Enter and View Report

Grafton House Residential Care Home

Date of visit – 10/12/18 Date of publication – 25/1/2019

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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 and staff 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

Main Purpose of Visit

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

Aims:

- 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 and management.
- Give care home staff the opportunity to share their opinions on residents safety in relation to falls risk

The care home was given prior notification of the visit one week before it took place. This gave the Manager the opportunity to complete the Managers questionnaire and collate the relevant information before the visit. However the care home was not informed of the exact day or time of the visit.

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

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Additional information

During this enter and view visit, the Healthwatch representatives observed a range of incidents that caused concern.

These issues were challenged on the day and during subsequent conversations with the provider.

Healthwatch also raised their concerns with the local authority, the adult safeguarding team and the CQC.

Although the purpose of this report is to look at falls prevention and management, it was deemed necessary to include all of the incidents that were witnessed and the responses within this report to provide context to the visit.

Care home - background

Grafton House is a residential care home situated in a busy residential area of Ashby, Scunthorpe.

The care home is split over two floors and can accommodate 24 service users, including residents with dementia. On the day of the visit, 18 residents were living at Grafton House.

The CQC inspected the care home in December 2018, and had not published results at the time of the publication of this report. The most recent published report in December 2017 rated the care home as requires improvement.

There was a new Manager on the day of the visit who had been in post for 6 days.

Summary of the Manager's questionnaire

The Manager explained that she had received the questionnaire the previous week and had completed it with support from other staff members. The questionnaire had been posted back to Healthwatch. At the time of writing this report the questionnaire had not been received.

The Healthwatch representative understood that the Manager was new, but in order to provide some context on the day of the visit, explained that it would be useful to try to discuss some of the questions together.

The Manager was unable to provide information on the number of falls that have occurred within the care home and the number of falls that have resulted in an ambulance call out, or hospital admission but said that this information was on the questionnaire that had been returned in the post.

When asked about the reason for the falls she said that most of them were unwitnessed in resident's bedrooms, and were a result of rolling out of bed and slipping off chairs, but was unable to provide specific information.

The Manager explained that the falls risk of new residents is assessed with a specific falls risk assessment and if the resident is deemed to be at a high risk of falls, this is noted in the care plan. This assessment takes place before the resident is admitted into the care home. This also includes respite clients.

Families are involved in the care planning of a new resident prior to their admission and are considered a big part of the pre assessment as they give a good idea of their capabilities.

Falls risk assessments are carried out again when a residents needs change, and care plans are updated immediately. They are not carried out regularly.

If any risks are identified in a new assessment, a moving and handling plan is adjusted. For example, if a client changes from using a walking frame to needing a stand aid. Staff are made aware of the changes.

When a new resident enters the care home, Care Workers show them around the building and asses their mobility. If they are considered a falls risk they are monitored more closely.

In the event of a fall, the Manager explained that staff would immediately attend to the emergency and make the environment safe by removing any obstructions. The injury will be assessed by the senior member of staff on duty and if there are no signs of injury or pain they will contact the out of hours service and the SPA (single point of access service) for advice. If there is an injury, the senior Care Worker will call 999.

To identify the cause of a fall, the environment will be assessed; including the resident's footwear etc and the resident's medical history will be reviewed (to check for history of blackouts/seizures etc)

To prevent further falls the Care Worker will complete observation charts and further risk assessments. The care home environment is assessed monthly, and care plans are reviewed. High risk residents are put into rooms on the ground floor.

Medications are reviewed yearly or six monthly if required or if a Care Worker raises any concerns, for example if they feel that the medications are not working properly.

To apply learning across the home, the Manager stated that the staff could undertake falls prevention training online. Information about falls and injuries are recorded in the accident book. If falls occur within a short time frame, the resident is referred to the falls team.

The GP is updated if a resident has a fall as it may require an assessment to see if there is an underlying medical condition.

All equipment within the care home is prescribed for individual use and the Manager carries out a monthly check to ensure safety (for example checking the rubbers on a walker are intact) any issues of suitability of the frames or equipment are picked up by the Care Workers and the occupational therapist is contacted.

The care home provides a physical activity programme (armchair Zumba) once a month to keep residents active. To encourage active ageing, the Manager said that they like to keep the residents occupied with lots of activities to keep minds active.

