Enter & View
Little Gaynes
Residential Care Home

12 April 2016

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.

Background and purpose of the visit:

Healthwatch Havering (HH) 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.

Management of the home

On arrival, two members of the team met the manager and the other two walked around the premises to observe and talk to staff, residents and visitors.

The operations manager told the team that the owner visits the

premises daily, supporting its management and maintenance; they had the opportunity to speak briefly with him as well during the course of the visit.

The previously registered manager had now left the home, following long-term illness, and the operations manager was currently temporarily in charge, with a colleague, and with the owner's help. There were plans for a new manager, a trained nurse currently working in the home for three days a week (and the niece of the owner), to become the manager in August 2016. Once in post, she will apply for registration with CQC. The operations manager, who had managed another home for many years, works two days a week (but is on call at other times) and is not registered as manager by the CQC.

The operations manager expressed commitment and enthusiasm for running the home, and told the team that she was making changes and improvements to bring the care home up to standard and planned to remain working in it part-time there when the new manager had taken over.

General description of the home

At the time of the visit, there were 17 residents, with another due to arrive in the coming week. Most residents had some form of dementia, Parkinson's disease or chronic diabetes, and one resident was blind. All rooms were in single occupation. One resident was subject to a Deprivation of Liberty statement (DoLs) as she was prone to disruptive behaviours.

The home is a converted corner house with a side extension, on 2 levels. The bedrooms in the older part of the house do not have en suite facilities: their residents have commodes in the rooms; bedrooms in the extension of the house did, however, have en suites. On the upper level there is a small office for the manager. All communal areas

are on the ground floor.

Most residents who have rooms on the upper floor are brought downstairs each morning. Staff cover both floors and residents are checked regularly when in their rooms during both day and night. Alarmed floor mats are available as well as alarm calls next to beds.

In the small entrance foyer, there was a very small notice board; although there was a notice on the board with photos of staff members, no names were shown of the staff members. There was also the latest CQC inspection notice, a Fire Risk Assessment notice dated 2001 (however, during the visit, a fire officer was seen speaking to a member of staff in the dining room and the team were told later that he was doing a risk assessment) and a certificate from the Environmental Health Service showing a 5 star rating for food and hygiene following an inspection carried out in February 2016.

The team was shown into the sitting rooms, which were warm, comfortable and decorated in sitting-room style with comfortable chairs along the walls. Two rooms were relatively small – long and thin with chairs along the walls on either side. In the front sitting room, the television was on but the three residents were dosing in easy chairs in this room and did not appear to be watching TV. In the middle sitting room there were three more residents who also were sitting in easy chairs. To one side of this sitting room was a small table, which was laden with four covered juice and water jugs together with several glasses.

Shortly after the visit began, a carer entered the sitting room with a tea trolley and started serving residents tea, coffee and biscuits. One resident was unable to drink unaided and so another carer stayed with her to make sure she could drink. In the third sitting room, six residents were playing cards, aided by the activity coordinator who called out card names while the residents checked whether they had those cards.

Other residents were sitting in easy chairs around the room and were also participating in the game, including one who was blind and was being helped by another carer to join in. When one of the players had won the game, she was given a little teddy bear as a prize. The game was suspended while tea and biscuits were served. The relationship between residents and carers appeared very good.

There is a relatively large, south facing walled garden with a level path around it. None of the residents were in the garden. The garden furniture, consisting of several comfortable chairs with arms and a large table under a large fixed awning, was stacked for winter storage. The team was told that residents were welcome to have afternoon tea in the garden if the weather was suitable but would not usually go out into the garden until about June, as earlier in the year they would feel the cold.

Staffing

Three carers and two seniors are on duty each morning (one of the seniors reviews the care plans as necessary). In the afternoons and at night there are two carers and one senior on duty. A handover book is used by staff to record events of the day and night. Seniors, who work long shifts (with a short overlap for a handover), discuss changes with staff as they come on duty.

The team was told that while the previous manager was ill, several managers came and went, which had unsettled staff and affected their morale but the current management had improved confidence and morale.

The team was also told that most staff liked to work long shifts, which suited covering late turns and nights.

