healthwatch Havering

Romford Care Centre

9 February 2015

What is Healthwatch Havering?

Healthwatch Havering is the consumer local champion for both health and social care. 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 are able to 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. There is also a full-time Manager, who co-ordinates all Healthwatch Havering activity.

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 reinforces 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 will be 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 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 an 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.

Background and purpose of the visit:

Healthwatch Havering (HH) 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 is not compromised in any way.

About the home:

Romford Care Centre provides accommodation and support with personal care and nursing for 114 adults, in four separate units.

About the visit:

When Healthwatch Havering representatives arrived at the Romford Care Centre there were two ambulances present. The representatives understand that residents were being transported to various clinic visits.

The receptionist greeted the HWH representatives at the locked entrance doors. The representatives signed the visitors' book. A welcome board with the names and photos of the staff was displayed on the wall in the entrance hall.

At the time of the visit there were 52 residents living at Romford Care Centre. An embargo was in place on placements at the home and the home was being visited by Havering Council officers every week at different times of the day and night. Council representatives had been at the home the night before and were working with the manager on improvements. The Council representatives had given positive feedback, which is helping staff to regain morale.

When asked what new initiatives the manager had put in place since she had started, she mentioned having introduced regular staff supervisions and increased activities for residents such as "Fruity Friday", baking sessions such as making scones and pizzas. The manager also had had to recruit new staff, as several staff members moved with the previous manager when she left. She had also implemented the "Rob Forsett system" in which residents' details are recorded to identify individual residents' likes and dislikes to personalise their care.

Two areas of the home have been closed under the embargo – Rom Valley and Amy units. A deputy manager's job was in the process of being advertised.

The second floor, Manor unit had 19 residents and was staffed by one nurse and four carers during the day and one nurse and three carers at night.

On the first floor, Raphael, the residential dementia unit, had 22 residents and was staffed by a senior carer and two carers during the daytime and two carers at night.

On the ground floor, Meadow unit had 12 residents and was staffed by one nurse and three carers during the daytime and one nurse and two carers at night.

In addition, there was a night manager on duty across all floors. The unit manager for Meadow had a nursing background and the unit manager for Raphael and Manor was an ex-home manager and was also head of dementia care for the home.

The manager worked from 9am to 5pm but would also sometimes come into the home early to see the night staff and also might stay on until 7pm to see the evening shift. Care and nursing staff mainly worked 12-hour shifts but the manager had tried different shift patterns. In addition to carers and nurses, the manager had had the services of two project managers over the last few months. Recently the home had lost 13 carers but the manager had recruited 16 carers during the period. The plan at the home was to continuously recruit staff and train them in order to be ready to fill empty beds and to be in a position to provide cover once the embargo was lifted.

The manager generally used bank staff who know the home but on occasions had had to use agency staff but had not had to call on agency staff for the past two weeks. The manager had introduced a twilight shift where staff came on duty at 12 in the afternoon and worked until 11pm at night. She said that this had advantages as it provided help in the evening to settle residents. Staff tended to prefer to work 12 hour shifts as they liked to have four days off at a time.

In answer to enquiry as to whether any of the residents had pressure sores, the manager said that only one resident had pressure sores and this resident had returned from a week's spell in the hospital with a pressure sore; the resident had not had a pressure sore before being admitted to hospital. Safeguarding had been informed about the pressure sore. The manager said that it was difficult to take photos of pressure sores; they might be in a position which could be a dignity issue and whether this could be done would be discussed with the resident or resident's next of kin. Prior to a resident returning to the home from hospital, a nurse or member of staff from the home would visit the resident in the hospital The home now documents the time and day the resident left the home and entered the hospital and also the time and day the resident returns to the home and prepares a body map on both occasions.

The manager had introduced regular residents'/relatives' meetings but had found that attendance by relatives was very limited. The last meeting had been held on 5th February 2015 but no one had attended. The manager has tried holding meetings on different days of the week. She said that the meetings are held by an independent consultant to try to get residents/relatives to feel comfortable with attending meetings and voicing any concerns. The manager has implemented separate residents/relatives meetings for each unit. The manager said that when no one attended the last meeting, the independent consultant went round to any relatives/visitors who were visiting on the day of the residents meeting to try to solicit their views. The independent consultant had sent out a survey form to relatives try to find out what relatives want from the meetings and when would be the best time to hold them.