A copy of the falls policy was provided on the day of the visit which is comprehensive and describes the definition of a fall, risk assessments and prevention of falls. A coy pf the risk assessment tool was also provided.

What did residents say about falls?

The enter and view team spoke to six residents, one relative and a visitor. Most of the residents were able to answer the all of the questions on the questionnaire but some were confused and only able to provide limited information.

Four of the residents spoken to had fallen within the care home.

One resident told the enter and view team that they had fallen about a dozen times and were in the care home due to the fact they had a medical condition that made them very unsteady. The resident had fallen in Grafton House four times in the last year and told the enter and view team that they are very worried about falling.

The last time they had fallen, was due to the fact that they tried to walk but was unable to, and fell out of the bedroom door. The staff responded quickly and contacted 999 as the resident had injured their back, side, ribs and elbows. The incident resulted in a hospital stay.

Fear of falling prevents this resident from taking part in any activities with in the care home.

“I sit here all day now. Sometimes they [the Care Workers] put me in bed. I used to like to walk about but I’m too scared now”

“I can’t walk with my frame properly, it tangles me up”

The resident also takes all their meals in their bedroom because the chairs in the dining room hurt their back.

The resident wears continence pads and said that the Care Workers sometimes take a long time to change them, particularly after lunch when they are busy.

The enter and view representative asked the resident how they felt about living in Grafton House;

“it’s as good as it gets I suppose but it’s not like home”

This residents main light in their room wasn’t working when it was switched on, which was mentioned to the Manager on the day of the visit.

One resident who had fallen within Grafton House said the reason for falling was due to lack of concentration. They said that they worry about falling to the extent that they no longer take part in the activities that they used to enjoy. They said they haven’t been outside, but didn’t specify how long this has been for.

The resident said they are aware that armchair Zumba is available but they do not take part in it.

Another resident spoken to by team told the representative that they had fallen within the care home but didn’t particularly worry about it happening again.

They said they had slipped over, which had caused them to fall but wasn’t sure how it had happened. The resident couldn’t remember how long it took for the care staff to attend to the fall but remembered that no medical attention was needed.

The resident told the enter and view team that they had not received any information on how to sit or stand properly to prevent a fall occurring.

They do not take part in any activities that involve moving around but do enjoy attending concerts within the care home in the afternoons. This resident said they are happy living at Grafton House.

The team listened to a resident who had fallen in their own home before coming into Grafton House, and hadn’t fallen within the last 12 months. This resident was sat in their chair and was complaining of pressure sores. They stated that the Care Workers relieve the pressure on their sores every two hours. They are mobile and able to walk about with a frame, but prefer to do so barefoot because it makes them feel steadier. This resident also said that they had been out to the pub a few days earlier with staff.

This resident does not take part in any activities that involve moving around but listens to music when the entertainers come in.

The enter and view team spoke to a relative of one of the residents on the day of the visit. The relative told the representative that their relative had fallen within the care home three months ago and suffered a broken arm. Since the incident, she is now completely bed bound. The incident occurred when the resident, who had mobility issues had fallen when trying to get out of a chair in the lounge. The resident had an infection at the time of the fall.

The relative felt his Mum is safer in the care home than in their own home as there is someone around all of the time. He also went on to say that the staff are lovely and really care.

The team spoke to a resident who said they had fallen when first entering the care home. The conversation took place in a communal area with a Care Worker and an activities assistant nearby.

"*I fell from the top to the bottom of the stairs when I first came in. I went for you* [talking to a Care Worker] *didn't I?*"

The Care Worker replied with; *"no, that's not what happened, you were looking over and I told you to get back or you will fall"*

The resident did not seem convinced at all by this explanation, but said that they must have been mistaken.

Another resident who was particularly distressed on the day of the visit did not want to answer any questions about falls but told the team that Grafton House is a prison.

They said ;

"*take me away to die*"

The resident needed to smoke but was unable to because she did not have enough cigarettes. This was causing stress and she was constantly asking for cigarettes and wandering around the care home, in and out of the back door. One of her visitors told the team that the she didn't seem happy in Grafton House, and had changed since being admitted, although said the staff seem ok. The visitor was concerned that the resident had a stoma bag that had needed changing when they came to visit, but the Care Worker said it could wait until after they had left.

What did staff say?

