Enter & View

The Oaks Residential Care Home

28 Hall Lane, Upminster, RM14 1AF

6 March 2017

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer 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, supported by two part-time staff and a number of volunteers, both from professional health and social care backgrounds and 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 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.

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

The Oaks is a residential care home with 26 rooms - 24 with en-suite facilities and 2 with wash hand basins; at the time of the visit, all were occupied.

On arrival, the team was met by the manager and, after an initial

discussion, split into two; two members stayed with the manager who answered their questions, and the others went around the home, speaking to staff, residents and relatives.

Overall, the building was clean, bright and welcoming, had a great atmosphere, and there were no unpleasant odours. The entrance lobby was bright and cheerful painted in a variety of colours. (Yellow, Orange and Green). All furnishing appeared to be of good quality.

In the reception area, there was a visitor's book that required signing in and out, a staff picture board, and contact details for various other organisations including NHS111, Healthwatch, the GP Hubs, Age Concern, and Havering Care Point. An activity schedule on show in the hall. These included:

Monday – Music moves us

Tuesday – Keep Fit

Wednesday – Visit from Pets as Therapy

Thursday – Magazines and social chat

Friday – Cake decorating for afternoon tea.

The Lounge and other areas had pictorial indications as to what the room allocated for. Every area was clearly signposted.

The staff

The registered manager will have been in post for three years in May, after working at the home for 8 years and holds the NVQ4 qualification. She is also the Secretary of the Havering Care Association. The manager told the team that it would not be appropriate to receive younger residents as the atmosphere was for an older clientele.

On speaking with care staff, the team was told that they felt they were well supported with ongoing training as and when required, and that this was sufficient to fulfil their roles. Domestic staff underwent renewal

training every 3 years, other training was renewed every 2 years and mandatory training was undertaken when necessary. Training was generally carried out in-house by e-learning and face to face, but some training was unpaid and done in the staff's own time. Training included manual handling, first aid, Health & Safety, fire training, dementia awareness, challenging behaviour and infection control. Havering Tapestry provide 3 stage training for Dementia and the manager has attended local authority forum training on the new acid test for Deprivation of Liberty statements (DoLs).

There was a staff meeting once a month. There were regular six monthly appraisals for all staff.

Three shifts were in operation, from 8am to 2pm, 2pm to 8pm and 8pm to 8am. For shifts the complements were:

Mornings - manager + Deputy manager + senior + 2 carers

Afternoons - 1 senior + 2 carers + Activity Coordinator

Nights - 2 carers + 1 carer on call

In addition, there is a cook, kitchen assistant and two housekeepers and a handyman/gardener. Domestic staff work 6 days a week, including Saturdays. Staff absence/illness is covered internally and agency staff are rarely used.

Staff – both care and housekeeping – used "Person Centred Monitoring Units", handheld devices on which they could record details relating to each patient such as nutrition, fluids mobility and care given, so that there was a full record should any concerns arise. The team was told that the use of these devices reduced care staff and administration time, improved the quality of care being delivered, measured care plan effectiveness and facilitated the management of problems before they become critical.

Staff wore uniform with name badges.

There is an Activities' coordinator who worked full time five days a week, including either Saturday or Sunday. All birthdays and special days would be celebrated – often with entertainers – with finger food buffets being provided along with birthday/special occasion cakes. The religious needs of residents were provided by a monthly multi-denomination service and visits of local church members. Outings for afternoon tea, visits to other care homes and trips to the Queens Theatre were all arranged.

Care services

Although this is a residential home there was a procedure for dealing with pressure sores through the GP and District Nurse.

Controlled drugs were kept in the dining area next to the kitchen, either in a locked cabinet on the wall or in a drugs fridge, located beneath the cabinet and also locked and were prepared by the manager or deputy manager and countersigned. Only senior staff gave drugs and they had received training for giving medicines. No resident self-medicated.

A local pharmacy carried out independent audits and reviews on medication and if someone had been on the same medication for a considerable time, they would advise the GP to carry out a review. At the time of the visit, one resident was subject to covert medication, authorised by the GP and had been subjected to a DoLs, approval of which was awaited. The manager commented that the wait for Havering Dols was especially long.

Mar charts are completed manually alongside the computer system.

District nurses visit regularly and on request from the home and the tissue viability nurse would be contacted via the single point access system as and when necessary. No resident required turning.

The accident book is monitored by the manager for witnessed and unwitnessed falls. All staff have first aid training – but anything more serious and an ambulance is called. If a fall is unwitnessed it is reported

to safeguarding, the District Nurse will be alerted and the GP will check the resident the next day. The District Nurse will attend to skin tears.

No physiotherapist had been assigned to the home. A Podiatrist visited every 6 weeks. Residents attended the local dentist, who was only a few minutes' walk from the home, although access could be a problem. An optician came to the home every six months.

