healthwatch Havering

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Enter & View

Hillside Nursing Home
(Second visit)

North Hill Drive, Harold Hill,

Romford, RM3 9AW

4 July 2017

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
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What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care in the London Borough of Havering. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff, and by volunteers, both from professional health and social care backgrounds and lay people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups, NHS Services and contractors, and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Occasionally, we also visit services by invitation rather than by exercising our statutory powers. Where that is the case, we indicate accordingly but our report will be presented in the same style as for statutory visits.

Once we have carried out a visit (statutory or otherwise), we publish a report of our findings (but please note that some time may elapse between the visit and publication of the report). Our reports are written by our representatives who carried out the visit and thus truly represent the voice of local people.

We also usually carry out an informal, follow-up visit a few months later, to monitor progress since the principal visit.

Background and purpose of the visit:

Healthwatch Havering is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the safety of the resident, patient or other service-user is not compromised in any way.

The home

Hillside Nursing home lies back from a main road and has extensive gardens to the front. On arrival, the team noted that the gardens appeared to be poorly maintained in general, although there was evidence of trees being cleared. It was disappointing to note that residents could not avail themselves of these gardens as there were no protective barriers. There were some parking spaces at the front of the premises and with more at the rear. The front of the building appeared in need of redecoration – faded and peeling paintwork and dirty external blinds were obvious to visitors; the decking boards around the raised flower beds were damaged and in need of attention.

The home is spread over 2 floors, roughly divided into three units - Chiltern, Pentland and Malvern – and there is a good-sized courtyard garden which had been planted out by the Activities Co-ordinator. However, the furniture in the courtyard appeared old (seemingly having been donated to the home) and really not fit for purpose; more furniture, in a better condition, would be desirable. No sunshades were available, despite the weather on the day of the visit being very hot.

Most painted surfaces were magnolia and, coupled with cream upholstery, there was a bland over all appearance. In general, the decor was in need of refurbishment. There did appear to be the beginnings of some attempt at re-decoration in the ground floor corridor.

On arrival, the team were met by the administrator who showed them into the manager's office; although the door was clearly marked as the office, the team felt that it could be better signposted elsewhere within the home. They were advised that the registered manager, who had only taken up her post earlier in 2017, had recently resigned and had left some two weeks ago, without completing her notice period. The acting manager introduced herself and explained that she was the residential manager for the home and was managing it, with the assistance of the Regional Manager and colleagues from other homes within the group (the nearest were in Hatfield Peverel and Sidcup); she had only been in post for a week. Although there were some areas where she was very knowledgeable, she was not yet fully conversant with the nursing unit, where there was a senior nurse manager. The team were advised that the manager's post was currently being advertised. Day to day, the acting manager was the nominated manager from Monday to Friday and that she had on-call responsibility. At weekends, and for the nursing unit, the dementia lead nurse carried management responsibility.

In response to a question about resident numbers, the team were advised that there were currently 40 residents - 19 in the dementia unit on the ground floor and 21 in the nursing unit, some of whom were also living with dementia. The low occupancy was the result of the owners, as a result of an adverse CQC report, suspending admissions pending improvements being made. The CQC had re-visited in June and their report was awaited; there had been no feedback from the inspection as yet but the manager believed that a number of improvements had been noted.

There were no respite residents at the time of the visit and, when asked about care plans for this client group, the manager advised that a modified version of the full, permanent care plan was planned for future respite admissions.

In view of the high number of residents living with dementia, the team asked about communication issues and were advised that Vision Call assisted with sight impaired residents and that hearing aids were obtained when required but that many residents chose not to wear them. It had been found that face-to-face conversations and hand signals were the most effective means of communication.

Staffing

Cover for staff sickness/absence was largely provided in-house by staff who were willing to undertake extra shifts, or by the extensive bank staff. Agencies were rarely used but, where this was necessary, preference was givens to staff who had previously worked at the home.

Shift arrangements were mostly on a 12-hour basis (8.00am - 8.00pm) but there were some variations for individuals who were currently studying at university etc. There was a minimum of 10-minute hand-overs between each shift but it was not clear whether or not staff were paid for this time, nor that information provided at these meetings was then cascaded down to relevant staff members.

Full staff meetings were held on a 3-monthly basis but 'take 10' meetings were held three times during the week, at which any issues would be discussed. All staff have supervision.

