healthwatch Havering

Enter & View

Barleycroft
(Unannounced)

Spring Gardens
Romford RM7 9LD

11 September and 1 November 2018

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 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 visits:

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.

We have visited Barelycroft several times in the recent past. We decided initially to carry out an unannounced visit in September in view of the nature of concerns expressed to us about the home; in the event, the team that visited then felt that a further visit would be necessary and this took place, again unannounced, in November.

Key facts

The following table sets out some key facts about Barleycroft. It is derived from information given to the Healthwatch team during the visit, and reflects the position at the time of the visit in November (except * below, which was September):

Number of residents/patients that can be accommodated:	80
Current number accommodated:	74
Number of care staff employed:	59
Number of management staff employed:	2
Number of support/admin/maintenance/activities staff employed:	14
Number of visitors per week:	163
Number of care/nursing staff spoken to during the visit:	5* and 3
Number of management/admin/reception staff spoken to during the visit:	2*and 1
Number of residents spoken to during the visit:	8* and 9

The home is arranged over three floors as follows:

Ground floor: nursing - 28 residents

1st floor: dementia/nursing -	27 residents
2nd floor: residential care -	18 residents
Total beds -	80 (7 vacancies)

Staffing is as follows:

Ground floor:	Days - 6 carers + 1 nurse
	Nights - 2 carers + 1 nurse
1st floor	Days - 6 carers + 1 nurse
	Nights - 2 carers + 1 nurse
	The nurses on this floor are registered dementia nurses
2nd floor	Days - 3 carers
	Nights - 2 carers

The ages of residents range from 60 to 93.

First unannounced visit: September

On arrival, the team were met by the manager and his deputy, both of whom had been in post only since June. Both posts were permanent. The manager advised the team that he was well aware of the shortcomings of the home and had been in dialogue with the local authority about how he intended to deal with the problems, admitting that it would take time to resolve them all. He explained that he and his deputy provided management cover between them but that, since his arrival, he had spent most weekends on site and had carried out five night-time visits, during which he had identified a number of problems which were currently being resolved.

He agreed frankly that, despite some improvements in the fabric of the home (including the replacement of some furniture), much remained to be done, including an urgent need to update the IT system. Alongside

this problem there had been some staffing issues with staff leaving as some were unhappy with his management style whilst others were being performance managed. Recruitment, as with many residential/nursing homes, was proving difficult - particularly of nursing staff. In order to ameliorate the problem of medication being dispensed by qualified nurses, he had arranged for a number of senior care staff to attend a Care Home Advanced Practitioner (CHAP) course (6 weeks at Mill Hill) to provide them with the skills to carry out this task.

There were no other Abbey Healthcare Group facilities in Havering, the nearest being Manor Farm in East Ham.

The manager confirmed that his regional manager (also newly in post) would visit every 2/3 weeks, when quality audits would be carried out.

A registered nurse was on duty on each of the nursing floors at all times. Where there was sickness/absence among nursing staff, locums are obtained from an agency - the only time agencies would be used. The manager told the team that he was trying to build up a bank base to cover vacancies etc where permanent care staff were unable/unwilling to cover.

The team considered that, since the last visit (in May 2017), the state of the premises had been improved but there remained a lot to be done.

Apart from pictures for food, there were no facilities for those residents with communication difficulties, although at the time of the visit there were no residents who lacked the ability to communicate with staff.

In relation to a comment about residents being moved between floors, the manager confirmed that this had only happened with one resident, who had been moved (with the support of their family) from the ground floor to the first floor because they were wandering and causing anxiety among other residents.

It was confirmed that respite residents were subject to the same assessment procedures as permanent residents and that the paperwork

used would be identical, although some points might not be relevant to short term stays.

Although there was no resident pet in the home, the manager confirmed that a therapy dog visited the home each Friday and family/friends were welcome to bring in well-behaved pets.

Staff

Full staff meetings took place every three months but 'flash' meetings were held on a daily basis to deal with immediate issues.

There was one member of cleaning staff on each floor, supervised by a housekeeper who would step in where necessary. In response to a question about a scrubbing machine, the team were advised that a replacement was on order.

One full time activities co-ordinator and one part-time (3 days) assistant were in post. Those staff provided cover from Monday to Friday, with weekend attendance for special occasions.

Training was largely carried out on-line, with some face-to-face sessions. On the day of the (September) visit, basic life support training was due to take place, and sessions in management of challenging behaviour were being arranged. Training was carried out on site or in employees' own time off-site (but no payment would be made for off-site work; the team pointed out that all training should be paid for as it was a requirement for employment and HMRC had been known to make enquiries about this).

