healthwatch Havering

Enter & View

Alton House Care Home

(Third visit)

22 Sunrise Avenue, Hornchurch RM12 4YS

20 February 2019

Healthwatch Havering is the operating name of
Havering Healthwatch C.I.C.
A community interest 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 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 welfare of the resident, patient or other service-user is not compromised in any way.

Key facts

The following table sets out some key facts about Alton House. It is derived from information given to the Healthwatch team during the visit, and reflects the position at the time of the visit:

Number of residents/patients that can be accommodated:	23
Current number accommodated:	18
Number of care staff employed:	15
Number of management staff employed:	2
Number of support/admin/maintenance/activities staff employed:	1
Number of visitors per week:	5-10
Number of care/nursing staff spoken to during the visit:	2
Number of management/admin/reception staff spoken to during the visit:	2
Number of residents spoken to during the visit:	2

Note: since this visit was carried out, the home has been re-registered by the CQC and both the Acting Manager and trainee Manager have been registered by the CQC as Managers. This report reflects the position as of the day of the visit.

The team were met by the Acting Manager and the trainee Manager, who had recently commenced duty at the home on 5 February this year. The Acting Manager advised that she had not wished to undertake the manager's role on a permanent basis and therefore a trainee manager had been appointed with a view to becoming *au fait*

with the home and then taking up the manager's post, subject to CQC registration, whereupon the Acting Manager would step down from the acting post. These plans were all subject to the CQC confirming the home's registration following a recent visit[1]. It was noted that the previous CQC report had resulted in the home being placed in special measures, in addition to complications caused by the death of the owner.

The team were advised that management responsibility for the home was currently being shared between the acting manager and the trainee manager, either of whom was available on a 24-hour basis by telephone. Additionally, an experienced consultant advisor (previously a longstanding Chairman of the Havering Care Association, owner of a Residential and Nursing Home and a retired surgeon) had been appointed by the company to ensure compliance with all CQC requirements. It was noted that there had been no variation of managers' shifts as had been recommended during a recent visit - the managers were on the premises between 8am and 4.30pm Monday to Friday and worked one day on alternate weekends; but the team were told that consideration was being given to the trainee manager attending on one weekend day, every other week. A competent person was always on duty and a manager was on call if required.

The trainee manager confirmed that she felt fully supported; she was shadowing the acting manager and would apply to be registered as the permanent manager, once the home's re-registration was confirmed.

The Premises

The home was registered to accommodate 23 residents but, at the time of the visit, there were 18 residents, with one other at that time in hospital. The vacancies resulted from the current lack of CQC registration. The home was registered for residents living with dementia but that not all current residents had been diagnosed as

[1] At the time of publishing this report, the result of that CQC visit was awaited.

such. Two residents were from out-of-borough. There were no respite residents in the home at present.

The Environmental Health Officer had awarded the kitchen a 4 star rating when he visited in April 2018 (since upgraded to 5 stars) and the team noted that the kitchen was spotlessly clean, with fridge and freezer being well organised.

Care of residents

New referrals to the home would be assessed in their own home or in hospital. It was also possible for prospective residents to spend a day at the home, when a more in-depth assessment would be carried out. Relatives were also welcome to visit the home prior to admission. Previous medical history is obtained. It was confirmed that arrangements could be made within 1- or 2-days subject to work load.

In response to a question about dealing with residents with communication difficulties, the team were advised that there was only one resident for whom communication presented a difficulty, as a result of their medical condition (which required the resident to speak slowly so the carers could understand). There were picture menus in the dining room and the chef was changing them during our visit. There were two choices of meals and should a resident not like either, an alternative would be offered.

It was confirmed that safeguarding incidents were logged and reported to the appropriate authorities, including Safeguarding, CQC and public health (in the event of cases of diarrhoea and vomiting (D&V), scabies etc.) In response to a query about falls, the team were advised that reports were submitted monthly (unless residents needed hospital treatment, in which case an incident would be reported immediately).

When the last published CQC visit took place, it had been noted that the washing machine was out of order and that there was no back-up system in place. Since then, a further machine had been purchased and a policy and procedure for dealing with faulty equipment had been

developed. A call bell system in bedrooms had been updated and was now working fully. A call bell system was also available in both lounges.

Details of residents' religious affiliations were documented on admission and, in discussion with clients and family, religious arrangements would be made by the home when requested or desired. Currently, one client's daughter preferred to make arrangements herself.

