safety, issues with heating and hot water and insufficient experienced staff. As a result we undertook a focused inspection 8 March 2015 to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, 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, there were times when there were not enough staff to meet people's needs. This impacted in a negative way on the support that people were provided with in the early mornings and on the discrete supervision that was required to keep people safe. Breakfast was disorganised and people did not receive support at the time they needed it and little choice was offered. Not all people ate breakfast. Equipment and some parts of the accommodation were not maintained to a clean and hygienic standard and areas of the home had an unpleasant odour. The provision of heating and hot water at the time of the inspection had not ensured people were warm and safe from the risks of the cold and poor personal hygiene.

Summary of findings

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Green Hill Care home was not safe.

There were not enough suitably experienced or qualified staff on duty to meet people's needs consistently and safely. Staff training in managing challenging behaviour had not been provided to meet people's identified needs.

People were being put at risk because cleanliness and hygiene standards had not been maintained.

Risk assessments that informed safe care were not reflective of people's individual and environmental needs. Poor standards of maintenance did not protect the people who lived at Green Hill care from risk of injury.

Inadequate

Green Hill

Detailed findings

Background to this inspection

We carried out this out of hours 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 by a whistle blower 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.

This unannounced inspection took place on the 08 March 2015. We spoke with 11 people who lived at Green Hill, three relatives, the registered manager, five 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 three 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.

Inadequate

Is the service safe?

Our findings

People told us they felt safe and comfortable. One person told us, "I don't have to worry about anyone here, I'm not worried about anything," the food is good, they ask what I want and bring it to the table." This person also told us, "The staff are nice people, I have no faults with this place." One visitor told us, "I am happy with the care my mother receives, I was asked to come and see you today." Another visitor told us that they were very happy with the care and the home. However although people told us they felt safe, we found examples of care practices and environmental concerns which were not safe.

Before our inspection we received information that people were got out of bed from 4 am onwards it being their choice and were left unsupervised and were at risk from falls. We were also told that the heating was problematic and did not always work and there was a constant problem with hot water which meant people were not receiving personal care. Additional concerns were made in respect of people's safety through poorly maintained premises and inexperienced new staff.

We found that there were not sufficient numbers of suitably qualified, skilled or experienced staff to promote and protect people's safety. Staff we spoke with said there were not always enough staff to meet peoples complex needs, and felt communication problems and staff delegation were the issue. We were told that new staff had recently been employed from overseas and the language barrier was difficult, especially at night when they were only two staff on duty. A staff member said, "It's really difficult because everything takes so much longer, because of explaining and directing new staff." They also told us that they felt the senior management was not listening to their concerns.

We arrived at 6 am. We rang the doorbell; there was no response from staff. We walked around the building and saw eight people sitting in the lounge and dining area. People were fully clothed and one person was sitting with their head on a table. There were no staff in the communal area and people who were potentially at risk from harm and falls were not being supervised. We rang the doorbell a further time and it remained unanswered. We then telephoned the home and gained entry at 6.15. Two staff were on duty and supporting 20 people who lived with dementia. Staff told us that they had been helping someone in their bedroom and had not heard the doorbell. We asked the staff why eight people were up and dressed and were told some people wake up early and were safer in the communal areas. We asked staff how they ensured people were safe if there were no staff with them, and were told they would be 'fine'. However this was not supported by people's care plans and had not ensured people's safety, one person who was sitting in the dining room was known to be unsteady on their feet and was at risk of falls. There was no call bell facility easily assessable for those that may be able to use it to request assistance or support and no alarm mats to alert staff that people were up and at risk. As staff had not been able to hear the doorbell, they would not be able to hear someone calling out.

There had been recent recruitment of staff that meant some staff who had not worked in the care sector before were not yet fully trained or competent in delivering care to people who lived with dementia. We were told that two staff members working on the day of our inspection were currently on an induction programme. However they were seen to be working independently without appropriate supervision. This this was their first job in working in care and had no experience of supporting people with dementia. We saw an example of inappropriate care delivery by one new member of staff whilst supporting one person. The bedroom door had been left open and visible to anyone walking past, the staff member was observed taking off soiled night wear and dressing them in their day clothes, with no visit to the bathroom for a wash. The person was trying to speak to the staff member but they were being ignored.

We observed that people were sat in the communal areas without being offered tea, coffee or breakfast. There was no radio or television on at this time for people to listen to or for people to engage with. Staff confirmed at 7 am, that as yet no-one had been offered a beverage or breakfast, despite having been up for up to two hours. People remained sitting in the same position for up to 3 hours (6 am to 9am) without being offered a change of position, or an activity to pass the time. Four people had been identified as being at risk from potential pressure damage.

On some people's bedroom door there was information that informed staff that the person may wake up at a certain time and need assistance. However this information was not available for everyone and for four people that were up and dressed by 6 am, the information stated that it

was normal for these people to wake up at 7 am. The registered manager told us that it was unusual for eight people to get up before 6 am. This conflicted with what staff told us, "People wake up and are wet so we get them up." A member of the day staff arrived at 06:50 am to assist the night staff as one staff member would be administering the morning medicines. A further two day staff members arrived at 8 am. By 08:30 am, 17 people were up and dressed and had either had breakfast or were receiving breakfast. We noted that people were given white toast and a drink. There were no alternatives offered. Staff gave people little attention and the breakfast was disorganised. We observed people take food off other people's plates and some people did not eat or drink. Care delivery was seen to be task orientated and was not meeting the individual needs of people. The team of staff were not able to prepare breakfast, administer medicines and supervise people appropriately to keep them safe.

