healthwatch North Lincolnshire

Enter and View Report

Holme Farm Residential Care Home

Date of visit – 5/12/18 Date of publication – 29/1/19

HWNL representatives : Carrie Butler, Carol Stothard, Patricia Trehan

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

Main Purpose of Visit

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

Healthwatch aimed 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

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

It is important to note that 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.

Care home - background

Holme Farm Care home is a residential care home in the rural village of Elsham near Brigg. The care home is laid out on one level with one side of the building dedicated EMI residents (elderly mentally infirm) and the other side caters for the needs of residents who have less complex cognitive needs.

The Care home has capacity to accommodate 30 residents, but at the time of the visit there were 28 people living in the care home.

The latest CQC report published in January 2017 rated the care home as good in all areas (safe, effective, well led, responsive and caring)

Summary of the Manager's questionnaire

The Managers questionnaire was completed on the day of the visit by the admin assistant as the Manager was unavailable when the team first arrived at the care home.

There had been 116 falls within the care home from February 2018 – December 2018. 39 of these resulted in an injury of some form. It was clarified that all slips, trips and falls are recorded- however small.

The reasons for falling were due to dementia clients forgetting they cannot walk, confusion (often as a result of a urinary tract infection) and impatience.

The Manager mentioned that some residents did not like waiting for someone to come to aid them in their daily tasks.

Nine of these falls resulted in an ambulance call out.

The falls risk of new residents is assessed by the use of a falls risk assessment. This carried out before admission to identify any specific needs that the resident may have. This is done verbally and built into the client's care plan and includes respite clients.

Family members are involved in the care planning of residents and are made aware if they are at a higher risk of falling.

The risk assessments are reviewed monthly and more frequently if there are any changes in a resident's health or they return from hospital. If a resident requires any specific equipment, this is sourced before the resident returns from hospital.

The Manager explained that one resident was currently awaiting discharge from the hospital due to injuries sustained from a fall. This particular resident had fallen trying to get out of the bed and to the toilet, and therefore an extra low bed had been ordered on recommendation from the falls team. A 'silent minder' had also been ordered for this resident which identifies when a resident is trying to get out of bed and alerts the care staff.

Any slips trips and falls are recorded on an accident form and the resident is monitored for 24 hours (if they are well enough to remain in the care home)

When new residents are admitted, they are shown around by a care assistant and guided to where they need to be until the resident is aware of their surroundings.

In the event of a fall the resident will be assessed for injury and medical assistance will be obtained if necessary. This involves contacting 111, 999 or the District Nurse.

To prevent further falls, extra preventative equipment is sourced and residents are encouraged to use the calls bells to ask for support. All members of staff are informed of the incident.

Daily checks of the care home environment are carried out and a review takes place monthly.

Medication reviews take place monthly with residents and a six monthly review also takes place.

Any changes to a residents needs are incorporated into their care plan which is updated monthly.

To reduce a residents falls risk, armchair exercise classes are held monthly within the care home. Physiotherapists attend to residents on a 1-1 basis if needed. Mobility aids belong to residents and the home has spare wheelchairs to use if needed.

The Manager added that they do not offer specific training on falls for staff, but they like to keep residents as mobile as possible. A copy of the falls policy was provided on the day of the visit.

What did residents say about falls?

The Enter and view representatives listened to the views of 10 residents during the visit. Ages ranged from 67 to 92.

Five of the residents spoken to on the day of the visit had fallen within the care home. On four occasions the care workers came to their aid straight away, on another occasion the staff were there within 5 minutes. Reasons for falling included, feeling wobbly, losing balance, trying to get out of bed unaided, infection and a blackout.

The residents are aware of the gentle exercise classes that are available once a month, but not all of them have attended.

One resident that the team spoke to had been discharged from hospital on the day of the visit due to a fall. She had suffered some injuries to her head and face as a result of the fall. She told the team that she had fallen whilst trying to get herself out of bed and that she like to try to do things for herself, which is why she falls. She told the enter and view representative that she was very worried about falling and hasn't been told about how to prevent a fall, such as how to sit or stand safely. She is aware of the armchair exercises but doesn't take part in them. This resident went on to say that she is very happy living in the care home and the staff are lovely.

Another resident had fallen due to having a blackout when she was first admitted to the care home. She is quite mobile with her walker and doesn't worry about falling as she considered it to be a 'one off'. The fall resulted in a visit to the hospital. She said she hasn't taken part in any activities that involve moving around but would like to.

An enter and view representative spoke to an 88 year old woman who had come into the care home as she had fallen at home and was no longer able to live on her own. This fall had resulted in a broken wrist.

She said that she was worried about falling, but she wasn't going to take any more unnecessary risks. She went on to say that when she first came into the care home she couldn't get about very well because the walker that she had was "no good" but she has one that had brought in from home and this has made a very big difference. She feels more independent now that she is in the care home but does worry about falling, especially as she has to go down the corridor that has a slope, but she did mention that the staff are very patient and help her with this.

The staff haven't spoken to her about how to prevent a fall but have provided her with a reflect cushion which helps her to get out of her chair more easily.

When asked if she takes part in any activities that involve moving around she said;

"no, but I do get a good bit of walking in"

One resident who hadn't fallen mentioned that she wasn't interested in taking part in any activities in the care home and hadn't been given any information on how to prevent a fall.

She said she could do with a taller walker, as she was given one by a member of staff that feels too short.

Of the 10 residents who spoke to the team, only two had mentioned that they had received information on how to prevent a fall.

Most of residents told the team they are happy living in the care home, and the staff take good care of them.

What did staff say?