The team noted that care staff were not permitted to carry mobile phones whilst on duty.

The team discussed the Red Bag scheme. The home had ben told that it had not been rolled out yet but the manager agreed to make further enquiries about when it might be implemented.

In response to a question about the provision of palliative care, the team were told that most staff had had training, but the team were advised that a nurse from St Francis Hospice attended the home and, for End-of-Life care, the facilitator attended on a monthly basis.

The home did not have a defibrillator or any other specialist medical equipment. The manager felt that a defibrillator was not necessary as the response team were very quick in attending and no residents were currently on oxygen therapy. The manager confirmed that she was aware of the need for a back-up cylinder when a concentrator was in use.

The home did not employ an activities co-ordinator, but care staff made appropriate arrangements. There did not appear to be any schedule but the team were assured there was an activities folder and that activities included painting, dancing, pet therapy, colouring etc, and that external entertainers were booked as often as possible. Cakes were provided for special occasions but families often preferred to make their own arrangements for birthday cakes.

Most residents were the subject of DoLS (but some authorisations had been delayed, some having to be re-submitted, and 6 were currently outstanding).

New care plans were being introduced and staff were being shown how to complete them. Dependency scores were calculated each month at which time care plans were reviewed with the relevant key worker and families would be involved as far as possible. Risk assessments and medication were also reviewed at this time but would be adjusted as and when changes occur.

Quality surveys were sent out to relatives every two months. Provider checks were completed on a monthly basis.

The consultant advisor and his wife had developed infection control procedures, including legionella etc. In reply to an enquiry about isolating residents with possible infectious problems, the team were advised that it was not practicable due to confusion but when the team spoke to a carer they were advised that residents exhibiting sign of infection, e.g. D&V, were confined to the small sitting room. Members of staff who reported infections, including D&V were required to remain off work for a minimum of 48 hours once being clear.

Reports of falls were made weekly, with a monthly report being submitted to Havering Council and the CQC.

In the event of Urgent Care being required, generally, the 111 service would be called initially unless there were clear signs that a resident needed to attend hospital, e.g. a fracture, an apparent heart attack or a head injury. There had few calls to 999 over the past year. The manager confirmed that a form had been designed to record all necessary information for ambulance/medical staff.

All moving and handling items of equipment were now the subject of 6-monthly checks and a variety of sling sizes was available.

Personal Emergency Evacuation Plans for all residents were available in care plans and relevant information from them would be included in the emergency evacuation plan.

The manager and the trainee manager had carried out a late evening spot check in the week before this visit and intended to do a further check in the small hours in the near future.

The medication trolley was stored in a locked cupboard and controlled drugs were kept in the Medication Storage cupboard. Temperatures of both cupboards were recorded daily to ensure that medication was stored at the correct temperature. No residents were the subject of covert or crushed medication. Medication was provided by Elm Park Pharmacy. The district nurse attended one resident who was on a warfarin regime. GP services for the home were provided from several local surgeries - Dr. Rahman, The Avenue, Suttons Avenue, Maylands and Wood Lane - as the previously designated surgery had withdrawn. GPs from each surgery carried out reviews as required.

Other than for residents recently discharged from hospital, access to physiotherapy would be arrange through the GPs, but the home did have regular attendance by an optician, a chiropodist and a dentist, and a hairdresser attended weekly. The team were advised that the resident who was currently in hospital was unable to return home because of mobility problems that were preventing their discharge.

A full emergency plan, regularly updated, was available at all entrances, for the use of emergency services staff if necessary. The home now made statutory reports on line to the CQC.

Residents were observed during mealtime to ensure that they remained nourished. Where there were concerns, referral would be made to the appropriate GP. Currently only one resident needed assistance with feeding although two others required a pureed diet. Finger foods were provided for clients whose dementia was advanced and were unable to use a knife and fork but who could eat unassisted using their fingers, thus sustaining their independence and dignity. Clients were given a choice of where they would like to sit at mealtimes.

Residents were weighed on a monthly basis but this would be increased to a weekly regime if there were concerns about an individual's weight loss or gain. New residents and those returning from hospital would be body-mapped to ensure good skin viability. Both fluid and food charts were kept for residents for whom there were concerns. The fluids' intake and output of two residents were being recorded daily. There were no residents requiring regular turning or having pressure areas. Some residents had special cushions and air flow mattresses to help prevent pressure areas developing.