The home had a whistle-blowing policy and there were posters appropriately placed for all to see. A dedicated external agency was not used.

There was a uniform policy and all staff seen were wearing badges. If a nurse was required to attend this floor, which is for residential care, a record of the circumstances would be made. Before the team entered

the home a male member of staff was seen to go to his car and it was noted that he was wearing Birkenstock-type footwear.

The uniform policy excluded the wearing of nail varnish and jewellery (apart from wedding rings). There was no indication of any staff wearing either of these.

Care

At the time of the visit, the home did not provide palliative care, but the manager was looking at training staff with a view to providing this service.

The manager advised that the home did not follow the Gold Standard Framework model for End of Life care, despite some staff being interested in doing so. However, arrangements were being made for advanced care planning training and a Do Not Resuscitate policy was in place. The home's GP (from the Lynwood Practice) reviewed those residents who were nearing the end of life and discussed their needs with all concerned. Fluids were never withdrawn.

The home did not have a defibrillator. At the time of the visit, one resident was a user of an oxygen concentrator but did not leave their room, so this did not present any risk problems for staff or other residents. A back-up cylinder was in the nurses' office, suitably fixed to the wall.

A considerable number of residents were subject to Deprivation of Liberty Safeguards (DoLS), most of which the local authority had confirmed. Response to applications was now much better than previously.

Care plans, MAR sheets and risk assessments were reviewed on a monthly basis, or more frequently if there were changes. The manager met the GP, who carried out a surgery each Friday, and the pharmacy reviewed medications. The pharmacist also carried out audits on medication.

Analysis of falls was included in risk assessments to ensure that any risks were mitigated as far as possible. A monthly report was prepared which included times, places, possible infections etc. All unwitnessed falls were reported to Safeguarding, in addition to those where residents suffer injuries requiring treatment. The NHS111 service would be contacted in all circumstances, except obvious fractures/head injury/heart attack/stroke when 999 would be called.

The manager advised the team that his attempts to arrange meetings with families had, so far, been less than successful, with only a few people attending; he felt that some relatives were not interested.

The manager and his deputy walked around the home regularly and carried out regular audits to ensure quality but attempts to involve families/friends had also so far proved unsuccessful.

Outbreaks of infection were dealt with by isolating residents and offering bland diets. The manager was well aware of the need to inform local authorities and the infection control nurse.

At the time of the visit, there was one resident with a pressure sore (which had been present on admission). This was being dealt with by the Tissue Viability Nurse, with whom there was good rapport.

Access to the usual paramedic services was via the GP. In addition, chiropody, dental and optical services attended on a regular basis. Additionally, an aromatherapist and hairdresser attended the home.

Residents were weighed on a monthly basis, unless there was concern about weight loss when it accelerated to weekly. Food and fluid charts were used as and when necessary. A number of residents required pureed food and assistance with feeding.

Residents were encouraged to bathe or shower as often as they wanted although some preferred to have all-over washes. All taps throughout the home were temperature controlled and these temperatures were checked weekly.

Up to four residents required regular turning and charts were in operation to ensure that this was carried out.

The manager confirmed that he had experienced no problems with Joint Assessment and Discharge Team. His cut-off time for admissions was 6pm but he appreciated that there were sometimes difficulties and he was always prepared to be flexible with later admissions. He reported that only once had a resident been returned to the home after midnight, and that was a return from the A&E Department. The home has been provided with two red bags to participate in the Red Bag Scheme but had yet to use them. It was thought that with a home the size of Barleycroft, two bags might not be sufficient, particularly where the resident remained in hospital for a lengthy period.

When asked about possible improvements to improve the efficiency of the home, the manager felt that staff co-operation was important but he felt the they were now getting used to him and that progress was being made.

Case notes were stored on shelves in the staff room which was accessed via a coded lock.

The premises

The team were surprised to learn that there was no IT facility on the individual units; staff had to go to the ground floor to make any entries on the system.

The lobby was clean and bright and there was no evidence of odours. Although the deputy manager's office was signposted, that of the manager was not. However, his office overlooked the lobby and he was able to see all visitors/staff who entered. There was no formal reception, despite the fact that the administrator's office led off this area. There were notices in this area detailing on-call staff, the process for 'clocking-in', information about training, details of a coffee morning that had been arranged, a staff communication box and a suggestion

box. As this was an unannounced visit, there was no Healthwatch poster on display. The area had recently been decorated. It was noted that a radio was playing.

The ground floor (nursing) appeared to be clean and tidy and comparatively well-decorated. The sitting room leading out to the garden had been decorated, re-carpeted and re-furnished since the last visit.

