Eastwoodhill Care Home
Care Home Service

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Telephone: 0141 638 5127

Type of inspection:
Unannounced

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Service provided by:
Pacific Care No. 1 Limited

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About the service

The Care Inspectorate regulates care services in Scotland. Information about all care services is available on our website at www.careinspectorate.com

Eastwoodhill is registered to provide residential care to 36 older people. The property is a large detached, two storey building with a modern extension. Set in extensive mature grounds in Giffnock, East Renfrewshire, it is close to public transport and other local amenities. Off street parking is available.

Bedrooms are located on the ground and first floor, 18 of which have en-suite facilities. Two lounges are located on the ground floor and one on the second floor. A lift provides access between floors, although some rooms are accessed via a corridor which has a few steps.

There is a secure garden which is accessed from the dining room.

What people told us

We sent out 15 care quality questionnaires for residents and a further 15 for their main carers. We received 10 completed questionnaires in total. One response was received from a resident and nine from main carers. The responses from carers indicated that overall, they were happy with the quality of care received by their relatives. An issue was raised, with regards to falls management.

During inspection several residents, and their visitors, raised concerns such as:
odorous smells in rooms,

- Nails and hair being dirty,
- Not being able to move around freely,
- Not being able to reach drinks that had been left out and
- Not being able to choose where to eat meals.

Some residents informed inspectors that they were bullied by staff in ways such as being spoken to in a derogative manner and being persecuted for sharing their views, leading to them feeling uncomfortable and unsafe in the home. We found evidence during the inspection to support these views. We have made specific comments under the quality themes within this report. .

Self assessment

The service was not asked to prepare a self-assessment, prior to this inspection. Inspectors looked at the services own improvement action plan.

From this inspection we graded this service as:

Quality of care and support	1 - Unsatisfactory
Quality of environment	1 - Unsatisfactory
Quality of staffing	1 - Unsatisfactory
Quality of management and leadership	1 - Unsatisfactory

Quality of care and support

Findings from the inspection

We found the service to be operating at an unsatisfactory level for this quality theme, it has been graded 1 - Unsatisfactory.

We highlighted wide ranging serious concerns during the inspection. We found that there was poor management of falls, which had led to some residents having repeated falls. This had significant detrimental impacts on their well-being which included serious injuries and hospital admissions. We found that staff and the manager did not recognise or report Adult Protection issues correctly which meant these were not investigated leaving some people at risk of harm. Due to our concerns about residents we made ten Adult Support and Protection referrals to the local authority to make sure that the health, welfare and safety of the residents involved could be reviewed.

We found that medical advice and/or assistance was not always accessed for residents when it should be. This meant that some residents had waited unacceptably long periods of time to be assessed to receive treatment, or had not been assessed at all, following falls or other incidents. Where medical advice was sought, the correct information was not always given to the agency contacted. This had led to some residents being placed at risk of serious harm, for example, there were residents who had remained in the care home when they should have been transferred to hospital for medical assessment and treatment. We also found examples of residents not being supported to have assessments and treatment carried out within the care home. Some residents were left in pain or discomfort as a result and we saw that some were distressed as a result of this. (Please see requirement 1)

We had concerns about the way staff responded to requests for help being made by residents, for example, people with mental health conditions. We saw that this led residents to experience increased stress and distress. Where care plans told staff how to minimise people's stress and distress, these were not always followed. Support from professionals to help staff to support residents in a way which minimised stress and distress was not always sought by the service. This led to residents experiencing frequent and unmanaged episodes of stress and distress.

At the time of inspection, there were 17 permanent residents and one person having a respite break. We saw a limited number of positive interactions between staff and residents however, there were other occasions where staff did not treat people with dignity and respect. Staff were heard making comments which showed a poor understanding of people's needs and a lack of respect and compassion.

Inspectors repeatedly raised concerns with staff about a resident who said they needed fresh air as they weren't feeling well. These requests were ignored by staff who also told another resident who raised the same concerns "I cant do anything for them" while laughing. Inspectors spoke to staff about how this type of response could impact on the residents' confidence, that staff will respond promptly when they ask for help. We would expect staff to immediately respond by supporting this individual to access fresh air and to provide reassurance.

