healthwatch Havering

Enter & View

Faringdon Lodge

1 Faringdon Avenue, Harold Hill

Romford, RM3 8SJ

8 October 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 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 Faringdon Lodge. 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:	23/28
Current number accommodated:	22
Number of care staff employed:	18
Number of management staff employed:	2
Number of support/admin/maintenance/activities staff employed:	5
Number of visitors per week:	40
Number of care/nursing staff spoken to during the visit:	3
Number of management/admin/reception staff spoken to during the visit:	1
Number of residents spoken to during the visit:	5

The visit

The team were met by the manager, who advised that she had been in post since 2015. She was supported by a deputy manager and, between them, they provided 24-hour cover to the home - either on the premises or by telephone. The manager explained that she had no administrative support and that she and her deputy carried out all administrative duties. The team felt that it was clear from what they saw that she carries out her duties very efficiently - in early October she had already

arranged Christmas staff rotas and menus (which were imaginative and unusual).

The Premises

Faringdon Lodge is a 28-bedded home situated on the edge of a busy industrial estate. The home has space for up to 8 cars, and on-street parking is unrestricted. Whilst the home is registered for 28 residents, only 23 places were usually available as 5 of the rooms were double and could only be used for couples - if appropriate. The home was registered for dementia care and all residents required that level of support.

At the time of the visit, there were 22 residents, with 1 vacancy. The home offered occasional day care. The client group was frail elderly people living with dementia, the oldest resident being aged 102. The same criteria for assessing potential admissions would be applied whether care was permanent or for respite, with 7-day care plans for respite residents.

The home was clean and tidy, and bathrooms were all clean with no evidence of limescale. A couple of toilets were a little smelly, and one room did not appear to have a notice about hand-washing. Some carpets in corridors were stained (but the home subsequently dealt with them). An external company attended on a regular basis to shampoo the carpets.

Generally, there was plenty of information in the form of notices, giving details of meetings newsletters, future events, movie nights etc. and Health & Safety legislation.

Toilet seats were coloured, as is good practice when working with people who are living with dementia. The laundry was well equipped with colour co-ordinated bins for various types of clothing and baskets for clean clothing to be returned to residents' rooms.

There was a picture of the manager in the dining room.

Care of residents

In response to a question about communication with residents who were unable to speak about their needs, the team were advised that "easy read" booklets had been tried but had not proved successful with current residents. Most residents were able to make themselves understood by making gestures, and staff members were usually able to anticipate residents' needs.

To meet residents' spiritual needs, one local church attended to administer communion on a regular basis. A few adherents of other religions are also accommodated in the home.

In respect of Deprivation of Liberty Safeguards (DoLs), the team were advised that five were in place.

The manager showed the team a blank care plan (which she had developed). Care Plans, risk assessments and MAR charts were reviewed monthly or sooner if appropriate, e.g. in the event of falls. MAR sheets were audited on a weekly basis.

In common with many other homes, the manager had found it difficult to encourage friends and relatives to attend meetings despite offering incentives (such as cheese & wine). However, there were a few families who were always willing to attend to give feedback. Residents' meetings were held every 6 weeks and menus were reviewed at these meetings.

In order to monitor quality, the proprietor visited alternate months and survey questionnaires were distributed to relatives, staff and professional visitors twice a year. The proprietor provided feedback on the day of the visit and expected - and would get - immediate responses to any problems. Safety issues were dealt with immediately.

Personal protective equipment was provided for staff and, if there were an incident of norovirus, the affected resident(s) would be isolated as far as possible. If more than 3 residents were involved, the outbreak would be reported to the relevant authority. Staff who experienced

their own symptoms of norovirus were required to stay away from work for 48 hours after becoming clear of infection.

All falls were reported to the manager who kept a detailed record of the circumstances in order to assess appropriate action. Pressure mats were available when necessary.

When asked whether 111 would be contacted in preference to 999, the manager said that she would use the 111 service but commented that recently she had contacted 111 for what she thought was appropriate to that service, only to be told to ring 999. In normal circumstance 999 would only be used in the event of a head injury or obvious fracture. In the last 4 weeks, seven 999 calls had been made with 5 residents being taken to hospital.

Drugs were stored in 2 trolleys in cupboards and controlled drugs were stored in a specialist cupboard. Currently, there was only 1 resident on pain relief patches. No residents were currently on covert medication, nor was anyone on warfarin or self-medicating.

The assigned medical practice provided a weekly GP surgery to the home and would also attend outside of that if necessary. The manager felt that the assigned GP had a good understanding of dementia.

Physiotherapy would be arranged through the GP, and an arrangement was in place for an optician. No formal dental care was in place but a chiropodist called every 6 weeks, and a hairdresser called weekly.

Residents' nutrition was monitored by regular weighing, usually monthly, but weekly if that appeared to be necessary. Food and Liquid charts were utilised as necessary and BMI indexes were checked as a guideline. Only 1 resident required a modified diet though some residents would require prompting. Finger foods were provided for those residents who found it difficult to sit down with others to eat.