Staff were very busy on the day of the visit but the enter and view team managed to speak to three them. There are 35 members of staff who work in the care home in total and during the day time, four care workers are on duty to attend to the needs of the residents.

On member of staff told the team that she was given information on falls from the management team when she started working at the care home, and it was covered in her NVQ that she completed a few years ago.

However she had not received any training specifically on preventing falls. She said that whilst completing her NVQ she had training on what to do in the event of a fall and was aware of the care home policy.

In the event of an injury the care worker stated that she would call 111 for advice, the district nurse if there had been a skin tear or 999 if there had been a more significant in injury.

This care worker told the team that she felt happy to raise concerns with Managers; she felt there was an open door policy within the care home .She had worked at Holme Farm for eight years and still enjoyed working there.

Another care worker told the team that she enjoyed working at the care home but said that there had been a lot of changes in residential care over the years, resulting in the support of clients with more complex needs. She felt that basic training doesn't equip them for this and would like more training. She said she felt able to ask for training, and believed that the care home Manager was looking into different options for them. This care worker told the team that she felt comfortable challenging members of senior staff if she didn't agree

with a decision about a residents care and was encouraged to escalate issues if she didn't receive a satisfactory response.

Observations

No falls were witnessed during the visit, but one resident returned from hospital during the visit after being admitted for a fall.

Most of the residents were up and about on the day of visit, either sitting in the conservatory or lounge area or walking around the building. Carol singers visited the residents, and residents were encouraged to take part in the activity.

On first entering the care home the team found it to be bright, airy and welcoming. However, the EMI section of the building was more dimly lit than the main entrance, and there were no signs around the building to explain where things are.

There were no handrails on the walls in any of the corridors throughout the building. The Manager explained that he has avoided installing these as (in his opinion) they could be more of a hazard as he had witnessed (a long time ago in a different care home) a resident falling whilst holding on to a handrail, and their arm had become trapped behind it, causing it to break.

In general, there was no unnecessary clutter in the hallways and they were wide enough to move around with mobility aids. However there were some obstructions noted that could pose a trip hazard. One of the disabled toilets was full of boxes and equipment. The team asked why this was the case, and whether the residents had access to this toilet. The care worker response was that residents do not use that toilet. The enter and view team noted that this particular toilet was not marked for staff use only, and was on the same corridor as residents bedrooms, so could be accessed easily by a resident who is unfamiliar with the environment.

In the EMI section of the building, two chairs were placed in the corridor either side of a Christmas tree, but were slightly obstructing access to the toilets. The Care Worker explained that the chars were there to allow a resident to sit and rest if they were walking around the building. The position of the Christmas tree meant that these chairs were now slightly in front of the two toilet doors. When challenged about this being a tripping hazard, the care worker said that most of residents in this section are assisted to the toilet anyway and would be guided around the chairs.

The enter and view team found a broken arm chair had been left in the corridor as it was awaiting repair. It was set back from the main walkway, but could be considered a tripping hazard. The Care Worker said they had been instructed to remove this from the lounge as the leg was broken. The Manager further clarified this, as he felt that this was safer than leaving it in the lounge.

The flooring was found to be mostly carpeted, with non-slip flooring in the bathrooms. All areas were level and even with secure threshold strips in place in doorways.

The corridor at one end of the building which led to a resident's bedroom was slightly sloped. The occupier of this particular room used a walker to move around and when asked if it was a problem she said she just used her brakes to slow down, and had plenty of help when she needed it but it did make her a bit nervous.

The beds in the residents bedrooms were all of varying heights. The Care worker explained that a resident could bring in a bed from home of they preferred to. She also explained that furniture could also be adjusted to ensure it was the correct height for the resident. Residents were seen to be sat on reflect cushions.

The enter and view team witnessed the Manager assembling a specially designed extra low bed for a resident who was returning from hospital following a fall. This bed had been purchased at the expense of the Care Home. A 'silent minder' alarm had also been purchased for this individual to alert the care home staff if she attempts to get out of bed unaided.

Conclusion

Holme Farm management and staff are responsive to falls when they occur within the care home. Care is taken to provide the correct equipment to prevent a fall re- occurring and learn from falls.

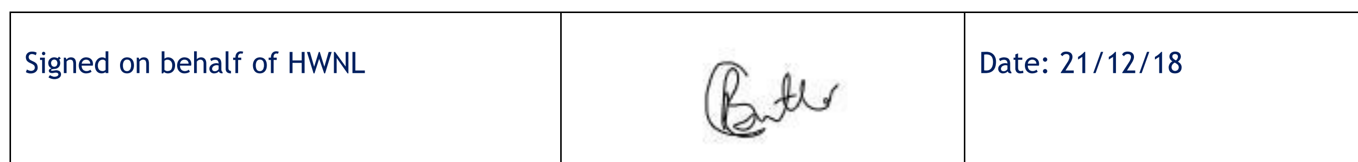
Care workers encourage residents to be independent where possible, and are patient and caring when assisting a resident to be mobile.

However, there appears to be gaps in training around identifying the risk of a fall and falls prevention. This is reflected by the fact that residents are not informed of how to sit and stand correctly, and the obstructions in the corridor.

Recommendations

- Specific falls prevention training should be made mandatory for all staff within the care home and updated annually.
- A review of equipment should be undertaken to ensure it is appropriate for the needs of the individual.
- Handrails should be installed as part of any updating of the care home.
- Management should consider alternative storage arrangements for boxes, unused equipment and broken furniture.
- 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: 21/12/18

UPDATE – the provider was sent a copy of this report on the 21/12/18 and was given 20 working days to respond to the recommendations. As of the date of publication, no response has been received.