Residents have an assigned carer and named nurse. In answer to a question whether staff were assigned to the same floor all the time, the manager said that she tried to keep staff to the same floor but sometimes, if they were short staffed on one floor then a member of staff would be moved to a different floor.

The home had four activity coordinators; the manager wanted to recruit a fifth to work for 5 hours a day. There are ten domestic staff at the home who work from 8 to 3.30pm and a maintenance person who had been with the home for two months, who also looks after the garden. There are three kitchen staff, one chef and two assistants, one of whom covers the chef's duties part of the time; the manager was recruiting for another kitchen assistant.

The manager said there were a number of residents who required help with feeding and that enough staff were available to help with feeding at mealtimes. The aim was always to get residents out of bed, to encourage them to eat meals in the dining room and for them to sit in the lounge. The manager identified success with one resident who was usually bedbound but who had been encouraged to walk during the last week. A physiotherapist had helped staff learn how to manage standing hoists and techniques for handling the resident to get them able to walk aided by carers.

The manager was in the process of getting a dentist to come to the home for those residents who were unable to get out to a dental

surgery. A chiropodist regularly came into to the home and the manager was trying to source a hearing aid specialist to come to the home. Although three GP practices were assigned to the home one practice in particular provided most of the support to the home. The GPs held weekly surgeries at the home, which works well. However, the manager said that when GPs were called to visit residents, they often had to wait for four hours or more for the GP to visit. This would often result in staff calling 999 to send the resident to A&E, especially when the residents were on the end of life pathway. In answer to the question whether GPs reviewed the residents' medication on a regular basis she said that this had not been done. However, she had called in the CCG pharmacist to check medications and four to five weeks ago had asked the pharmacist to speak to the GPs about medication.

Amanda (the end of life trainer) had seen the GPs assigned to the home to discuss end of life care and had supported the home in this respect. With respect to DoLs the manager had not applied for any MCA 1 forms but MCA 2 forms had been completed for the Manor and Meadow units. The home was in the process of completing forms for Raphael. DoLs had been submitted for Manor and were in process for Meadow. Cheshire-West had been necessary because the home uses keypads and wheelchair belts that certain residents would not be able to undo for themselves. The home had removed privacy gates at the entrance to residents' rooms, which were present when Healthwatch representatives visited previously. The manager said that none of the residents were on covert medication. Several residents were on warfarin and some staff members had had phlebotomy training to aid with taking blood samples for warfarin testing, which is then sent off.

In answer to a question regarding the accusation that many homes tended to put large incontinence pads on residents rather than make sure residents are taken to the toilet, the manager said that they tried to ensure that residents are taken to the toilet but in some cases the resident needed to use pads. The carers tried to ensure the size of the pad was correct for the resident but there had been issues with pads being delivered that were not the correct size as ordered. Residents were weighed monthly.

The manager came in early to see night staff and to do supervisory assessments. She had also talked to the staff about career aspirations and found that a number of the staff wanted to do NVQ 2 and 3 and customer care training. The manager said that seventy-five percent of carers had NVQ 2 and 3 level qualifications. Several new staff did not have NVQ qualifications but it was good to train them to make sure they followed good practice. Staff were required during their shift to identify whether residents were continent or incontinent during the period. The manager checked 10 personal care charts a day. In addition, fluid charts were checked. Some residents were able to go to the toilet on their own: at night, any carer would take a resident to the toilet. The manager said that she was very aware of maintaining the residents' dignity and tried to ensure that at all times residents were dressed appropriately and had access to drinks in lounges and elsewhere.

Some residents required special feeding arrangements; staff appeared to have had appropriate training to ensure that the proper procedures were followed. There are some other residents fed via peg tubes. At least two residents' buzzers are checked daily. Failure on panels are checked on floors. If a resident cannot use the buzzer to gain attention this is put in the care plan and therefore the resident needs to be checked more regularly – every half hour instead of every hour. There are no cameras allowed at the home.

Religious needs are observed by church services being held at the home each week and Holy Communion is provided by lay church members. A choir came into the home at Christmas and carols were sung around the Christmas tree in the foyer. The home provided mulled wine and mince pies. Residents and staff were encouraged to write memorial messages and hang them on the tree. The home collected toys for the Salvation Army.

The manager has tried to implement regular staff meetings but has found that there is not very good uptake as very few staff come to meetings if they are not on duty at the time. It is often difficult for staff to come in after a 12-hour shift.