The enter and view team spoke to five members of staff on the day of the visit. All staff members seemed to be very busy and some were reluctant to speak to the representatives.

The admin assistant spoken to on the day of the visit explained that all staff members are made aware of the falls policy and procedures and are provided information about falls through the CQC portal. She said they also work closely with a GP.

Training is provided by the local authority via a an e-learning package - 'be steady, be safe, preventing falls'

She also said that as part of training of new recruits, they are accompanied around the care home on and asked to identify falls risks.

This member of staff was aware of the falls procedure, and if a resident is alert and not in pain, the single point of access would be contacted. If there is an injury, the emergency services are called.

This member of staff said she would feel able to raise concerns with her Manager and went on to explain the complaints procedure for service users and visitors.

Other staff members spoken to said they had received information about falls risk and prevention. When asked about specific falls prevention training, one Care Worker said that they learn from each fall. Another staff member said that they could do online training. Another staff member also said that online training was available but it had to be done in their own time. In the event of a fall, a staff member explained that a meeting is held and to discuss what happened and what is needed to be put in place, and regular checks on this resident take place, especially at night.

All members of staff were confident that they knew what to do in the event of a fall which meant not moving the resident, assessing the injury and contacting the SPA team, 111 or 999 depending of the severity of the injury (if any)

One member of staff told a representative that that previous Manager and Senior Care Worker had recently 'stepped down' which made for a very interesting place to work. She also disclosed having been told to shut up in the past.

One Care Worker wasn't sure if they could raise concerns as they were in the middle of transition with the new Manager and weren't sure if they could approach her. Another said there seemed to be an open door policy.

Another member of staff felt that they could raise concerns to the compliance officer. There had been some problems in the past but after a meeting this had all been dealt with.

Observations

On entering the care home, the team were shown around by a Care Worker who had been working at Grafton House for quite a few years.

No falls were witnessed on the day of the visit.

On walking around the care home the enter and view staff saw that the environment was generally clear of clutter. There were some walkers and frames in the activities area that were slightly obstructing the doorway but these were moved by the activities worker when brought to her attention. The activities worker appeared to be interacting very well with the residents by encouraging them to take part in making Christmas decorations, and singing with them.

One resident who was sleeping was observed to be laid with the top half of her body in bed and the bottom half on the floor. The bed was quite low, but the residents safety in this position was questioned. The Care Worker answered that this particular resident is able to get back up off the floor themselves, therefore it was okay to be laid in this position. The issue was raised with the Manager, and assurances have been given that the provider will look into this.

At the top of the stairs that lead to the first floor, the team noticed a gate that had been made to prevent resident from using the stairs (there was a lift adjacent to this)

The gate is unusual in the way that it is constructed as it opens towards the person trying to access the first floor. This meant that whoever trying to go through the gate needed to step backwards at the top of the stairs to do so. There was a sign on the gate stating that it should be closed at all times, but it was seen to be left open and a resident was observed going up and down the stairs several times during the visit.

Concerns were raised over the safety of the gate on the day but the Manager was unable to offer any comment on this other than the fact that it made her nervous too. Following the visit, the provider stated it was a necessary intervention to avoid falls at night if a dementia patient is 'wandering' and was designed to 'slow them down'

The lift next to the gate also had a sign to say that it should not be used without supervision, but a resident using a walking frame was observed getting himself into the lift.

The lighting within the care home was adequate in the main entrance but a bit dim down the corridors and upstairs. One resident's light in their room was broken, and the Manager was alerted.

The flooring on the ground floor was even but the threshold strips between the rooms required attention as they did not appear to be secured well. On the upper floor the vinyl flooring was uneven and a bit bumpy as though it had lifted from the floorboards.

Not all residents were wearing footwear on the day of the visit. One resident was barefoot in the main lounge area, and a Care Worker explained this was due to the fact that she always takes her slippers off. However, she did bring the resident a pair of slippers to wear. Unfortunately, these were the wrong ones and didn't fit, so had to collect another pair. Another resident was wearing a pair of slippers that were in a very poor condition, with large holes at the front. One resident was wearing non slip slocks provided by a relative.

The beds were all of varying heights, and one resident was using an adjustable bed which lifted at the head to help breathing. Some residents had beds with guards on to prevent rolling out.