During the inspection residents were restricted to the main lounge and seated in the lounge without any choice over seating type, position, who they wished to sit with or activity. Some residents faced the back of other residents seats in their wheelchairs which meant that they could neither move nor see from where they were sitting. One resident who enjoys watching television had been positioned behind someone else's seat preventing them from seeing the screen. There was no reason for them to be sitting restricted in a wheelchair in this position, an inspector asked if they would rather sit in a comfortable chair.

They told us they would but not to make a fuss because it wouldn't happen anyway. We concluded that seating was used at the service to restrict people's ability to move. This is not acceptable and has led to isolation and boredom for most residents.

In the large lounge either the television or music was switched on. We repeatedly saw that staff controlled the use of these, not residents, as we would expect. Residents told us about this and that they could not see the television, we spoke to staff about this however, this was not addressed. Inspectors observed staff switching the TV on or off and changing channels without any consultation or explanation being provided to residents. This caused confusion and frustration for residents. There was no encouragement from staff for people to use the other two lounges.

During the inspection we saw bingo take place in one lounge, however, there were long periods of time where residents were sitting without any meaningful interaction or activity. Staff were generally observed to spend their time sitting looking at residents rather than encouraging them to interact with each other and be involved in activities of their choice. There were other occasions when there were no staff in the lounge. Residents should be able to spend their time doing the things they enjoy or want to do.

At lunch time, some residents wanted to stay in the lounge for their meal, staff either ignored their requests or tried to prevent people remaining in the lounge. They did this by standing over residents whilst repeatedly asking them to go to the dining room in a way which we and residents found intimidating. Other residents were told by staff that they would have to wait for their lunch until all of the residents joined them which interrupted their meal time. We would expect people to be able to eat their meals wherever and whenever they choose to and not to be confined to any room for the convenience of the service or staff.

During lunch we saw some staff denying requests from residents. One example, was a resident asking to use the toilet. The staff response was to encourage the resident to eat and drink first. They did not respond promptly to help the person to manage their continence. We were concerned that having to wait meant that people were uncomfortable and continence was not well managed. This could also have an impact on the residents ability to eat and drink properly as they would be uncomfortable. More generally, staff did not take the time to respond to individuals requests for support and care.

Staff controlled the lives of residents in other ways, for example, during the inspection the TV was turned off by staff at 7pm, causing some residents to leave the lounge to go to their rooms. Staff were heard to tell residents they were tired and they could help them to their rooms, making statements such as "it's been a long day" and "you must be tired now". We concluded that this was to meet the needs of the service due to staffing levels and not to meet the wishes of the residents .

Overall, we concluded that staff were not used to responding to residents in the way that we would expect. The service was institutionalised with residents discouraged and sometimes prevented from using their home or living in it as they chose.

We found that buzzers were not answered in a timely manner, this was partly due to insufficient staffing, no allocated time for care staff to be included in the handover and a perception by staff that some buzzer's did not always need to be answered. This meant that people who were using buzzers to summon help were regularly ignored. This could mean that a resident who has fallen or needs other assistance was not able to get this. (Please see Requirement 2)

As a result of the serious concerns identified at this inspection, the Care Inspectorate have made an application to the sheriff at Paisley Sheriff Court seeking cancellation of the care service's registration under Section 65 of the Public Services Reform (Scotland) Act 2010.

The application is based on the Care Inspectorate's belief that in the absence of an order there will be serious risk to the life, health or well-being of persons cared for by the service.

Requirements

Number of requirements: 2

1. The provider must ensure access to medical advice, assistance and treatment is sought and/ or adult protection referrals are made, if appropriate, when the need arises and in particular, but not limited to, the following circumstances;

(a) following an accident or fall where an injury is sustained or suspected,
(b) where a head injury is sustained,
(c) where there is a decline in physical or mental health and wellbeing,
(d) increase in stress and distress related behaviours,
(e) decline in oral health including dentistry.