The extractor fan in the shower room appeared to be out of order.

In the garden, the lawns were becoming overgrown and needed to be mowed as a matter of urgency. There were few chairs/tables etc. for the use of residents and the flower beds were in very poor condition.

The laundry was well-equipped, with a separate machine for soiled linen (very good practice) and a dosing system for soaps etc. There was reasonable space for hanging garments and there was a basket delivery system in operation. Because of the design of the department it was not possible to provide strict separation between clean and dirty areas, but it was reasonably arranged. The laundress said that she was under pressure to complete all the laundering required in the hours provided and that she had requested assistance which had not, as yet, been forthcoming. However, the hours she was allotted seemed similar to those provided for this service in similar sized homes.

The 2nd floor was visited and it was noted that the sitting rooms appeared to be rather dull with few pictures to brighten the areas up. The dining room was bright, clean and homely and there were pictures on the walls. There were a number of flags and England bunting hanging here (following the recent World Cup tournament). It was noted that the table mats were in need of cleaning/replacing. There was no evidence of menus on tables or on walls. There were a number of books and CDs provided in this area. The day was hot and the windows were open and there was an upright fan to provide further cooling.

The corridors on this unit needed re-painting, with evidence of paint peeling off. The condition of all flooring was good.

In the assisted shower room, it was noted that the sink plug hole needed cleaning but that there was no evidence of scale build-up.

In the main kitchen it was noted that there were out-of-date yoghourts in the fridge; this was pointed out to the cook who immediately disposed of them. There was a four-weekly menu available in the kitchen. The dishwasher was not working (but it has subsequently been reported that it has been attended to and is now working).

The residents

Residents all appeared to be clean and appropriately dressed but there was no evidence of activities or stimulation apart from the TV, which was being viewed by some residents. Staff appeared to be treating residents with respect but, following an altercation between two residents about armchairs, one of the ladies was berated by a senior member of staff in front of other residents: it was felt that, if even necessary, this should have been a private matter. There did not appear to be any information board detailing activities. In the small kitchens off the lounge it was noted that the water machine was not working and that the floor needed to be scrubbed (the scrubbing machine was being replaced).

Those residents spoken to appeared to be accepting of living in Barleycroft, although they would like more activity and stimulation. However, one resident complained that he had to use a bottle as he is unable to flush the toilet. The team considered that this was not acceptable.

Second unannounced visit: November

On arrival, the team introduced themselves to the manager (whom they had met on the previous visit).

Although the manager was surprised by this unannounced visit, he was very hospitable and raised no objection to the visit taking place.

The team split into two to visit areas that they had not been able to cover previously; the other member of the team spoke briefly to the manager, staff and residents and then carried out a number of observations.

On speaking with the manager, the team came to the conclusion that he had started to make a real improvement – on arrival, the team had noted that there was a very large skip at the front of the garden which was overflowing with broken wheelchairs, old chairs and general rubbish; they were told that it was one of many he had hired. It was apparent that work in the garden was on-going, with decking being repaired and taped off.

The manager told the team that he had undertaken five, unannounced night time visits so far, on average one a month; and various staff were being performance managed. The home was seeking to recruit a further Maintenance Assistant.

The team noted that staff and residents remained basically the same as at the time of the previous visit, on 11 September, and the residents across all floors again were more or less the same.

The home was still in the state of some disrepair but the team did notice some improvements and were advised – and saw – that new mattresses, bed linen and pillows had been acquired (although not yet distributed).

The team also noted that a member of staff was being paid to come into the home at weekends to paint the walls.

Some laminate flooring had been put down, and more rooms and corridors were still to be attended to; once done, this work would help will alleviate the odours emanating from certain rooms (these odours were overpowering; when drawn to the attention of the manager, he asked a member of staff to investigate). The odour in the green lounge was particularly strong, no residents were using it and chairs were aligned around the walls of the room – not at all stimulating.

The team were told by a resident (who had been spoken to during the September visit) that the toilet in his room was still out of order for some 8 weeks. With the resident's permission, a member of the team investigated and found that the flush mechanism was broken, and that a plastic box had been placed on the floor at the back of the toilet to catch drips. The resident informed the team that he had to relieve himself into a bottle and promptly showed it to them. The content was very dark and this was bought to the carer's attention, as that could be indicative of dehydration. The team also informed the Manager, who was aware of the situation and told them that the resident in question did have use of the Residents' toilet near his room.

The team were not encouraged to learn from the maintenance operative that he was still awaiting a replacement part for the defective toilet mechanism before he could repair it.

