healthwatch Havering

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Enter & View

Hillside Nursing Home
(Third visit)

North Hill Drive, Harold Hill,

Romford, RM3 9AW

2 May 2018

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
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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.

Having met the new Manager together, the team split into two groups – one group interviewed the Manager, while the other toured the home to talk to staff and see the residents.

The Manager had been in post since November 2017, having come from the Thurrock area. She had quickly realised that there were issues requiring her attention and she had been working long hours. At her request, a post of Deputy Manager had been created and filled; the Deputy covers during the Manager's absence and is a qualified nurse.

The home had recently been broken into, in consequence of which CCTV cameras had been installed. There had also been some difficult staff disciplinary issues, now resolved.

The Premises

The capacity of the home is 55 but, at the time of the visit, there were 47 residents.

Since the previous Healthwatch visit, new chairs had been provided and the home was clean but the team's impression was that it did not feel 'homely'.

All heaters were suitably guarded.

The toilets and baths were clean.

There were no unpleasant odours but the living areas were not bright and cheerful. Most walls were painted in magnolia.

All white goods in the kitchen appeared to be in good working order. The team were unable to view food being served as it was too early and, for reasons outside the manager's control, there were no menus available.

The laundry appeared to be well equipped.

The garden areas were accessible but those to the front of the building were unguarded and it was, therefore, not possible for residents to use them unless members of staff were available to be with them. The central courtyard was safe but appeared dingy and the furniture was very old. Some attempt had been made to provide colourful flower display in the raised beds.

Staff

Day staff comprises 2 nurses, 2 seniors and 6 carers; at night this reduces to 1 nurse, 1 senior and 4 carers. Agency staff are used if necessary, with 8 bank staff available. Shifts run from 8am to 8pm with a one-hour break, 8am-2pm, 2pm-8am and 8pm-8am, all with a 10-minute handover. Staff meetings are held on Friday and the Manager was seeking to establish them on a monthly basis. An open-door policy operates. The Manager plans to establish meetings for key workers. Residents all have a named carer, who is introduced to them on admission.

Ancillary staff comprise a laundry person, a cleaner, 3 maintenance operatives, an activities co-ordinator (currently working Monday to Friday, with an additional member to be appointed), a kitchen chef and a kitchen assistant.

All training at present is in-house including e-learning, is paid and the targets for care staff are NVQ levels 2 and 3.

One nurse is trained in palliative care, with the others undergoing training with the help of St Francis Hospice. Training for emergencies needs attention; no defibrillator is available.

Staff confirmed that they wear uniforms once before laundering - it was not clear whether they were personally responsible for this.

Staff had name badges and uniforms. The team did not see any member of staff wearing jewellery or nail varnish.

A whistle blowing policy is in place, and there is a notice to this effect on display.

Care

35 (of 47) residents are subject to Deprivation of Liberty Safeguards DoLS).

Quality issues are recorded on a computer system, which uses a traffic light system.

Falls Management is in place with medical reviews, infection checks, and bed rails as a last resort. GP services are provided through Health 1000 at King George Hospital, Goodmayes.

The use of care plans and MAR charts is under review.

The Manager told the team that there had been communication difficulties between residents and staff so she had put in place training for all staff to deal with hearing, easy read and dementia. There is always a registered nurse on duty.

Drugs are stored securely in lockable cupboards. There is a nurse in charge on each floor and drugs are checked at every shift handover. Medication rounds take about one hour, a tabard is worn by staff on medication duty and they ensure that residents take their medications. The team were told that the home has experienced problems with medication when residents have been discharged from hospital, and

that residents have also been discharged without appropriate medical notes. The home will take late discharges, but reluctantly.

At the time of the visit, only one resident was being treated for a pressure ulcer, with daily monitoring, and a pressure mattress and a chart for repositioning. The policy is for residents who may present with ulcers is to have food and fluid charts kept and for dietary advice and tissue viability advice/treatment to be sought.

The nutrition of residents is being reviewed and changed – and training for staff on feeding is being improved. There are always two choices of menu. At the time of the visit, nine residents needed to be fed or to be assisted with feeding. Residents are weighed monthly with referral to a dietician if necessary. There are fluid and food charts for the residents who need them.

At the time of the visit, there were no residents with special dietary requirements for reasons of ethnicity or religion.

Showers or baths are available weekly or as necessary. Water temperatures are tested regularly. There are some residents who need turning and this is monitored by liaison with district nurses and TVN. Air mattresses are used. Most residents are persuaded to leave their beds for exercise or activities.

It was confirmed that a hairdresser visited the home but those residents to whom the team spoke did not avail themselves of the service - one person was taken out to the barbers and the second no longer wished to have her hair done.

The team were told that the home had found that working with the Joint Assessment and Discharge team could be difficult.

All residents appeared to be appropriately dressed and were treated with respect, but there did not appear to be a happy atmosphere - residents were just sitting around. The TV was on but no-one was watching it. They did not see any information about social events.