The home took a person-centred approach to bathing and showering (rooms only had en-suite toilets and wash basins). Residents were encouraged to have at least one shower or bath per week but some liked

to do so daily. All taps in residents' areas were fitted with controlled valves which were checked on weekly.

At the time of the visit, no residents were bedfast or required regular turning, and there were no cases of pressure sores.

The cook was appropriately dressed. There was a 4-week menu and residents completed their choice by 11.30am each day. All food was cooked fresh and there was evidence of plenty of fresh fruit and vegetables being available. There was no dishwasher but the cook on duty did not appear to regard this as a problem. When asked about residents with allergies, staff advised that there were none at the time of the visit. Meals were taken in the dining room and the cook went around after breakfast to take orders for lunch. A cooked breakfast was available at weekends.

There appeared to have been little interaction with Joint Assessment and Discharge scheme although the manager did say that there had been some residents returned home from Queen's Hospital in the early hours (possibly because they who had been sent to A & E but had not needed to be admitted and were therefore returned home as soon as possible). The manager understood the demand for beds at the hospital and was flexible about times for new admissions, although she preferred them to take place before dark, given the nature of the residents. She confirmed that relatives were always informed when a resident was attending hospital.

The team members who toured the home noted that there was a key worker system in place and that key workers' names were on each resident's door.

Drinks and snacks were available on demand and were offered on an hourly basis to ensure residents were sufficiently hydrated. Residents who were vulnerable to pressure sores would be turned every two hours and checked daily. Families and/or staff took residents out, weather permitting. Staff had no concerns about the care provided at the home.

All residents were properly dressed and well-groomed and it was felt the they were treated with respect and that there was a happy atmosphere in the home. There were no residents in their bedrooms.

At the time of the visit residents were having tea and were offered biscuits, toast and bananas.

Staffing

Absences due to sickness/annual leave etc. were all covered in-house; it had not been necessary for agency staff to be used for more than 2 years. The staff base was very solid, with no vacancies at the time of the visit. Shift patterns were: days: 8am-2pm, 2pm-8pm and nights: 8pm-8am. There was a 15-minute handover between day and night shifts and staff involved in this were paid appropriately. Staff meetings were held on a bi-monthly basis, or ad hoc if required, with separate meetings being arranged for night staff, who may also attend day staff meetings if they wish to do so.

The home employed a maintenance assistant for 2 days per week - the remainder of his hours being spend at Meadowbank, the sister home in Upminster. Additionally, there were 2 housekeepers and one laundry assistant each day. 3 cooks covered the kitchen between them. Additionally, there was an activity co-ordinator who worked from 9am-12noon each weekday; care staff helped provide activities during the afternoons. Students from the Sixth Form College undertaking work experience had proved successful and the team were gratified to learn that these students were paid an hourly rate. There was an activity rota which the manager described as “loose” due to the nature of residents. Activities offered included arts and crafts, nail care, hand massages etc. Outings were arranged to local shops and restaurants, and canal boat trips and trips to the seaside had also been undertaken. Residents celebrating special occasions always had a party and a dedicated cake.

The usual schedule of training was undertaken, with COSHH training taking place during the week of the visit. Training was often undertaken

in conjunction with the sister home Meadowbank and was on a face-to-face basis. Staff were paid for training undertaken outside their normal shifts. Palliative care was provided by an external agency within the home and all staff had undertaken appropriate training, including End-of-Life training. The District Nurse attended daily as there are two residents who were living with diabetes. The home did not carry any equipment requiring specialist knowledge.

There was a whistle-blowing policy, of which the manager reminded staff at every meeting.

There was a uniform policy and all staff had name badges. There was no evidence of staff wearing nail varnish or inappropriate jewellery.

The manager advised that she carried out about four visits at night during a year, each at different times: the last had taken place on 15th September, at 3.30am. The manager confirmed that she had never identified anything untoward and that she had confidence in her staff.

Staff views

Staff spoken to said that they felt supported, that they had had dementia, mental capacity and DoLS training within the last year and that other training included Safeguarding and End of Life as well as other statutory issues. Training was sometimes done in staffs' own time but on a paid basis. Sometimes booklets were issued about training. Staff had supervision on a regular basis.

Staff confirmed the information about infection control and medication that had been given by the manager; they also confirmed that they changed uniforms on entering and leaving the building.

Residents' views

The team spoke to some residents who were able to understand. They said they were happy in the home and felt safe there, that the food was good (although one resident expressed a wish for a greater choice of food), and that plenty of drinks were offered. There were no adverse comments about staff - one resident described them as "lovely".

Call bells were available in each bedroom.

Recommendations

- That, in view of the fact that some visitors do not appear to sign in, it was recommended that a notice be put up in the hall asking that this is done to comply with fire regulations. It was noted that one visitor with a learning disability who attended twice daily did not sign in; the manager said she would ask staff to do this on his behalf.
- That, when arranging redecoration, consideration be given to rendering that door frames in a contrasting colour to the surrounding walls.

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 8 October 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.

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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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