In response to a question about the home's experience of hospital discharge, the team was advised that it had not been good. It was not unknown for patients to be discharged in the late evening – early morning. Staff at Queen's Hospital had even threatened to call the police if the home did not take a resident back; the resident in question had been returned to the home at 1.00am, inappropriately dressed in a hospital gown even though she had been sent into hospital in her own night gown. The team was told that all residents are body mapped on admission and on return from hospital.

Food and fluid charts were completed as and when required. Residents had a choice of two main meals at lunch time and some residents may wish to have something different. Mews (modified early warning score) scores were recorded. Residents were weighed monthly unless there was cause for concern and if a resident was underweight, the GP would contact the nutritionist to visit the home, and a fortified diet might be prescribed if necessary. There would then be a telephone follow up and the resident would kept on the pathway if weight was being gained, otherwise the GP would arrange further investigation. Only one resident needed feeding.

Quality was monitored by the use of audit forms, which were available for all visitors, and the manager carried out her own audits. Care plans were reviewed monthly and updated if there were significant changes.

One local GP had been assigned to the home, whom most residents see. The GP held a session at the home once a week and the home was very happy with the GP's support. One resident had to go to the local pharmacy for blood tests (although the long wait sometimes involved meant that this was not always easy to arrange).

The team observed a member of staff carrying out the drugs round. She had a use of a tabard while engaged on that task. The round seemed to the team to be rather hurried and, from what they observed, they were not entirely confident that all residents took their medication: asked whether some residents would try to avoid taking their medication, the carer confirmed this was the case but added that she always checked that drugs had been taken.

The home was signed up to the Gold Standard Framework (GSF) for end of life care. Both the manager and deputy manager had been trained but at the time of the visit no accreditation had been given. Palliative care was given with the aid of district nurses and Marie Curie nurses. St Francis Hospice advised on medication and support for staff.

There were two chefs: one for week days, the other for weekends, with other staff stepping in if necessary. Mealtimes were organised by carers, who assisted residents to go to the dining rooms, which were small but adequate and homely. One dining room was adjacent to the kitchen. One resident required help with feeding.

Drinks and snacks were always available. Drinks were evident both in the lounges and dining room.

All diet requirements would be catered for. Pureed food and thickeners could be provided if necessary.

Menus were completed which provided various choices with plenty of vegetables. On the day of the visit, the menu consisted of beef cobbler or lamb with rosemary, with a selection of potatoes, green vegetables and a choice of deserts, which looked very appetising. The team was

told that the evening meal generally consisted of finger foods and fresh fruit.

The kitchen appeared well maintained and clean and all white goods were fully functional. The fridges were well stocked.

The team was told that residents were weighed once a month, which was substantiated by the Personal Centred Unit. Key workers were allocated but residents told the team that they had different carers throughout the day.

Call bells were evident in the lounge by residents' chairs and within easy reach. Residents and relatives advised that they were involved in decision making.

Residents could choose to have showers or baths (there is a bath with a hoist), although most residents preferred a full body wash. There were two walk in showers on the ground floor and one on the first floor. There is no rota for bathing and residents can have showers/baths every day if they wish. There used to be a rota system for bathing but the CQC had advised against that practice. All taps have temperature limiting valves to ensure safe bathing and showers. Temperatures were checked by the maintenance assistant on a monthly basis. There were temperature charts and a floating bath thermometer.

A hairdresser attended fortnightly.

All residents were dressed and well groomed. They were mobile and able to converse freely with each other and staff.

The manager had an open-door policy for residents and staff.

Facilities

The team was told that the laundry machines were disinfected daily. The clean and dirty areas were separated, with baskets for each individual resident. All washing was washed at the appropriate temperatures with guides on the machines. Soiled washing was given a

sluiced wash first. The Laundry was located outside the main building, together with a Staff Room.

The toilet and shower areas appeared exceptionally clean, with hand washing instructions clearly shown.

The garden area was small but well ramped and paved, with raised flower beds and an area for barbeques. The raised flower beds provided residents with the opportunity to partake in planting.

Residents' and relatives views

There had been 23 visitors to the home in the week before the visit, mainly family and friends.

All residents spoken to during the visit told the team that they felt they were treated with dignity and respect and that they were very safe.

The son of one resident who is over 100 years old told the team that her health had improved, that she was more mobile, and that her legs were well cared for. He visited her regularly and was very positive about all aspects of care and encouragement given.

Recommendation

The team was concerned that the medications round they observed might not have been conducted entirely appropriately. Staff should ensure that residents do take their prescribed medication at all times and, therefore, procedures should be revisited and enforced to ensure that this is so.

In her response to this report, the Manager has advised that, prior to its publication, the home had identified the shortcomings in medication administration mentioned in the report, had taken steps to retrain the staff member in question and could confirm that the process had improved significantly as a result.

The team would like to thank all staff and patients who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit on 6 March 2017 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 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**; or email **enquiries@healthwatchhavering.co.uk**

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