Enter and View Falls in Care Home Report

Randolph House

Announced Visit Residential Care Home

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Disclaimer: This report relates only to the service viewed on the date of the visit and is representative of the views of the service users who contributed to the report on that date.

What is Enter and View ?

Enter and View is the statutory power granted to every local Healthwatch which allows authorised representatives to observe how publicly funded health and social care services are being delivered.

Healthwatch North Lincolnshire use powers of enter and view to find out about the quality of services within North Lincolnshire.

Enter and View is not an inspection, it is a genuine opportunity to build positive relationships with local Health and Social Care providers and give service users an opportunity to give their views in order to improve service delivery.

Enter & View allows Healthwatch to-;

- Observe the nature and quality of services
- Collect the views of service users (patients and residents) at the point of service delivery
- Collect the views of carers and relatives of service users
- Collate evidence-based feedback
- Enter and View can be announced or unannounced

The purpose of Enter and View can be part of the Healthwatch prioritised work plan or in response to local intelligence. Broadly, the purpose will fit into three areas of activity:

1. To contribute to a wider local Healthwatch programme of work
2. To look at a single issue across a number of premises
3. To respond to local intelligence at a single premises

Aims of the visit

The main purpose of this visit was to look at safety, specifically around falls in the care home.

We wanted to:

- Observe the environment and routine of the care home with a particular focus on resident's safety in relation to falls prevention
- Speak to as many residents as possible about their experience of living in the care home and their personal view on their own safety in regards to falls prevention
- Give care home staff the opportunity to share their opinions on residents safety in relation to falls risk

As well as this short individual report, the information will form part of a larger thematic report from all 11 care settings visited. Healthwatch aim to determine best practice for preventing falls in care homes with a view to sharing this with all providers to encourage an overall raising of standards

Randolph House Background

Randolph House is a residential care home situated on the outskirts of Scunthorpe.

It has the capacity to accommodate 63 residents but at the time of the visit was under occupied with only 36 people resident within the home.

There are two separate units within Randolph house split over two floors. The upper floor caters for residents with advanced dementia and other mental health needs, and the ground floor provides residential care for elderly and frail residents who may also have early stage dementia.

The most recent CQC report (March 2018) rated the care home as requires improvement overall.

Summary of the Manager's questionnaire

The Manager had been in post for 10 days on the day of the enter and view visit and needed some support from her Deputy Manager to complete the questionnaire.

There had been 131 falls in the care home since the beginning of 2018. Most of the falls were unwitnessed and a cause wasn't recorded but the most common cause of falls that were known were due to infection and a loss of balance when trying to move around.

The Manager was unable to provide any details as to how many of these falls resulted in a hospital admission or an ambulance call out as although this information was recorded it was not in an easily accessible format that allowed her to find the details.

The falls risk assessment of new residents is assessed prior to their admission to the care home. This is completed by the Manager or Deputy Manager.

A copy of the falls risk assessment template was provided on the day of the visit, which uses a detailed scoring system to identify a resident's risk of a fall.

All new residents have the falls risk assessment completed weekly for the first month after their admission. Following this, the frequency changes to monthly unless the resident needs change, for example if they have reduced mobility or have been discharged from hospital.

If an increased risk of fall is identified, a referral is made to the appropriate team and an evaluation is completed and all professional involvement is recorded.

When a new resident enters the care home they are given 1-1 support and guidance from a care worker to help them get used to their new environment.

If there is a fall within the care home the Manager explained that the care home staff assess the resident and call 111 for advice. If there is an obvious injury, emergency services are contacted. An incident report is completed and family members are made aware.

Information about the fall and the associated injury is recorded in the clients' daily notes and care plans and includes discharge notes and paramedic reports where appropriate.

To identify the cause of the fall the Manager speaks to the resident and the staff member on duty and assesses the environment and any underlying causes, such as medications or illness.

The Manager holds daily meetings with senior members of staff from every department within the care home to feedback on any issues that have come to light and share learning from events that have happened.

The environment within the care home is assessed daily by carers to ensure that it is clear of clutter and equipment is in stored in the correct place.

Weekly and monthly medication audits are completed by the Manager and the deputy Manager, and a medication action plan is put in place with senior members of staff.

The care home has direct pathways with Physiotherapy, Occupational therapy, the continence service and hearing assessment. An optician and the podiatry service visit the care home on a regular basis.

There is an Activities Coordinator who visits the care home and offers regular 'Move it' mobility sessions.

What did residents say about falls?

The enter and view team spoke to seven residents on the day of the visit with ages ranging from 73 to 99. Five residents had recently fallen, two in their own home and two within the care home. One wasn't able to say where they had fallen.

One resident told the enter and view team they were not scared because "I don't try to do it (walk) myself anymore" but went on to say that worrying about falling was stopping them from taking part in activities. This lady had suffered a fall within the care home when trying to get to the toilet unaided (whilst waiting for staff to assist her) and no longer felt confident to do anything on her own.

