Enter & View
Moreland House

28 July 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.

The team was aware of comments made by the CQC following an unannounced inspection in September 2015, which had resulted in an overall rating of Requires Improvement. The comments in that report were taken into account by the team during this visit.

The home

The team was met by the Acting Manager, a registered nurse, who was formerly the deputy manager and whose registration in the post of Manager by the CQC was currently in hand.

Moreland House is a residential home providing nursing care, registered for 50 residents. At the time of the visit, there were currently 38 residents and the second floor had only recently been opened. Moreland House was originally three houses, which have been interlinked and adapted/extended to provide the current accommodation. As a result, the layout of the home can appear somewhat complicated.

The entrance to the home was clean and welcoming but the team members were a little concerned that, although they were admitted, they were left waiting in the foyer for a few minutes, despite the fact that they were visible to the acting manager and the administrator.

Currently the home provides 20 residential care and 12 nursing beds, provided over 3 floors. It was noted that 32 of the residents had some degree of dementia. Respite care is offered on an ad hoc basis and subject to availability. Two of the current residents come into this category. The Acting Manager was fully aware of previous CQC comments concerning the care and record keeping of respite residents, having been in charge of the home on the day of the unannounced visit. She confirmed that such residents are now treated in exactly the same way as long stay residents.

Staff

A 12-hour shift system is in place and staff are paid an extra 15 minutes for handover between each shift. There is always one nurse on each shift, with a second nurse on some day shifts. Additionally, there are two senior care staff and nine care staff on days with one nurse and six care staff on at night. Sickness/absence cover is provided through the home's staff bank – agency staff are not generally used although there are three agencies available for

use if need be. Cover in the Acting Manager's absence was usually provided by the manager from Ashbrook, a sister home nearby.

Ancillary staff include a housekeeper, three domestic staff, one laundry assistant, a chef and one catering assistant. Maintenance duties are provided through the owning company's head office although it was noted that the housekeeper checks water temperatures on a weekly basis.

A full range of training is available, with some being provided by Tapestry (a local charity for the elderly). All staff udergo dementia training. Training may be carried out during working time when staff shifts coincide with training sessions but it is otherwise unpaid. The Acting Manager confirmed that staff were now aware of the equipment on site and were fully trained to use it.

The home is not yet signed up to the Gold Standard Framework (GSF) for End of Life Care but the team was pleased to note that two training sessions provided by St. Francis Hospice had been arranged as a preliminary step to developing the GSF.

Care arrangements

The team was told that Deprivation of Liberty statements (DoLs) applications had been made for 29 of the current residents but that, at the time of the visit, only 3 had so far been confirmed. This needs to be monitored.

Risk assessments, MAR sheets and Care Plans are reviewed on a monthly basis, or more frequently if changes warrant this. Drugs are stored in the treatment rooms, with separate facilities for controlled drugs. At the time of the visit, eight residents were receiving controlled drugs and these were checked daily between shifts. The Park Lane Pharmacy provided a drug service. No resident was on covert medication; one resident was able to self-medicate, and was monitored on a regular basis; and one resident was on warfarin, with the pharmacist checking that person regularly.

Three residents were confined to bed, each on a 2-hourly turning regime, with charts in place for monitoring. Two residents with leg ulcers were under the care of the Tissue Viability Nurse, as was another who had been admitted from the community with pressure sores.

Residents who experienced falls were monitored for a minimum of 8 hours. There was a full protocol and residents were body-mapped for on-going monitoring, all such incidents being reported to Adult Safeguarding and any resident suffering a head injury being referred to hospital.

A GP had been contracted to provide a regular service to the home but this contract had now ended, although many residents are still registered with the practice. As a consequence, newly admitted residents were currently either being registered with other local GPs or were remaining with their original GPs. The CCG had, up to the date of the visit, been unable to re-provide a GP for the home.

Access to physiotherapy and occupational therapy was arranged only through the hospital but there were regular visits by a dentist, opticians and chiropodists. The home also had a beautician who attended every 6 weeks, and a hairdresser who attended weekly.

All kitchen staff have been trained to level III Food and Hygiene standards. The kitchen has full details of residents' dietary requirements (particularly for four residents who required pureed diets), likes and dislikes and any allergies. The residents who require nursing also require assistance with feeding. Residents are weighed monthly, or more frequently if there are concerns, to ensure that their dietary requirements are met. Fluid charts are kept for all residents to avoid the risk of dehydration.