The staff ratio was based on dependency level. No resident required a hoist at present but one was available for use if needed; staff were

aware that two staff were needed to operate it.

Agency staff were not used; colleagues were happy to cover for each other's absence, which worked well.

The team was told that it was proposed to employ two additional carers to work 3 hours each per day, 7 days a week; the outcome of DBS checks was awaited.

One cleaner worked from 10am to 2 pm Mondays to Fridays, with weekend cleaning covered mainly by care staff. The team was aware that, in a previous report, the CQC had criticized the cleanliness of the home but were assured that, since then, the cleaning regime had been improved: the home was vacuum cleaned daily and baths and sinks were also attended to daily, while skirting boards and tops of cupboards were cleaned monthly. The cleaner normally cleaned the floors but the handy man was responsible for deep cleaning them as and when necessary. The care staff also carried out cleaning as necessary. Every Thursday all the beds were decontaminated.

Night staff also did the laundry and iron some clothing, mainly shirts. A tumble dryer was available.

A handy man was available daily to do gardening and small jobs but the owner dealt with major maintenance issues himself. Any maintenance needs were recorded and checked daily by the handy man and the owner, and repairs arranged as necessary. The alarm calls were checked regularly.

Staff were trained in Dols/Mental Capacity, Medicine Management, End of Life Care, Dementia, Prevention of pressure ulcers, Infection Control, Fire, Health and Safety, Moving and Handling, First Aid and COSHH (Control of Substances Hazardous to Health). A senior carer was responsible for overseeing staff training; the home's aim was to train staff to NVQ level 2. The team was shown the training course available to staff, covering 43 relevant topics, including training delivered on

line. Each member of staff would be offered three courses this year. The team was told by staff who were spoken to that they did all their training in their own time.

Management and staff spoken to appeared enthusiastic about their jobs. Staff meetings are held monthly.

A whistle blowing policy was in existence and staff are aware of it

Care for residents

The team was told that care plans were reviewed monthly or when changes occurred. A GP, whose surgery was next door to the care home, visited regularly and also ran a weekly clinic for residents. The only controlled drugs in use were Morphine-type patches, which the district nurse applied. One resident was currently receiving medication using a special procedure, of which the resident was aware and a MAR sheet recorded the details. Any resident requiring warfarin would be checked regularly by the district nurse, who also visited twice daily to administer insulin to a particular resident. The home deals with a single pharmacy, which has provided training for staff and provided safety equipment.

The medication room was kept locked. It was very neat and tidy; there was a fridge for keeping certain medications at the right temperature. It was well appointed and included equipment for the district nurse's use.

The team was told that a carer would stay with each resident until their medication had been taken. No resident was self-medicating and there were no bed-ridden patients who needed turning or monitoring. Any tissue viability problems would be referred to the district nurse; staff had good rapport with district nurses and the GP's surgery.

The team was told that, if a resident went into hospital, on their return the GP and staff would do an assessment and review their

medication and care plan.

At the time of the visit, all residents were dressed in day clothes and looked comfortable and well dressed. The only resident who was in their bedroom was dressed in day clothes and sitting in a comfortable chair. The team was told that most residents used the communal rooms but some, particularly older residents, preferred to stay in their rooms. There were two hoists available in the dining room but none of the present residents required to use them.

All residents had regularly visitors, either relatives or friends, and many were taken out for part of the day or for walks to the park.

There were buzzer pads beside each bed so that any resident who had a fall could summon help; in such cases, the GP would check for any injuries and look at medication.

In conversation with the team, the operational manager seemed unsure about reporting falls, especially unwitnessed falls, but said that she would look into the matter. She did state that, if there were any concerns, she would call Adult Services Safeguarding Team for advice.

The activity coordinator spoke about the different activities she arranged for the residents. At Easter they had had an Easter Hat making event; preparations were being made to commemorate St George's Day and the Queen's 90th Birthday; other activities included the use of memory cards showing old wartime scenes or domestic events in the old days to stimulate memories and discussion. Another activity was cards seeking residents' opinions, such whether they liked how their rooms were decorated. The team was told that, generally, the male residents played more board games. Most residents would join in singalong events, which are run about twice a week. One resident knits a lot of for charity. Special celebrations would be arranged for residents who had significant birthdays or other events;

for example, one resident had recently turned 100. The activity coordinator has done an online course in dementia and Health and Social care.