This is to ensure care and support is consistent with the Health and Social Care Standard 1.28 which states "I am supported to make informed lifestyle choices affecting my health and wellbeing, and I am helped to use relevant screening and healthcare services".

It is also necessary to comply with Regulations 4 (1) (a) and 4 (2) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

Timescale: 27 July 2018

2. The provider must ensure that all residents' needs are fully met and that they are supported to have choice and stimulation in their day to day living and have access and use of all areas of the environment. To achieve this they must:

(a) complete an activities assessment for each resident and devise individual and group activity planners taking account of those assessments. Activities should be reviewed and outcomes recorded for each individual resident,
(b) ensure all staff contribute to providing activities and stimulation within the environment. This is in addition to the organised activities facilitated by the part-time activities coordinator,
(c) ensure a choice of seat and seating position within communal areas and organise seating in such a way as to encourage interaction with and between residents,
(d) enable residents to have control over their daily routines, including but not limited to, choosing where they eat their meals and the time they go to bed,
(e) enable free movement of residents throughout the environment, independently and with assistance where this is required,
(f) ensure that needs are met when identified or at the request of the resident. This includes, but not limited to, responding to calls on the alert system and the promotion of continence management.

This is to ensure care and support is consistent with the Health and Social Care Standards:
1.25 which states "I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day, both indoors and outdoors",

1.3 which states "If my independence, control and choice are restricted, this complies with relevant legislation and any restrictions are justified, kept to a minimum and carried out sensitively" and
1.1 which states "I am accepted and valued whatever my needs, ability, gender, age, faith, mental health status, race, background or sexual orientation".

It is also necessary to comply with Regulation 4 (1) (a)of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

Timescale: 27 July 2018

Recommendations

Number of recommendations: 0

Grade: 1 - unsatisfactory

Quality of environment

Findings from the inspection

We found the service to be operating at an unsatisfactory level for this quality theme, it has been evaluated as 1 - Unsatisfactory.

The kitchen area was found to be clean and tidy. However, there were out of date food items and decanted items without use by dates, within the fridges, pantry and dining room areas. These were brought to the attention of the senior care worker however, most of these items were still present 24 hours later. This means that people were at risk of eating out of date food which had the potential to make them unwell. (See requirement 1)

Requirements about the environment of the home had been made by the Care Inspectorate as part of the conditions of registration of the service. During the inspection we saw that residents had difficulty moving around the home independently, due to there being no directional signage and a lack of adequate lighting. Residents were therefore reliant on staff to assist them to move around the home. The lack of signage and poor lighting also created a risk of falls for residents who had cognitive and sensory impairments. We observed residents waiting for long periods of time for staff to arrive, to assist them to areas such as the toilets and their bedrooms. We would expect that the residents would be supported to live as independently as they can within their home.

The residents garden is accessed via the dining room. The home discourages people from accessing the garden independently and there is an alarm on the door. Once in the garden it is not possible to re-enter the home without being let back in via the dining room. Inspectors have asked the home to look at ways of allowing

independent access by residents, where this is safe to do so, to ensure that those in the garden can get back in independently.

Requirements

Number of requirements: 1

1. The provider must ensure that food stocks are properly rotated and discarded appropriately, when out of date and no longer fit for consumption.

This is to ensure that food safety practices are consistent with Health and Social Care Standard 4.11 which states, "I experience high quality care and support based on relevant evidence, guidance and best practice".

It is also necessary to comply with Regulation 4(1)(a) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, (SSI 2011/210).

Time Scale: 14 July 2018.

Recommendations

Number of recommendations: 0

Grade: 1 - unsatisfactory

Quality of staffing

Findings from the inspection

We found the service to be operating at an unsatisfactory level for this quality theme, it has been evaluated as 1 - Unsatisfactory.

During this inspection we gathered the views of twelve members of staff. Some staff said there was good team work and that recent improvements had been made to the environment.