There is a four-week rolling menu for meals. Examples of main meal options include: braised chicken breast or omelette, shepherd's pie,

gammon steak and pineapple, chicken stew and dumplings, battered haddock fillets, beef casserole and roast beef. Desserts include rhubarb crumble but there is always a choice of jelly if they do not like the desert. Evening menu usually includes soup or sandwiches. There are some residents who are diabetic. Food is tested with a thermometer. A visit to the kitchens on Manor floor was very favourable. The chef has been at the home for a number of years. The representative noted that a light fitting needed replacing and where pans had been washed and turned upside down to drain, this had left a wet floor to slip on. Storage of food was excellent.

The Healthwatch representatives visited the laundry, which was well organised with dirty washing etc., at one end and clean laundry at the other end of the room. It was felt that a member of staff who was ironing at the time at the dirty end, should have been ironing clean clothes in the clean end of the room, however space was very limited. Following a discussion about this with the Manager it was felt that she would look into the organisation in the laundry.

The residents' care plan holds details of showering and bathing. It depends on circumstances and the residents' preference whether they have showers or baths. However, sometimes residents have to have full body wash in situ as they do not like being put in hoists.

The manager was asked what training the activity coordinators had to do their job and said that they all had customer care training. They are also planning to do "Oomph!" training, which was the only one she knew of specifically for activity coordinators.

The manager said that residents are more active in the late afternoon/evening and tend to walk around the corridors more at that time of the day rather than in the morning when the HWH representatives were visiting the home.

Residents have been taken to Broxbourne Zoo in the summer and to Queen Elizabeth Park. However it is difficult to arrange such visits for residents as the home does not have a coach to transport residents and staff. Thus arranging such visits require quite a lot of extra

coordination, permissions and paperwork. Relatives often wish to go on these trips with relatives, which is encouraged.

Some of the relatives take residents out for trips in cars or taxis. The activity coordinators buy daily newspapers for residents.

The administrator holds money for residents or money is obtained from social services. These monies are held to pay for residents' hairdressing and chiropody services mainly. Payment is often made late by the home.

A tissue viability nurse comes in to the home.

Observations around the home:

In the ground floor sitting room there was a residents' activity in progress. A company had been brought in with a range of pets in order for the residents to interact with. There was one resident smoothing a rabbit and another one petting a guinea pig. This activity was in progress for approximately two hours. The residents really seemed to enjoy this activity. In addition to this sort of activity some residents' visitors bring in dogs to pet. The manager has two dogs herself one of which would be suitable to bring in. One particular visitor brings in dogs that have been trained as dogs for the blind.

On the second floor, the dining room looked very bright and cheery with flowers on the tables. The manager said that residents are not given menus to choose what they want to eat as they would forget what they had chosen from one day to the next so they use the method of showing the meal plated on the day and let them chose which they want at the time.

The corridors of the home are very wide and very good for wheelchair access and for residents walking around. Since a previous visit by the HWH representatives the carpet in the corridors has been replaced by non-slip flooring.

Several residents' rooms were observed with residents in their beds either asleep or resting. Each room appeared clean and did not have any odours. The manager said that they were beginning a programme of adding a coloured feature wall in each residents room so that this will help with residents being able to recognize their own room easily and aid in navigating from communal rooms back to residents' bedrooms.

On Raphael unit there was an odorous smell of urine coming from one of the rooms. The manager who was accompanying the two representatives said that the resident needed changing prior to lunch, but the representatives did not see anyone go in to change the resident while they were there.

At the end of a corridor there was a small sweet shop area with sweet jars on shelves and pictures.

One assisted bathroom appeared clean with no unpleasant odours and had two different types of hoist in it. There was no bath temperature chart in the bathroom so the representatives asked about the charts and were shown two sheets of charts, which recorded the residents name and temperature of the bath over recent weeks.

Another resident's room appeared clean and did not have any unpleasant odours. The resident was dozing in their bed and had a water-filled jug on a bedside table.

After the activity with the pets had finished one of the residents who was in a wheelchair was being taken back to their floor. Two carers helped the resident into the lift in their wheel chair. The resident had a cast on and both carers were very careful and spoke to the resident in a friendly and caring manner all the time.

One resident was being taken out by a relative to do some shopping at a supermarket. The resident looked cheerful and pleased to be going out on a trip with the relative.