Activities at present include a Knitting Club, Bingo, Jigsaws, liaison with Drapers' Academy (visits, and 2 residents have pen pals so far) church services. The team suggested that consideration be given to offering residents chair exercises as most activities are sedentary.

The team discussed with the Manager the need for residents to get outside and how the front garden could be made safe with fencing and gates, for which she was seeking funding. The inner courtyard garden was secure but appeared very shabby and needs attention

Views of residents, relatives and staff

The second group of members from the team toured the home. They noted that the activities lady was only able to spend two hours per day in each of the three lounges but were advised that a second activities person has been appointed and was due to commence shortly. During the visit it was noted that a relative arrived with their dog and all residents present were happy to see it.

Staff to whom the team spoke were both trained in dementia, mental capacity and DoLS and had also undertaken Safeguarding training. Staff to whom the team spoke felt that they had received adequate training to care for dying residents and confirmed that their training was updated on a regular basis. There is a 15-20 minute handover between shifts when information about residents can be passed on to the new shift.

When asked about infection control, staff advised that barrier nursing is undertaken and is the subject of a monthly audit. There was evidence of hand-cleansing dispensers and signs around the building. The local authority would make decisions on whether to limit visiting if there were an outbreak of infections such diarrhoea and vomiting.

It was noted that dining tables were appropriately laid (it was later suggested that this happened because of the visit - apparently some residents throw things!) but residents could stay in their armchairs should they wish to do so. There is a choice of food and residents could

point to their choices if they found communication difficult. On the floor visited, 11 of 26 residents required assistance with feeding. The team were advised that snacks were available throughout the day (sandwiches etc) and that beverages were offered on an hourly basis.

Most residents are the subject of DoLS and can only go out accompanied by a member of staff or a family member or friend.

When asked if there was anything they would like for the home they asked for new curtains.

There were a number of comments from residents/relatives etc.

Most appeared to be happy at the home and with the choice/quality of food offered. One visitors said that he has a meal each day for which he pays. In general, it was confirmed that drinks are offered on a regular basis. Residents who were spoken to confirmed that there are a number of activities but that residents who wished to be left alone were respected, and that staff responded promptly to calls for assistance. It was noted that call bells were available and were working.

Residents and their families appeared to be involved in decision making.

There was music playing in the first floor lounge but no other activities were observed to be taking place during the visit.

The team visited the first-floor lounge, which also had 3 tables laid with flowers and set for lunch. The first floor was occupied mainly by residents living with dementia but also for those with physical problems that needed 24 hour attention. The team met a qualified nurse and an activity coordinator told them that she only had time to arrange activities for 2 hours per lounge a week, the home having 3 lounges. They both told us that they had safeguarding training and also trained in looking after dying residents. They both said their uniform, which they had to buy, was changed daily

The team were told there was a choice of menu and that drinks, biscuits and sandwiches were available at all times. Liquids were offered hourly and also they anticipated the needs of residents.

Concern was expressed about a lack of wheelchairs to enable residents to be more mobile, especially for those who needed a more specialised type for their needs, which had to be funded by relatives or friends. Referrals were made to Havering Wheelchair Service, which can supply basic chairs if necessary.

The team also spoke to three relatives who were visiting, and had quite varied comments, from being very pleased with the care and food in the home, to one woman mentioning that her husband had not been washed "again" and another stating she did not think her husband had been given a drink as there was no cup or glass in his room. They all said they felt the home was safe and felt involved in decision making.

The team then visited the ground floor, where they came across a resident who was very distressed in bed as she had called for help in going to the toilet, but nobody had come. The team immediately found a care assistant, who went to her aid.

The team was unable to visit the kitchen as the staff were busy preparing meals for the lunchtime service. It was not possible to view any menu.

The laundry was visited; it looked very well organised with cubby holes for each resident's items.

Overall, the home looks clean but institutionalised and bland, with nearly all walls beige. It would be improved with some colour. Also chairs in the lounges were mainly against the walls with residents looking into space and not talking to each other, whilst a TV was on with nobody watching it. No information or posters were seen about any social events or activities, but a board about activities was set up in the foyer by the entrance to the building.

Conclusions

The team considered that the Manager was aware of shortcomings in this home and that there were a lot of issues for her to deal with. Some aspects of the home required attention: for example, the spacious front garden needed to be made secure for residents to use; this would help the Manager's desire to connect the home with the local community. Some money needed to be spent on the inner garden, which could be a good social area for residents in the warmer months; perhaps some residents could be involved in the gardening (there are raised beds) under the supervision of the Activities Co-Ordinator.

More staff needed to be employed so that the residents (especially bedridden ones) could have the attention they need and could feel engaged. The named carer and resident link needed to be strengthened.

Recommendations

That:

- The system of named carers be firmed up so that residents are aware of their named carer
- Staff rotas be arranged so that named carers are rostered to work within their residents area
- Menus be available in all dining rooms
- Efforts be made to provide secure fencing to the front of the home to ensure that residents my use to gardens in a safe environment
- A more imaginative decorative colour scheme be introduced, ensuring wood and walls are of contrasting colours in accordance with good practice when caring for those living with dementia.

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 26 April 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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