In response to enquiry about the Gold Standard Framework for End of Life Care, the operations manager said that they would look into it.

Access to a physiotherapist, optician, dentist and chiropodist was available. The GP made referrals to the physiotherapist as necessary. Dental care would either be arranged by residents' relatives or by the senior carer where no relative was available. Arrangements were in hand for opticians' visits. A chiropodist visits every 6 weeks.

Weekly baths were offered (all baths being formally recorded) and residents were washed daily.

All radiators have thermostatic valves, evidence of water temperature charts, reported that water temperature is checked monthly, however, there did not appear to have been a record made during the previous 2 months, which the owner said he would investigate. The carers reported that the bath water temperature was recorded prior putting a resident in the bath, evidence of which was seen.

Food is cooked fresh on the premises. The kitchen was quite small and galley-style. It appeared very clean and tidy there was an appetizing aroma of lunch being cooked. A choice was offered of two main meals, such as roasts, pies, fish or shepherd's pie or salads with a choice of ham, egg or cheese. Residents could have a baked potato or other food.

For the evening meal, residents could choose items such as soup, sandwiches, salads or cheese on toast, prepared by afternoon staff.

Residents usually have cereal and toast for breakfast but a cooked

breakfast was offered twice a week.

Residents were weighed monthly, more frequently if there were any concerns with their weight. Fluid charts were maintained for those needing them.

A residents'/relatives, meeting was held monthly, and the team was told that these meetings are well attended. There was a residents' information book for recording comments and complaints.

Staff comments

The members of staff who were spoken to all said that they had done a number of courses NVQs and/or HNDs in Health and Social Care. These courses are paid for by the staff and in their own time.

Speaking to a relative of a resident at the home

The team spoke to a resident's relative, who was happy with the care and attention given at the home and was satisfied that their relative was eating well at the home, and that staff responded to their requests and answered any questions they had. The relative said that they were encouraged to take the resident out of the home for lunch or tea and generally for walks. The only suggestion was that the relative's room was in need of some redecoration.

Overview

Overall, this was a well presented care home where residents appeared to be treated with respect and good care. The management and staff were positive and enthusiastic, reporting that they were looking for change and improvements. Management appeared to appreciate the work of staff, reporting that they were trying to boost

staff moral and to provide training to facilitate culture and attitude change in staff.

The operations manager reported that she was aiming to computerise care plans next year, which would speed up making amendments and change.

Recommendations

At present, carers wash up by hand as there is no space in the kitchen to put a dishwasher. It is recommended that the installation of a dishwasher be considered, despite that difficulty, as that would enable care staff to use their time more effectively.

One of the visitors who were spoken to suggested there were not always enough staff around and that residents did not always have a shave or clean clothes on. It is recommended that management investigate this.

It was noted during the visit that the fridge temperature was the same was recorded as the same everyday i.e. 2° min and 8° max, which is the recommended temperature, and this suggests that the actual temperature may not be being recorded. Actual temperature should be recorded to ensure that any temperature failings will be spotted.

The team was told by a member of staff that a limited number of hand sanitizer dispensers were available. It is recommended that the management review the supply of such equipment in order to be confident that infection control is not compromised.

The notice board display should be improved. Staff names should be provided, so that residents and relatives know who does what and with whom they are dealing, and better information provided – e.g. about the food hygiene rating, which was excellent and only recently awarded. In addition, certificates and other indications of staff achievements and training could be displayed,

Staff should be issued with name badges, again so that people know with whom they are dealing.

The events coordinator undertook a lot of work with the residents and it would be appropriate for examples of it to be displayed, perhaps in the conservatory where there is blank space on the walls.

Whilst acknowledging the point about residents feeling the cold, the good sized and well kept garden appears under-utilised, and it is recommended that consideration be given to improving its use for the benefit of the residents.

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 visit on 12 April 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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