Baths and showers were arranged according to residents' preferences – weekly, or more frequently if required. Four rooms in the home had en-suite showers and there were two rooms that did not have en-suite toilets. All taps were checked weekly to ensure that temperature-limiting valves were functioning appropriately.

To date, the home has had little dealings with Joint Assessment and Discharge Team but the team were advised that there were often issues with medication for residents returning from hospital; medication often had to be sent by taxi after the resident had returned, and paperwork could be sketchy or even missing. The home's policy was to accept discharges into the late evening as they appreciated the pressure on the hospital.

Staff

Shift arrangements provided for 3 carers to be on duty during the day and 2 at night. Additionally, there were 2 domestics from Monday to Friday and 2 hours' cover at weekends. Care staff carried out laundry duties. Agency staff were not used and, if it was not possible to cover sickness/absence with extra shifts, management staff were expected to cover.

Vacancies were advertised on the government website and interviewees were expected to provide references and to undergo DBS

screening with the cost of this being paid back following commencement of employment.

Staff meetings were held on a monthly basis, with a residents and relatives meeting being held every two months (attendance at the latter being quite low).

Staff had supervision sessions every two months, followed by annual appraisals. There were daily handover meetings between shifts for the sharing of information, in which all staff participated.

All mandatory training was undertaken, including Safeguarding, Mental Capacity and Deprivation of Liberty Safeguards (DoLS), and additional training was available. New staff would undergo a 2-day induction followed by shadowing permanent staff for 2-3 weeks. Most training was carried out face-to-face, but some distance learning modules were used; staff were able to carry this out off-site but would not be paid for doing so. The team suggested that the managers should check whether all training should be paid since failure to do so might be considered a breach of national wage requirements. A training matrix detailing all staff and training records was available.

It was confirmed that all care staff undertake Moving and Handling training and training in the safe management of medication. Medication round times were variable, depending on how much medication was dispensed. 2 members of staff undertook this to ensure that the trolley was never left unsupervised; the member of staff administering medication would ensure that it was taken before progressing to the next resident. Medication was checked against MAR sheets and monthly audits were carried out.

Whistle-blowing issues were dealt with locally with other external agencies being involved as necessary. The manager had an open-door policy and would record any issues raised by staff, residents and visitors.

Staff were wearing uniform and had name badges.

Staff views

The team were able to speak to one staff member, who had worked at the home for several years (others were engaged in carrying out their own duties). She confirmed that she felt supported by management and that she had undertaken training in dementia, MCA, DoLs, moving and handling and Safeguarding and that she understood the procedures. She confirmed that training was updated on a yearly basis.

The member of staff spoken to also confirmed that they had undertaken training in palliative care and end-of-life care and that they felt confident in those duties.

She confirmed that there was a 15-minute handover between shifts, with all outgoing and incoming staff involved to ensure all relevant information was passed on.

In the light of a recent D&V outbreak, the team asked about the procedure and were advised that affected residents were confined to the smaller sitting room. They were given a bland diet and plenty of fluids and were clear of infection within 3 days.

Drinks and snacks, e.g. crisps biscuits, chocolate and fruit as well as beverages and juices were available throughout the day and residents were reminded of the need to drink often. All residents took their meals in the dining room.

The team noted that the garden was small; it was unfurnished at the time of the visit but the team were told that the furniture was in storage for the winter period. Although many residents were unwilling to go out, some did, who also enjoyed going into the local park (which the gardens look out onto).

Views of residents' relatives

The team spoke to a relative of one resident, who advised that their relative had been in the home since October 2017. They were very

happy with all aspects of the care given - the home having successfully treated pressure areas which developed whilst in King George Hospital. This resident was not really interested in activities as she suffered from macular degeneration. There was a call bell in her room and staff responded when called and she had a named carer.

The laundry was very small but there appeared to be no build-up of dirty laundry and it was pleasing to note that bedlinen was drying outside – at the time of the last visit it had been draped over radiators.

Recommendations

There are no specific recommendations relating to the accommodation in the home.

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 20 February 2019 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.

healthwatch Havering

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**

Find us on Twitter at @HWHavering

healthwatch
Havering

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

Registered Office:
Queen's Court, 9-17 Eastern Road, Romford RM1 3NH
Telephone: 01708 303300

Call us on **01708 303 300**

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

Find us on Twitter at **@HWHavering**