On Manor unit, representatives spoke to a member of Staff, who said two residents had loose bowels, one resident was in bed because of this. Samples had been sent away for testing as this problem had been there for quite a while (representatives believe 4 weeks). The linen store was not locked and the sluice room next door had a very stale smell due to very poor if any ventilation.

Also on Manor unit there was an indoor garden frame, which was obviously being looked after by the residents. There were several bedroom doors locked. The dining room, which was being decorated when the representatives' previously visited the home, had been decorated and seemed very pleasant, clean and colourful.

There were two residents walking around who were still dressed in night clothes at the time of the visit. When the representatives asked a member of Staff why the residents were not dressed in day wear, they were told the residents had refused that morning to get fresh clothes on. One of the two residents had a "onesie" on, which may have been a present from a relative.

Representatives were invited into the bedroom of a bed-bound resident. A mattress had been placed on the floor next to the bed and a member of staff explained that the resident had episodes when they would become very agitated and try to get out of bed, so the mattress was provided for protection. There was a padded bed guard in situ, but this was set in a low position, which did not appear to offer any real protection as it was at the same level as the resident lying in the bed.

The member of staff was unable to explain why this was not raised to a higher position, which would provide the protection needed. The resident in question appeared to be in an agitated state at the time of the visit

Staff interviews:

One staff member said that they had been at the home three years and was very happy working at the home. They said there had been a lot of new staff recruited recently.

Another staff member said they had been at the home for a few months and liked working at the home. The staff member was asked what training they had received whilst at the home and listed Control of Substances Hazardous to Health (COSHH), first aid, Safeguarding of Vulnerable People (SOVA), mental capacity, food hygiene and infection control. Most of the training is face to face training with trainers coming in to the home to give training whilst there is some e-learning. There are eleven mandatory training courses.

Another member of staff had been at the home a short time and was hoping to get a contract as they had been studying health and social care at college.

Two of the staff had been doing the Gold Standard training (for end of life care) over the last four to five months.

All staff were wearing uniforms and had name badges. Male carers have recently had a new uniform.

Resident discussions

The representatives spoke to one resident in the upstairs sitting room but the resident was unable to sustain a conversation. There were also five other residents appropriately dressed sitting in comfortable chairs. Some were dozing whilst others were sitting and being cared for by a carer.

Issues

8 light fittings needed replacing; a number of quotes for the work had been received but the electrician whose quote had been accepted was now unable to proceed so a new quote and electrician needs to be obtained to get this work done quickly.

The representative pointed out that one bathroom on Manor floor had a very unpleasant odour, which appeared to be emanating from a drain. The manager said that she was aware of this issue and that it was due

to a trap not having been fitted on previous work done and therefore could not be flushed. This needs to be resolved urgently.

There were concerns about the two residents on Manor unit who had loose bowels for a considerable period. There were concerns about the sluice room smelling stale and lacking ventilation.

Recommendations

- The eight light fitments need to be repaired as soon as possible.
- The drain in one bathroom needs to be fitted with a trap this appears to need reconstruction so that it can be flushed clean. This should be given urgent attention.
- For continued work with the Lead Palliative Nurse, Hospice and GP to work towards achieving The Gold Standard Framework for end of life care.
- To ensure care plans document clearly and have been discussed with relatives about end of life care pathway and to avoid unnecessary emergency ambulance callouts to A&E.
- The lack of attendance at residents/relatives meetings is a concern and it is hoped that the management can find a way to obtain feedback from residents/relatives. The questionnaire is a good initiative. Holding meetings at weekends perhaps on a Sunday may be more popular when relatives do not have to take time off work to attend.
- "Oomph!" training or a similar type of training for the activity coordinators seems to be a good initiative as singing and movement activities are particularly good for residents with dementia.
- Staff meetings should be encouraged by the Manager to ensure that all Staff attend these meetings.

Healthwatch is also concerned about the reported delays in GPs responding to requests for visits, especially as that is likely to generate (possibly unnecessary) calls for ambulances or visits to A&E. There are a number of initiatives which have been developed with some of the care homes, using the Community Treatment teams from NELFT.

This is not a matter for the home's management but Healthwatch will be raising it with Havering Clinical Commissioning Group.

Disclaimer

This report relates to the visit on 9 February 2015 and is representative only of those residents, carers and staff who participated. It does not seek to be representative of all service users and/or staff.

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

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**; or email
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