Enter & View
Barleycroft Care Home

Spring Gardens
Romford RM7 9LD

29 March and
23 May 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 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.

Visits are usually announced in advance but, where the circumstances require, may be carried out without advance notice unannounced visits where it is considered appropriate.

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 is not compromised in any way.

Healthwatch has reported on visits to Barleycroft on several previous occasions: in March and September 2014, and in January 2016. A visit was also carried out in December 2016 but (for reasons beyond their control) the visiting team was unable to complete it and no report on it has been published.

This report arises from an announced visit carried out by Healthwatch members in March 2017 and a follow-up visit in May, which was unannounced. The March visit was intended to cover ground that it had not been possible to deal with during the unfinished visit in December 2016; the purpose of the May visit was primarily to follow-up the March visit.

About the home:

Barleycroft Care Home is now owned by the Abbey Healthcare Group, having previously been part of Festival Care Homes. It is a three storey, purpose-built home providing accommodation, nursing care and support with personal care for up to eighty older people. At the time of the March visit, each floor was designated to provide care for a particular group of residents:

Top Floor – Bonsai –	Nursing care
Middle Floor – Birch –	Nursing care for people living with dementia
Ground Floor – Beech –	Residential care (without nursing) for people living with dementia

This has since changed, as explained in more detail in the report of the May visit.

Barleycroft is located in a cul-de-sac road, not far from Romford Town Centre.

The building is clearly in need of refurbishment. Some work was being undertaken at the time of the visits but it was apparent that much remains to be done.

The visit in March

This report follows from the visit in December 2016; a new manager had begun work at the home that same day and, since it was clearly inconvenient for the visit to go ahead, it was postponed.

The team was met by the Deputy Manager, a registered nurse, who was about to interview a possible new staff member. As the Deputy Manager was at first unavailable, they began the visit unaccompanied. The team were concerned to notice an operating, wall-mounted heater without a suitable cover, which they were told had been removed for cleaning. They noted that there were a number of notices etc in the foyer, although the notice advising of the visit was not there but in a lift.

The team were informed that the Manager and her Deputy had worked together before at another care home.

The team were told that, although the home could accommodate up to 80 residents, there were 38 at the time of the visit, and that the nine residents normally accommodated on the second floor had been temporarily moved to the first floor to enable decoration and renovations to take place. The team were advised that the refurbishment was being carried out by two members of staff and an elderly relative of one of the residents.

During the visit, the team felt that the décor of the home needed attention. Although the bedrooms were acceptable and adequate, the communal areas and corridors were badly in need of attention, with the paintwork of the door frames and doors being very badly worn and all doors needing a metal guard at the bottom.

One bathroom had no working cold tap, there were no hand towels in another, and there were unpleasant odours in these areas, which were either without extractor fans or, where fitted, they were not working or very noisy and too loud to have on. Several bathrooms were clearly in need of cleaning and one toilet was out of use and had, apparently, been out of use for some time.

In the view of the team members, the dining room on the first floor left a lot to be desired. The kitchen floor appeared not to have been thoroughly cleaned recently and was dirty and greasy. The menu cards and table mats also needed a very good clean.

One resident who was seen had clearly been trying to eat her breakfast porridge for some time; the food had gone cold, the table was covered in it and much of it had spilt on to her clothing.

It was also noted that there were no duvet covers on most of the beds.

The team was told that Deprivation of Liberty Safeguarding statements (DoLS) were in place for most residents and that care plans were updated monthly.

Nurses and HCA's work 12 hour shifts with a half an hour for handover. Staff ratios were generally 1:5 residents, and never less than 1:4.

The deputy manager was unable to provide details of staff training arrangements.

The team were told that the Gold Standard Framework (GSF) for end of life care had been tried but found to be unworkable for the home.

One member of staff administered medication, which was audited daily by the home's management. A GP from a nearby practice was registered as the designated GP for the home.

The team was told that a resident had developed pressure sores but they were healing; the Tissue Viability Nurse was involved and a safeguarding report had been submitted. Residents confined to bed were turned every two hours. Falls management was being worked on and hip protectors were in use.

Nutrition, weight and fluid charts would be monitored when necessary, especially during the first week of admission to the home.

The home had a large number of visitors every week and staff meetings and relatives' meetings were held regularly.