Others told us that communication could be poor between staff, managers and the provider. Staff told us about a bullying culture that was affecting some staff and residents. We were very concerned to see the direct impact of this bullying culture on residents at the service.

One resident told us that they felt bullied by some staff. The resident had complained to the manager about being bullied. They felt that the service had not listened to them and had not taken steps to protect them. We found evidence this individual had been treated unfairly and disrespectfully and had been placed at risk of psychological harm by some staff. This was very concerning. We found that neither the manager or provider had carried out a thorough or effective investigation into the concerns raised by the resident. As a result of this, we reported our concerns as an Adult Support and Protection matter to the local authority.

Some staff spoke of feeling bullied by other staff and also feeling unsupported by management. We looked at staff supervision records and found that some staff had reported to the management that they had felt bullied, but no action had been taken. We found that some staff had felt intimidated and undermined by colleagues.

We saw hostility between care workers and also between care workers and the registered manager. We concluded that there had been a number of bullying issues within the staff team that had negatively impacted upon staff morale and motivation and critically on the lives of residents.

There were many occasions during this inspection where we were concerned about the negative impact on residents caused by staff being dismissive of them, ignoring residents stress and distress, failing to respond to requests for help and failing to take appropriate action when residents appeared unwell.

We found that staff were not receiving appropriate training. New members of staff, without previous care working experience, were found to be delivering care without the required basic training and skills. Due to a number of staff leaving the service and the inexperience of those joining the service, there was a lack of skills available in dementia care and continence care. We concluded that some staff were inexperienced and were not appropriately trained to effectively communicate with or to meet the needs of the residents. (see requirement 1)

As a result of the serious concerns identified at this inspection, the Care Inspectorate have made an application to the sheriff at Paisley Sheriff Court seeking cancellation of the care service's registration, under Section 65 of the Public Services Reform (Scotland) Act 2010. The application is based on the Care Inspectorate's belief that in the absence of an order there will be serious risk to the life, health or well-being of persons cared for by the service.

Requirements

Number of requirements: 1

1. The provider must ensure positive outcomes for those who use the service by ensuring that the main focus of all staff is the care and support of the residents. Staff must have the necessary values and core skills, to deliver the service and work as a team to do so. To support this staff must undertake training in the following areas;

(a) social care values and principles,
(b) SSSC Codes of Practice,
(c) effective communication, reporting and record keeping,
(d) continence care,
(e) dementia care including stress and distress behaviours,
(f) effective team working,
(g) adult support and protection.

This is to ensure the quality of staffing is consistent with the Health and Social Care Standards:

3.14 which states "I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes" and
3.7 which states "I experience a warm atmosphere because people have good working relationships".

It is also necessary to comply with Regulations 4(1)(a), 9(1), 9(2)(b) and 15 of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

Timescale: 27 July 2018.

Recommendations

Number of recommendations: 0

Grade: 1 - unsatisfactory

Quality of management and leadership

Findings from the inspection

We found the service to be operating at an unsatisfactory level for this quality theme, it has been evaluated as 1 - Unsatisfactory.

We found that there had been a high level of falls within the service, with many of these not being reported. Some of the injuries sustained by residents included:

a) a broken wrist,
b) cuts and bruises,
c) fractured hip,
d) fractured shoulder,
e) fractured femur,
f) suspected fractured nose and
g) internal bleeding to the brain.

We would expect the manager to have an overview of falls, to allow preventative measures to be identified and put in place, this was not found during the inspection. The provider failed to carry out effective reviews of incidents which led to failings in the safe care and protection of residents. Therefore, residents were left at risk of potentially serious injury. Where residents sustained serious injuries, relevant records were not updated to reflect these. Records were not always accurate and we found evidence of different versions of events being recorded in accident and incident records. We were generally concerned about the volume of alterations made within individuals records. (Please see requirement 1)

We evaluated the management of the home to be ineffective and negatively impacting on the welfare, health and safety of the residents. As a result, we made adult support and protection referrals to the local authority, to ensure that residents involved had their welfare, health and safety reviewed. These included:

a) failure to access appropriate dental care and to provide support with oral hygiene,
b) failure to access timely medical assistance and assessment following falls or incidents which had potentially resulted in broken or fractured bones,
c) unreported brain injury,
d) failure to register resident with a GP,
e) failure to manage medical conditions,
f) lack of adequate personal care,
g) bullying and alleged assault,
h) poor falls management leading to repetitive falls and
I) failure to respond to call system buzzers.