Although the dishwasher had been repaired in the main kitchen, a pile of washing up in the sink was observed, posing a potential infection risk.

It was noted all food in the kitchen was in date. The two kitchens in the dining rooms were due to be updated, which the team felt was urgently needed.

Staff to whom the team spoke said that they were still getting used to the new manager's approach. It was said that several staff had left because of this but some staff spoken to advised they had found the

manager ready to take action without necessarily awaiting head office approval, and others seemed happy with the new management.

A Housekeeper was now employed (but the team found it difficult to communicate with her) in addition to the three domestic staff.

At the time of the visit, fire alarm contractors were carrying out their six-monthly check on the fire system, which appeared to be in order.

Activities

A four weekly activities planner was displayed on each floor, a Resident of the Day would be given special treatment, and a pat dog would be brought in once a month. A volunteer was due to start as a befriender to the residents. Students also attended to shadow staff and learn awareness of elderly people.

Although the team was told that available activities included dancing, singing, quizzes, film shows and, from to time, a visiting choir, no activities were taking place at the time of the visit and there appeared to be a general lack of stimulation, which residents to whom the team spoke confirmed. However, there was evidence that Halloween celebrations had been taking place. A copy of the Activity Planner for the week of the visit is appended to this report.

The Activities Co-Ordinator worked 4 days a week, with an Assistant working 3 days a week. The Activities Co-ordinator had over 30 years' experience in the care of the elderly and specialist training in dementia care and sensory awareness; team members were concerned to note, however, that the Co-ordinator did not seem to know her way around although she had been working in the home for a number of years.

Conclusions

As the home was left in poor condition for a number of years with numerous changes of manager, staff had become less diligent and the

home had fallen into disrepair. It was clear that, although in post for a relatively short time, the new manager had made considerable efforts to bring the home up to an acceptable standard. While there remains a way to go, the manager deserves congratulation for having taken "the bull by the horns" to re-impose effective staffing and physical improvements. Healthwatch trusts that these efforts will continue.

Recommendations

The following recommendations are made following both visits:

- That urgent attention be paid to the various maintenance issues referred to in this report, in particular the need for repair of one resident's toilet (knowingly to take in excess of eight weeks to do this is simply unacceptable)
- That the IT system be upgraded and extended to provide access on all floors
- That consideration be given to enhancing the availability of cleaning staff. Relying on one person to clean 28 rooms, as well as communal areas, bathrooms and corridors does not appear to accord with best practice
- That if it is not possible to arrange gardening duties with existing staff, consideration be given to contracting this service out. It is detrimental to residents not to be able to use the gardens in a safe condition
- That funds be sought for extensive re-decoration/refurbishment of the home, paying particular attention to colour schemes, especially on the dementia unit
- That menus be displayed in all dining rooms
- That staff training be given in providing appropriate assistance to residents who are unable to use the toilet unattended

- That communication material be provided for those residents who are unable to communicate verbally
- That urgent attention be given to the lack of stimulation for residents
- That urgent attention be paid to the plumbing of the home, including extractor fans, taps and wash basins
- That kitchens be improved as a matter of urgency
- That, when the dementia floor is redecorated, the door frames be decorated in colours contrasting with those of the walls

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

Disclaimer

This report relates to the visits on 11 September and 1 November 2018 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.

Appendix – Activity Planner

ACTVITY PLANNER 29thOCTOBER- 4TH NOVEMBER

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Suite Bonsai 2nd floor	9 LETTER WORD FUN QUIZ	DANCING STYLES QUIZ DECORATING DINNING ROOM HALLOWEEN	TALKING ABOUT HALLOWEEN HOW IT STARTED HALLOWEEN QUIZ	SWEET TROLLY	Pat a dog FILM SHOW	Watching movies	Word search quiz one 2 one
Birch 1st floor	SENORY GAME REMINISENCE TO FAVORITE SONGS With staff	COFFEE SOCIAL MORNING	HALLOWEEN TEA PARTY	SWEET TROLLY Manicure Arom hand massage	Pat a dog one 2 one FILM SHOW	LISTENING TO FAVORITE SONGS A SINGALONG	Manicure ONE TO STAFF
rBeech Ground floor	SINGING FAVORITE SONGS	ONE TO ONE WITH RESIDENTS IN THEIR ROOM	One 2 one with residents in rooms (Jo pm)	SWEET TROLLYONE TO ONE WITH RESIDENTS IN THEIR ROOM	Pat a dog (Julie am) Film show (Julie pm)	Reading papers	Manicure ONE TO ONE

Thursday Hairdresser all day Note all activities are subject to change

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

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Havering

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