In addition to the care/nursing staff there were 4 permanent cleaners and 1 bank cleaner: 2 laundry assistants: 2 chefs; 2 kitchen assistants, 2 maintenance assistants (one of whom spent half of his time on housekeeping duties); 1 activities co-ordinator, with another due to commence shortly; and 1 administrator. The team felt that, in view of the size of the home, the number of cleaning staff was insufficient to carry out all duties effectively but they were advised that this staffing position would be reviewed when the home was fully occupied.

The team were pleased to note the appointment of the second activities co-ordinator. Activities provided for residents included

bingo, special day celebrations (the day of the visit was American Independence Day and there were flags etc around the home), reminiscence, nail care, home atmosphere activities such sock pairing and towel folding, and sing-songs. It was not possible to provide organised outings although some residents were able to go out with friends or relatives for lunch etc. Some outside entertainments were arranged - Owls Are Us, other animals and entertainers etc. The current Activities Coordinator had worked at the home for a number of years, initially as a domestic assistant, and was familiar with many of the aspects of the home management.

The team was told that all training is provided on the premises on a face-to-face basis, by outside contractors, and that staff were paid for attending when not on duty. Palliative care would be provided when needed, and staff had undertaken training in this, although it was not clear not clear whether training had been provided for End of Life Care and there was no evidence of the gold standard framework for such care being used.

The home did not have emergency equipment other than for fire-fighting but many staff had received basic life support training.

Details of whistleblowing procedures were shown on noticeboards but staff were encouraged to approach local management in the first instance about any concerns.

Care of residents

In response to enquiry, the team were advised that 17 residents were subject to Deprivation of Liberties Safeguards (DoLS) with 3 more awaiting confirmation; one DoLS application had been declined.

Care plans, risk assessments and medication were reviewed on a monthly basis unless there were indications that a more frequent review would be advisable. Following adverse criticism by the CQC, it was now practice to remove blister packs from the drugs trolley when

a resident no longer required the medication - for whatever reason - and these items would be kept separately and returned to the pharmacy when the next medication delivery was made (on a 4-weekly basis); a separate record was kept of these items. Controlled drugs were kept in a separate locked wall cupboard in a locked medication room, two members of staff were required to sign for and witness administration and to confirm remaining doses. These items were checked on each shift. Some residents were on covert medication, approved by the GP and pharmacist advice was obtained where appropriate. Homely remedies are usually provided as PRN medication but simple remedies such as paracetamol may be given for one-off situations, e.g. headache. No residents self-medicate and there are no residents currently subject to warfarin medication.

Infection control was achieved by the provision of hand sanitisers, disposable towels, red bags for fouled linen and yellow bags for clinical waste. There were soap dispensers and hand towel dispensers in all toilets and bathrooms. In the event of an outbreak of infection, e.g. norovirus, residents would be confined to their rooms and placed on a bland diet. Stool samples would be collected for analysis and the home would be closed to visitors until at least 48 hours following the last clear report.

Accident/incident reports were completed for every fall and each was scrutinised for possible causes - infection, poor footwear, trip hazards etc. rather than immediate referral to the falls clinic; a resident would be referred to the clinic only if there had been a number of unexplained falls.

The team was advised that, in most cases, a call would be made to NHS111 initially, rather than to 999, other than in the event of a head injury or epileptic episode. When it was clear that a resident was nearing end-of-life, the wishes of the resident and/or their family would be considered.

The GP to the home was provided by Health 1000, based at King George Hospital, from where a doctor carried out a weekly surgery at the home. The pharmacist was involved in reviewing medication on a monthly basis with the GP. Physiotherapy was available through the GP and the home had regular visits from opticians and a chiropodist. The acting manager was unaware of any dentistry requirements.

Residents' nutrition was monitored by monthly weighing to ensure no worrying gains or losses were missed: checks may be increased to weekly where there were warning signs. The home used whole milk and would add cream to milk puddings and fortified menus where possible. Food and fluid charts were completed for residents whose weight gave cause for concern. At the time of the meeting, fluid charts were kept to ensure that residents did not become dehydrated in the hot weather. A number of residents required feeding and some residents required soft/pureed diets.

Showers/baths were offered to residents as and when required but some prefer to have all-over washes. Water temperatures were limited and checked on a regular basis.

There were a number of residents in the nursing unit who required turning and repositioning charts were completed for these residents.

The manager appeared to be unaware of the Joint Admission and Discharge (JAD) team at the local hospitals but reported few, if any, issues with discharges. She confirmed that residents who had been hospitalised for more than a few days would be reassessed before readmission in view of possible changes in care requirements. Late evening readmissions would not be accepted.