On this occasion the staff took ten minutes to come to her aid. This resident also shared with the team that she would like to take part in activities that involve moving around sometimes but she doesn't always know when activities are taking place and staff do not always go to collect her. She spends all of her time in her room.

This resident told the enter and view representatives that she would like to get outside in the garden more but knows that she will not be able to alert anyone when she is out there if she needs to go to the toilet so chooses to stay indoors.

The team spoke to a gentleman who said he was frightened of falling as it had happened twice within the care home, but added "I've slowed down, I've accepted that as you get older you start to lose your balance"

One of these occasions resulted in a pelvic fracture when he lost his balance after visiting the ensuite toilet in his room. The gentleman didn't know there was pull cord in the toilet that could be used to alert staff. He dragged himself across the bedroom to get to the pull cord near his bed. As soon as it was sounded the staff came to his aid immediately.

He told the team that fear falling now prevents him from getting around independently. He was given a walking frame but it was three inches too small and was causing him to have more pain in his pelvis. This was preventing him from attempting to be mobile. This frame has now been replaced with one of the correct size which has helped a bit but he doesn't feel confident to walk too much. Staff had not talked to this resident about how ways of preventing falls. He told the team-

"I don't need it, I'm not silly and I'm more careful now"

This resident chooses not take part in any activities in the communal areas:-

"I stay in my bedroom because I don't like sitting in seats that have been peed on" he has everything he needs in his room and the staff really look after him.

One resident told the team that she wasn't afraid of falling, as she doesn't really think about it unless it is icy outside.

She had fallen previously within her own home and was admitted to the care home soon after this. When asked if the care staff had spoken to her about ways of preventing falls she said she was advised to be careful, and they always ask where she is going. She doesn't use any equipment to help her get about but said if she felt she needed it, she would.

This resident chooses not to take part in any activities, but likes to go to the smoking room with her friends. She likes living in Randolph House and said that she gets on with the staff, adding

"It's a two way street- you have to make the effort with them (the staff) too"

Another resident who had fallen in her own home and broken her wrist told the team that she had fallen a few times because she has got out of bed to quickly and felt dizzy. She said she feels safer in the care home as she will get responded to quicker. She has lived at Randolph house for just over 12 months and had not fallen during this time.

What did staff say?

The enter and view team spoke to four care assistants who were on duty on the day of the visit. Three members of staff said they had received information about the risk and prevention of falls. One member of staff said this information was given when they first started in their role. Another care assistant told the team she had not seen any information regarding this subject since starting work in the care home (new care worker). One care worker said that the senior staff carried out falls risk assessments and they were not involved in them.

Three of the care workers said they had not received any training relating to falls prevention, and they were not aware that such training existed. However, they had received moving and handling training which was part of their induction and refreshed yearly.

All of the staff members that were spoken to shared their knowledge of what to do in the event of a fall, which involved using the call system to alert a senior care worker and wait for them to arrive. The staff explained that all decisions about the residents care in the event of a fall are made by the senior on duty but they were aware that they shouldn't move a resident who is on the floor, and that an ambulance is called if there is an injury. A falls sheet is then completed.

When the care assistants were asked if they felt able to raise concerns with managers, three all said that they do not feel that they had been listened to under previous management but are hoping the new Manager had brought about positive change. One member of staff said there had been a high staff turnover in the last two years due to poor management, and too much change.

Another care worker said that morale amongst staff has been very low. One reason for this was said to be due to the fact that senior care workers do not listen to their point of view and they do not feel involved in any decisions within the care home. This was comment was echoed by another member of staff who stated that she had been told to 'shut her mouth' previously when she had raised a concern.

Another care worker said she had made suggestions about a residents mobility in the past, suggesting that a stand aid is used for a resident who had some mobility. Her point of view was dismissed as the senior care worker believed using a hoist was more efficient. She stated that staff often feel under pressure to 'get the job done' and some care workers prefer to use wheelchairs for residents rather than encourage independence as this can be very time consuming. This care worker also mentioned that sometimes the residents do not attempt to be mobile and will 'let the staff do everything for them- even if they can do it for themselves' The enter and view representative asked why she thought this was the case. She said it could be due to the fact they are used to it, or due to the fact that they lack confidence in being more independent.

Another care worker expressed a concern that when a call bell is sounded, all care workers run towards the bell, which then leaves other residents unattended. She felt that a better system was needed.

The overall impression when speaking to the care assistants was that they felt as though the senior members of staff had the last word and they did not take their views into account at all. All of the care workers shared the same view that the appointment of the new Manager was a very positive step forward and that she would be more willing to listen and take their views on board.

Observations

No falls were witnessed during the enter and view visit.

During a guided tour of the care home the enter and view team noticed that although the building was large and spacious there were a number of obstacles that could have been potential trip hazards.

On the ground floor along the corridors there were several wet floor signs present. However, these were not needed as the floors were carpeted, and not wet. It appeared to be that they were positioned the corridors outside of bathrooms and toilets that could potentially be slippery so that they could be used when needed.