Walking about on the ground floor (residential part of the home), the team spoke to the activities co-ordinator. She was employed part-time

and the other activities co-ordinator was on sick leave. The team felt that more activity could be provided to stimulate the residents.

It was noted that special occasions were celebrated and religious needs met.

Observations

The team formed the impression that the home lacked the resources (both human and financial) to carry out the degree of both current maintenance and refurbishment that appeared to be needed. The team also felt that there was a risk that some staff members lacked a sufficient command of English to enable them to communicate meaningfully with residents and visitors.

The visit in May

No advance notice had been given of the visit as its intention was to follow-up the visit made in March, reported above, when concerns had been noted in particular about the need for refurbishment of the home.

On entering the building, the team noticed that there was a stale smell. A bouquet of flowers was displayed in the reception area; the team were told that this had been sent as a thank you from a relative.

Despite the absence of advance notice of the visit, the team were warmly welcomed by the manager, who had been in post since December. Her registration by the CQC was still in hand (mainly owing to a number of changes in the information required), but was understood to be nearing completion. As noted earlier, the manager and her deputy had worked together in the past and appeared to have a good rapport with one another. Other staff included 9 registered nurses; 12 senior care staff; 36 care staff; an administrative assistant; a maintenance assistant; a housekeeper and 7 domestic assistants; 3 laundry assistants; 1 chef, 1 assistant chef and 5 kitchen assistants; and 2 activities co-

ordinators. When neither the manager nor the deputy is on the premises the senior nurse on duty is the nominated person in charge.

The visitors book indicated that there had been 120 visitors to the home over the previous week.

The team were advised that Abbey Healthcare has 15 homes across the country with 7 in London and the home counties for which the regional manager has responsibility. The manager advised that the regional manager had been visiting the home on a weekly basis, sometimes formally but otherwise on a 'drop-in' basis.

At the time of this visit, the number of residents accommodated had risen to 50 - 15 for residential care, 13 for nursing care and 22 living with dementia. Following recent fire training provided by an external professional and discussion with him, the manager had concluded that it was inappropriate for the most vulnerable residents (those receiving nursing care) to be placed on the top floor. Those residents were now accommodated on the ground floor, with residential care clients on the second floor and the others, those living with dementia, were on the first floor.

In response to a question about facilities for residents with communication difficulties, the team were told that there were currently no residents who were completely unable to express their wishes.

In response to a suggestion (made to Healthwatch by a member of the public) that residents living with dementia had been displaced whilst redecorations were being undertaken, assurance was given that no such residents had been displaced as the top floor had previously provided accommodation for residents requiring nursing care - all residents living with dementia were accommodated on the first floor.

At the time of the visit, there were no current respite admissions - there had been one but this had been converted to a permanent placement.

The manager confirmed that respite admissions were largely treated as if permanent, but with slightly less paperwork.

One resident had a pet bird and one of the activities co-ordinators would occasionally bring her dog into the home. It was confirmed that the dog has had all required inoculations and that most residents are very happy to see it.

Staffing

The shift pattern comprises 12-hour shifts, with a registered nurse on duty at all times (both the manager and deputy are registered nurses but are not included in this total). Since the manager took up her post there had been no use of agency staff, all cover being provided in-house. The manager was seeking to recruit two additional nurses and advised that, since joining the home, she had been able to negotiate additional pay for a number of staff.

One domestic assistant was allocated to each floor, each day for 7 to 8 hours, depending their contractual arrangements. In the view of the visiting team, this did not appear sufficient time given the number of rooms on each floor (30 on ground floor, 25 on each of the others), but they were told that this was the industry norm. Nonetheless, the team felt that as these staff were expected to clean all the rooms, bathrooms, public rooms and corridors, the time allocated was not sufficient to maintain a high standard of cleanliness, especially as their duties also included scrubbing hard surface areas and shampooing carpets as and when necessary.

The maintenance assistant had worked in a number of roles within the home and was expected to maintain the fairly large gardens as well as carry out all regular maintenance tasks (such as checking water temperatures; testing the fire alarm; and carrying out minor repairs). With a home of this size, the team felt that consideration should be given to providing more hours for this role or, alternatively, contracting

out parts of it, e.g. gardening, plumbing and electrical work to enable the maintenance assistant to spend more time on duties more compatible with her role.