Despite the fact that the team arrived relatively early - about 9.30am - most residents were up, well-dressed and well-groomed. Most had had breakfast and were sitting in the lounge. One lady was being coaxed to eat porridge in the lounge and it was clear that staff were very

supportive of one another, clearly a good multi-disciplinary team working well together.

Staff views

The team spoke to staff who expressed frustration at current lack of a substantive manager but were hopeful an appointment would soon be made. Many said that they liked their jobs.

The team spoke to a member of staff doing the drugs round, which was nearly finished. Despite the availability of a tabard, used as an indication that the wearer should not be disturbed, the staff member in question was not wearing it. The team were assured that the drugs trolley was never left unattended and that it was locked and kept in a locked room - which they later saw. One member of care staff told us that she enjoyed care work so much that she would be leaving to start on a nursing degree in September.

All staff seemed satisfied with their training, which was often carried out in groups, in-house and during working time. Care assistants did not appear to be rushed off their feet and had time to talk with the team. Each lounge had a fully fitted kitchen where staff could prepare drinks and snacks at any time. There was a TV on in each lounge and many residents had TVs in their rooms, provided by their families.

Few residents were confined to bed and all had drinks in their rooms.

Accommodation and facilities

There was a small hairdressing salon and a hairdresser came in once a week.

The team spoke to the three female kitchen staff who were on duty whilst they were preparing lunch in what appeared to be a well-appointed, clean kitchen. One of them reeled off the names of the

residents who had specific dietary needs and also knew their dislikes, which was impressive and an indication of interest in her work.

The team also visited the laundry which was run in a very methodical way by an older man who advised that he has an assistant. There were two large washing machines and one very big dryer in action at the time of our visit. All clean clothes were on hangers and were all either named or coded. Each resident had a plastic basket to hold underwear, socks etc. All programme temperatures appeared to be correct.

Generally, the home was clean and free from odours (except for one room which the team were told had been flooded). Most rooms had hard flooring and the few remaining carpeted rooms were being changed over to hard flooring because it was reported there were 'too many accidents' (which appeared to be an allusion to incontinence issues). The team felt, however, that the installation of hard flooring in all areas would not lend itself to a warm homely atmosphere and wondered whether other means of dealing with incontinence (if that is an issue) could be pursued. Some rooms were not as well decorated as others, which could be a disincentive to prospective residents and/or their relatives.

Bathrooms and toilets were clean and free from limescale but were dated, apart from one brand new, multi-purpose bath. Very few rooms had *en suite* facilities.

The team spoke to the maintenance assistant, who is a former teacher and had worked at the home for five years and told them that he loved the job. He advised that all call bells were in working order, although we did not hear any during our visit - possibly because most residents were in the lounges. There were numerous hand sanitisers around the home but we did not notice any request to visitors etc. to use them.

Whilst walking around we noted that there were no net curtains or blinds to provide privacy and dignity to residents and this was particularly true of the ground floor where rooms could be overlooked.

Residents' and visitors' views

In view of the indisposition of most residents, it was not practicable for the team to talk with them. There were no visitors to whom the team could talk.

Recommendations

- That a review of continence policies and procedures be undertaken to ensure that any incontinence issues are dealt with. This would ensure that the need for non-carpeted floors was reduced as they make the home appear bare and compromise attempts at making it homely. Whilst there may be a need for carpet to be dispensed with in some rooms, it seems unnecessary that all should be so fitted. A more robust continence policy would reduce the number of "accidents".

- That staff carrying out the drugs round be required to wear a tabard to indicate that they should not be disturbed while carrying out that duty.

- That all areas be redecorated, paying attention to the recommendation for areas given to caring for people living with dementia that there should be a good contrast between doors and walls, and a move away from bland colours generally.
  Note - the home have advised that, since the visit, this is receiving attention as the building is undergoing refurbishment

- That the lounge furniture and soft furnishings be refurbished.

- That new bedding be provided.
  Note - the home have advised that, since the visit, new bedding and towels have been provided

- That barriers and additional garden furniture be provided to the front gardens to enable residents to enjoy this space.
- That net curtains or blinds be provided to give privacy and dignity to residents, particularly in the ground floor where rooms could be overlooked.

Healthwatch Havering thanks all service users, staff and other contributors who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit on 4 July 2017 and is representative only of those service users, staff and other contributors who participated. It does not seek to be representative of all service users and/or staff.

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Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**

email **enquiries@healthwatchhavering.co.uk**

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