We found that the culture of the service did not protect the health, safety and welfare of residents. Serious complaints of harm had not been investigated effectively, with residents feeling victimised for raising issues. Staff have resorted to whistle blowing to external agencies to protect residents health, safety and well-being. Two residents told us that they felt bullied by staff. They shared that they had felt frightened and continued to do so.

Staff supervision records show that issues of bullying have been raised and either not acted upon, or no effective action had been taken. This has resulted in a culture of not reporting things because `nothing will be done`. This placed residents at serious risk of harm. (see requirement 2)

To ensure the health, welfare and safety of residents, It is important that the provider ensures that appropriately skilled staff are on duty at all times. We found that this was not consistently the case. One example was a late shift, run by an agency senior carer, who had not been to the home before, with a team of staff most of whom had just joined the service. This resulted in a lack of knowledge of the residents and their needs and staff experience in delivering a service, to meet their needs which had a detrimental impact on residents. (Please see requirement 3)

As a result of the serious concerns identified at this inspection, the Care Inspectorate have made an application to the sheriff at Paisley Sheriff Court seeking cancellation of the care service's registration under Section 65 of the Public Services Reform (Scotland) Act 2010. The application is based on the Care Inspectorate's belief that in the absence of an order there will be serious risk to the life, health or well-being of persons cared for by the service.

Requirements

Number of requirements: 3

1. The provider must protect the health, welfare and safety of residents. This includes but is not limited to doing the following:

(a) Introducing for each resident the use of a multi-factorial risk assessment tool,
(b) accurately recording details of all falls and related information; analysing these records on a regular basis and identifying and implementing preventative strategies,
(c) ensuring that management are competent in, and compliant with, the organisations accident and incident reporting and investigation policies and procedures.

This is to ensure the management of the service is consistent with the Health and Social Care Standard 3.18 which states "I am supported and cared for sensitively by people who anticipate issues and are aware and plan for any known vulnerability or frailty".

It is also necessary to comply with Regulation 4 (1) (a) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

Timescale 27 July 2018.

2. The provider must ensure that the residents concerns and issues about their protection and safety are taken seriously with appropriate assessment, investigations and referrals being made. In particular the provider must:

a) provide adult support and protection training to all managers that may be involved in investigating or determining conclusions and outcomes of complaints and allegations of harm,

b) investigate and act upon all allegations of harm following the provider's policy regarding this,
c) ensure that residents are encouraged to comment on the service they receive without negative consequences or fear of reprisal.

This is to ensure the management of the service is consistent with the Health and Social Care Standards;
3.20 which states "I am protected from harm, neglect, bullying and exploitation by people who have a clear understanding of their responsibilities",
4.1 which states "My human rights are central to the organisations that support and care for me".

It is also necessary to comply with Regulation 4 (1) (a) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

Timescale: 27 July 2018.

3. The provider must ensure that each shift has the right skill mix and appropriate levels of experience in such numbers as are appropriate to meet the health, welfare and safety needs of residents.

This is to ensure the management of the staffing is consistent with the Health and Social Care Standard 3.15 which states "My needs are met by the right number of people".

It is also necessary to comply with Regulations 4(1)(a) and 15(a) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

Timescale: 27 July 2018.

Recommendations

Number of recommendations: 0

Grade: 1 - unsatisfactory

What the service has done to meet any requirements we made at or since the last inspection

Previous requirements

There are no outstanding requirements.

What the service has done to meet any recommendations we made at or since the last inspection

Previous recommendations

There are no outstanding recommendations.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Enforcement

No enforcement action has been taken against this care service since the last inspection.

Inspection and grading history

This service does not have any prior inspection history or grades.

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