The team were advised that the level of training when the manager took up post was comparatively low, at 39%; this had now improved considerably, to nearly 90%, and evidence of training arrangements was posted in the foyer. Training was by a mixture of e-learning and face-to-face training, with e-learning carried out on the premises (when any time spent is paid for) but those members of staff who undertook training at home did so in their time. The manager checked that training has been carried out. Training provided included first aid; infection control; fire marshalling; Mental Capacity and Deprivation of Liberty Safeguarding statements (DoLS); and end-of-life care (but not to GSF standards). It should be noted that, when carrying out observations during the visit, the team formed the view that not all staff were as familiar with infection control procedures as they ought to be.

Basic firefighting equipment was available and the manager told the team that a de-fibrillator might be useful. In that connection, the manager explained that she was ensuring that Do Not Resuscitate notice (DNRs) were available in all care plans if required.

Approximately 65% of residents have DoLS or were awaiting confirmation of them from the local authority. New care plans were being introduced.

MAR sheets were checked daily, and care plans and risk assessments were updated on a monthly basis as a minimum, and more frequently if required. The GP from the Lynwood Medical Centre reviewed medications as and when necessary.

'Flash' meetings were held daily for the manager and senior staff to meet to discuss any issues. Attempts at meeting with relatives etc had not proved successful so far, but it was hoped to arrange some special events to which relatives and friends would be invited.

The team were told that any falls were judged on an individual basis, as they could be due to infection rather than an underlying condition. Where a resident suffered several falls and there appeared to be no underlying condition, referral to the appropriate clinic would be made.

Referral to NHS111 or 999 would be dealt with by the senior nurse on duty and would be dependent on the particular problem. 999 would be contacted in the event of head injuries or apparent fractures but all others would be referred to NHS111 if the registered GP could not be contacted. The Lynwood practice provided a regular weekly GP surgery and details of residents who needed to be seen were faxed to the surgery each Wednesday as the GP would visit on Thursday or Friday.

The manager told the team that she had carried out a night inspection at 3am shortly after the team's previous visit and was had confirmed that staff were all present and correct.

Medication and healthcare

Medication was provided on a monthly basis and all unused items were returned once new supplies had been received. Only one resident was currently on controlled medication, which was checked at each handover.

In order to monitor nutrition, residents were weighed at least monthly - more frequently if there were noticeable weight losses or gains. A daily record of food taken was kept and any concerns would be referred to a dietitian. Currently, five residents required puree diets and there were a similar number who required assistance with eating. Finger foods were provided for those residents who lacked long attention spans and were unwilling or unable to sit at the table for long periods. Fluid charts were kept for residents for whom there were concerns about intake, or for at least week for new admissions.

In response to a question about bathing the team were advised that residents were offered baths at least twice per week and more frequently if they wished. However, some were unwilling and preferred to be washed and their wishes were respected.

A number of residents required turning and charts were kept recording those details. One resident had a bedsore, which was responding to treatment. All residents were body-mapped on admission.

In general, there were no issues with discharges from Queens Hospital.

Activities

In addition to the pet dog that attends occasionally, films (sometimes for reminiscence purposes) were shown weekly. Residents who wished to go to out had the opportunity to do so but were always accompanied.

Recommendations

The team that carried out these visits felt that the home was in need of thorough refurbishment. Accordingly, they recommend that:

- All communal areas and bathrooms be redecorated and modernised
- New furniture be provided
- Damaged paintwork to doors and frames be rectified and metal door guards provided. The colour scheme should provide contrasting colours for the benefit of those who live with dementia
- The large garden be given a reasonable makeover and safety check, that new tables and chairs be provided and generally tidied up
- Staffing levels for domestic tasks be reviewed to ensure that sufficient staff are available for the workload that is presented
- Extractor fans replaced to eliminate odours in bathrooms

In addition, it is recommended that:

- Steps be taken to ensure that all staff employed have a sufficient command of English to enable them to communicate meaningfully with residents and visitors
- More activities be provided for those residents who receive only residential care
- Staff training be reviewed to ensure that all have an adequate appreciation of infection control

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 visits on 29 March and 23 May 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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