We were not assured that all staff had received the necessary induction training and supervision to perform their role safely. One person was assisted to walk with staff supporting them in an unsafe way, which put both the person and staff at risk from injury. The lack of hot water and the evidence that everyone's soap, toothbrushes and flannels were dry and unused indicated that people had not received the care they should have. Not all staff had received training in dementia care and managing behaviour that challenges. A new member of staff confirmed that they had not received training in caring for people who lived with dementia and had not worked in care before." We saw that some staff were not confident in talking with people and many tasks were undertaken with little or no verbal interaction. Some staff experienced difficulty in communicating with people, because English was not their first language. One staff member told us they were going to be attending English classes soon.

The provider had not taken appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff to look after people.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises were not consistently safe for people. We visited all areas of the home and found that the heating throughout the building was not on and the premises were cold. One person told us that they had been chilly and another said their room was cold. Radiators were cold and the staff said there had been problems that hot water and heating had been an on-going problem as long as they had been there. They thought the heating oil for the boiler that heats the water and central heating may have run out. We were shown an Oil Watchman which monitors the amount of heating oil in two oil storage tanks on site. The Oil Watchman had a red light flashing and was showing the minimum reading. We were told by the provider that some emergency oil had been delivered on Friday 6 March 2015 and thought sediment may have blocked the filters preventing the oil flow. We saw that there were some portable heaters in the premises. Some people had extra heaters in their room to use if they were feeling cold and we were told it was their choice. However there was no evidence that these heaters were tested, safe and individually risk assessed for people. The mini heaters were potentially a risk hazard for people that were mobile and lived with dementia. There were also uncovered radiators that were a potential scalding risk if touched and there was no risk assessment undertaken to protect people from this potential risk.

Water was cold in people's rooms and in communal bathrooms. We found one electrical shower on the ground floor that was hot but the hot taps in the sink were running cold. This meant many people had not received personal care or washed on the day of our inspection. We found dry soap and toothbrushes in bathrooms which confirmed this. The registered manager said that the staff would have boiled water and carried it to the rooms to wash people. However this was not confirmed by staff on duty or observed during our inspection. We looked at bath/shower schedule records for the current week but there were no temperatures recorded. This meant we could not be assured that people were receiving showers and baths or if the water temperatures were comfortable and within the range suggested by the health and safety executive.

There were empty bed rooms with ensuite facilities and wash basins and we requested the legionella risk assessment and water safety management plan. We were told that it would be emailed to us the following day, 09 March 2015. We have not received this at the time of writing this report.

Inadequate

Is the service safe?

A stair well fire door was insecure and partially obstructed by an arm chair. This was tested and found that the door could be opened from the outside. The chair was positioned so that it propped up the door handle but had no effect on the security of the door. It could be opened from the inside or the outside. No alarm sounded when tested and there was no device to alert staff to unauthorised access or exit via door. Two other fire doors had broken handles, but were securely closed. The senior staff member said they would release automatically when the fire alarm sounded. This was later confirmed by the manager.

People's bedrooms contained potential risk hazards to people, such as broken handles on drawers with exposed sharp nails, exposed sharp metal edges on bed, gaps where headboards were missing, broken tiles with sharp edges on window sills and other maintenance issues. A communal bathroom had exposed pipework sticking out from the wall following the removal of a radiator which could cause potential injury if brushed passed . People who live with dementia have a reduced awareness of potential risk to themselves and staff had not taken appropriate actions to reduce the risks to people and protect them from injury. The provider had not ensured that people were protected from the risks associated with unsafe or unsuitable premises.

These issues were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not safe because they were not protected against the risk of infection and there were not enough staff to provide the support people needed. Staff in the home had not taken action to ensure people were provided with a clean and hygienic environment to live in. We found problems with the cleanliness and hygiene of the home. The laundry room had an industrial washing machine which although had recently been repaired was again not working. A second domestic washing machine was being used but did not have the same sluicing and heat cycles required for soiled linen/clothes. Therefore the linen may not have been cleaned to an adequate standard to prevent cross infection as there were a high number of people who lived with incontinence problems. We were also told that some soiled linens had not been washed but kept in red sacks unsealed in the laundry room with clean laundry until the industrial washer was repaired. We received confirmation the day following the inspection that new parts had been ordered and whilst waiting for the parts, they were going to rent two industrial machines. There were areas in the home that had unpleasant odours, these were identified to staff during the inspection, some odours were linked to furnishings. Chairs in bedrooms and lounges were not clean which created an unpleasant environment in which to live. There was no daily cleaning schedule or check list completed.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person had not ensured that the premises were safe for service users and visitors. **Regulation 15 (1) (c) (e)** which corresponds to Regulation 15 (1) (a) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person did not have effective systems in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained. Regulation 12 (1)(a)(b)(c) (2)(c)(i)(ii)(iii) which corresponds to Regulation 15 (1) (a) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not have suitable systems in place to ensure that at all times there were sufficient numbers of suitably qualified, skilled and experiences persons employed to meet the needs of the service users. Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning Notice