A hoist was left in the corridor outside a resident's bedroom on the ground floor and again on the first floor. The care worker guiding the enter and view team around the care home tripped slightly trying to navigate around this, clearly highlighting the risk. When asked why the hoists were there, the care worker didn't seem sure about why, or where they should be kept. This was brought to the attention of the Manager on the day of the visit who explained that all equipment including hoists were supposed to be stored away in a designated room and should only be brought out when needed.

Generally, lighting within the care home was good, however one resident who spoke to the enter and view team mentioned that their light wasn't working in their bedroom. They had a lamp next to the bed, that a care worker put on for them but this was very dimly lit. The care worker was asked why the main light didn't work – she didn't know, and said it had

been reported to maintenance 3 days earlier. This was brought to the attention of the Manager who assured the enter and view representative that the issue would be rectified immediately.

The flooring within the care home was even and not slippery or wet. The majority of the flooring was carpeted, with the exception of the dining area and the bathrooms which had non slip vinyl. Upstairs, the flooring was also vinyl flooring but was quite sticky to walk on.

In one of the bathrooms, a drain cover had been removed for cleaning and not replaced. This could have been a tripping hazard for a resident. This was brought to the attention of a care worker who said this would be placed back in position. It was still out of the drain hole when the team finished their visit. Another of the bathrooms on the upper floor had been used to store Christmas decorations and boxes littered the floor. This bathroom was unlocked and could be easily accessed by the dementia patients on this unit and could be considered a trip hazard.

All chairs, toilets and beds appeared to be in good order and at an appropriate height for the residents.

Call bells were present in the resident's bedrooms, in en-suite facilities and the main bathrooms but not in the communal areas. The care workers are present in the communal areas at all times and therefore it is not considered necessary to have call bells in these areas.

All residents were seen to be wearing footwear that was well kept and looked safe, and equipment within the care home appeared safe and well maintained.

One resident was having his 'afternoon stroll' around the care home with his walking frame which had wheels at the front and rubber stoppers at the back. This resident was pushing his frame with the stoppers making contact with the carpet, causing resistance which could cause a fall. These observations raised the question whether this piece of equipment was appropriate for the needs of this particular gentleman.

The enter and view team saw that most of the residents were sat in their chairs in the communal areas or in their own bedrooms and therefore did not witness many of the residents moving around the care home.

Walking routes inside the building appeared to be safe, although there were no handrails on the ground floor, and no sign to aid navigation around what is a very large building. Some of the toilets and bathrooms doors are painted in bold colours to help them stand out against the bedrooms but this is not consistent across the care home.

The outside environment looked safe and well maintained with a ramp to go outdoors.

A care worker explained that the residents tend to stay indoors during winter.

Conclusion

Randolph House is not proactive at preventing falls, and staff training in this area is limited to moving and handling training which is not falls specific.

Staff culture and attitudes to falls prevention seem to be more around taking away the risk (by doing everything for the resident) rather than empowering the individual to be mobile and independent and managing the risk appropriately. Feedback suggests that senior staff members encourage this practice as it is a more efficient approach than taking the time to support and assist a resident. As seniors are responsible for carrying out the falls risk assessments, care workers do not feel they can challenge any decisions that are taken as a result of this.

Care workers are aware of the procedure when a resident does fall, but are not empowered to make any decisions over the actions that are needed to treat the resident, as this is the responsibility of the senior care staff. This could potentially lead to a delay in the correct actions being taken.

Residents are nervous about falling and lack the confidence to attempt to be mobile, which is resulting in them not taking part in activities.

Staff morale has been very low, but there is a general positivity about the arrival of the new Manager who seems very proactive and keen to improve this.

Recommendations

- A more robust system for recording the cause of falls and injuries as a result of a fall should be implemented.
- The care home should consider installing handrails on the ground floor along the corridors where possible.
- The care home should consider installing signs to direct residents to the bathrooms, dining rooms and communal areas. These should be colour coded and correspond with signs on the doors to aid identification.
- All members of staff should undertake training specific to falls prevention and management. This should also form part of the induction process, and be refreshed regularly.
- Care workers should be encouraged to contribute to a resident's assessment and care planning, and systems should be put in place to allow them to raise concerns and have their views listened to.
- A review of all equipment used by residents should take place to ensure that it is appropriate and the correct size, and are being used safely.
- The care home should consider mobile alarms to allow residents to enjoy the outdoor space without fear of not being able to ask for help.
- Mechanisms to be put in to place to ensure that appropriate learning from a falls incident can be applied across the care home and at all staffing levels.
- Basic information to be provided and communicated to residents about how they can self reduce their risk of falls. The Chartered Society of Physiotherapists in partnership with SAGA have produced a patient friendly guide that could be used;

‘Get up and Go’ – a guide to staying steady
https://www.csp.org.uk/system/files/get_up_and_go_0.pdf

Signed on behalf of HWNL		Date: 7/12/18