In response to a question about the frequency of baths/showers, the team was advised that residents may have as many as they liked – all rooms had en suite showers and separate bathrooms are available. Residents who did not wish to have a shower or bath were able have a bed bath if they prefer.

Staff meetings were held monthly and were well-attended. The frequency of residents'/relatives' meetings had been increased from 6 to 3 monthly

intervals but, in general, attendance was poor. Staff were supervised on a 3-monthly basis, but this could be more frequent if necessary.

The last provider quality monitoring report had been made 2 months ago, following which the manager completed an action plan. She reported that she was well-supported in her efforts to carry out recommendations. The home was visited on a monthly basis by the owners' Head Office Quality Auditor.

The last CQC report had questioned the possible recruitment of volunteers. The Acting Manager commented that a retired former employee was now coming in to the home as a volunteer but it had not been possible to recruit others. It was suggested that the local 6th form college might be a possible source of volunteers.

There was a full time Activities Co-ordinator who worked from Monday to Friday but who was available at weekends for special events. Activities provided include painting, bingo, ball games, reading books and discussions. The Activities Co-ordinator confirmed that, whilst she did not usually work at weekends, she ensured that there were games etc. available for residents. Weekly film days included a variety of films, ranging from musicals to dramas.

There was no regular inter-denominational service but arrangements could be made for ministers to attend as required.

The home appeared to have a very good whistle-blowing policy, with a procedure flow chart displayed for staff/visitors' use. This included details of the Whistleblowing Helpline for NHS and Social Care Staff, CQC, Local Authority Safeguarding and Public Concern at Work.

Special occasions such as birthdays were always celebrated with a birthday cake and other days such as Halloween, Mother's Day etc. were also celebrated.

Staff spoken to confirmed that staffing levels were acceptable and that there was a mandatory requirement for them to undertaken training, updated regularly, in their own time if they were not on duty when it was provided. Arrangements were in hand to provide facilities for e-learning on the premises.

When asked about the ability to care for a dying resident with confidence it was confirmed that training in this was also mandatory. Staff did not appear to be aware of GSF.

Staff spoken to also informed the team that air mattresses were used in order to prevent pressure areas, that staff received training and that the GP was called to assess any residents who appeared to be at risk. Medication rounds took around an hour and staff remained with residents while they take their medication. It appeared that all staff had been trained to administer medication.

Facilities in the home

Dining tables were provided for residents but they were free to take their meals in their rooms or sitting in armchairs if they wished to do so. Drinks and snacks were provided outside of mealtimes. Drinks were always available and were offered on an hourly basis.

Residents were able to use the excellent garden facilities and some were taken for walks and to the local pub.

The laundry was large and airy and had sufficient equipment but the team noted that the layout prevented a proper separation between clean and dirty, which was disappointing.

The kitchens were clean and tidy. The staff were appropriately dressed and said that they had full details of residents' requirements including likes/dislikes and allergies to enable them to provide a good service.

There was good signage in the home, plenty of information and a good number of pictures of residents' activities etc. around. There had been some attempts to change colour schemes but it was noted that door frames blended in with walls rather than being painted a different colour to provide contrast for residents with dementia.

The gardens were clean and tidy with adequate seats and tables for residents. However, it was noted that the lawn mower, although not in use due to the

maintenance assistant being on his tea break, had been left plugged into a socket outlet in the lounge with a trailing lead, which could have been hazardous.

Residents' views

Residents, relatives and a visitor spoken to appeared satisfied with the levels of care and the activities provided. Some felt that the response times to calls were too long. All residents had named carers.

Thanks

The team was impressed by the Acting Manager, who appeared to be fully aware of the CQC recommendations and had taken action to deal with them.

The team thanks the Acting Manager for her contribution to their visit and wishes to acknowledge her excellent responses to their questions.

Recommendations

That

- When re-decorating, consideration be given to contrasting colours, in particular between walls and door frames, as is recommended for residents with dementia.

- To further help residents' orientation, different corridors be painted in different colours.

- Urgent contact be made with the CCG to ensure that an appropriate GP is appointed to the home.

- When the proposed e-learning is introduced, adequate monitoring take place to ensure that staff fully understand what they are learning.

- Arrangements are made to install a socket outlet in the grounds which is suitably insulated so that the supply leads to electrically-powered garden and other equipment do not trail into the building and the equipment can be easily disconnected if not actually in use.

- Consideration be given to changing the layout of the laundry to ensure a proper separation between clean and dirty areas.

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 28 July 2016 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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