Call bells were not heard on the day of the visit, but the residents did have access to a pull cord call system in their bedrooms. A cord in one bedroom had been lifted out of the way, preventing the resident from using it. An enter and view representative questioned this practice, after noticing it had been out of the way for 40 minutes. The Care Worker said it was because they had been changing the bed and it gets in the way. It was then given back

to the resident to use. After feeding back to Grafton House management, the owner provided a contradictory response, stating that this resident is unable to use the 'buzzer' but has 30 minute observations instead.

Call bells were not available to use in communal areas. In dining room, there was a staff presence at all times, but in the lounges there was no consistent presence of staff. A resident was seen to be banging their cup loudly on a table to get attention. This resident was also seen to deliberately push a table over.

A resident had been escorted to the toilet and the door was left wide open whilst she was using it. Enter and view staff witnessed this whilst walking by. Two members of staff were stood nearby. This incident was questioned and the door was closed immediately. The Care Worker did not offer an explanation as to why the door was left open. The provider explained that this resident doesn't like the door closed and this is detailed in their care plan.

The team visited a resident in their room who had a commode full of excrement. She said she had asked for it to be emptied but no one had been. This was mentioned to the Care Worker who was showing the team around. She said she would get someone to sort it, but continued with the tour. An enter and view representative said that she should not let the visit stop her from doing her job, and suggested that this was a priority over showing the team around the building. This member of staff went on to ensure that the commode was emptied.

Doors to the kitchen and the laundry room were left open, despite the fact there was clear signage stating they should be closed at all times. The enter and view representatives noticed there was a step into the kitchen which could be a potential risk for residents and a resident was seen going in and out with her frame. One Care Worker (who was making sandwiches) said she felt she needed to keep the door open to keep an eye on another resident who was wandering up and down the corridor. The provider has told Healthwatch that this will be addressed at the next staff meeting.

Corridors within Grafton House are quite narrow, and the team observed that it was quite difficult for residents to move past each other, particularly if a walking aid was being used. There were no handrails on any of the walls within the Care Home, and no seating areas along walking routes, and the corridors are too narrow to accommodate this.

The rooms were colour coded to help residents easily identify the bathroom and toilets etc. Bedroom doors were painted in bold colours.

Conclusion

The safety of residents in Grafton House in terms of falls prevention is a concern.

Members of staff are aware of how to respond in the event of a fall but as an organisation there seems to be a very nonchalant attitude to falls prevention.

The staff were caring, and interacted with the residents but was also evidence of poor care on the day of the visit which indicated a disregard for resident safety and lack of dignity and respect.

Explanations as to why certain incidents occurred on the day of the visit were inconsistent, with staff members offering no explanation or differing explanation to the provider. This shows either a lack of understanding of residents needs or a lack of transparency.

Concerns

The Healthwatch enter and view team immediately escalated the following concerns:

- Approach to safety of residents in bed. This was in relation to the resident whose upper body was in bed but her lower body was out of bed, however care staff advised this to be ok as she is able to pull herself back up.
- Access to call bells across the home. This was in relation to call bells not being available in communal areas.
- Access to call bells in resident's rooms. This was in relation to a call bell of a bed bound resident being out of reach.
- Attitude towards dignity and respect. This was in relation to a resident escorted to the toilet with the door open; and also in relation to the approach to managing resident's smoking needs.
- Timeliness of changes of continence pads, stoma bags and commodes.
- The safety of the environment. Particularly with regards to the gate on the stairs, open doorways to staff areas and access to the lift.

Recommendations

- The provider should review the safety of the gate at the top if the stairs with the Health and Safety team at the Local Authority.
- The provider should consider installing handrails along corridors to provide a more enabling environment.
- The Manager should conduct a full review to ensure that staff members are complying with the policies and regulations within the care home. In particular this should include resident access to restricted areas, changing of sanitary needs, dignity and respect of residents, and consistent access to calls for support by residents.
- Staffing levels should be reviewed to ensure that members of staff are not having to 'multi task'
- Mechanisms to be put in to place to ensure that appropriate learning from a falls incident can be applied across the care home.
- 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 Healthwatch North Lincolnshire .		Date: 21/12/18

UPDATE- 25/1/19

Grafton House Management team were given the opportunity to respond to the recommendations contained within this report within 20 days. As of the date of publication, no response has been received.