healthwatch Havering

Enter & View

The Lodge

Lodge Lane, Collier Row, Romford RM5 2ES

19 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 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 The 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:	**94**
Current number accommodated:	**76**
Number of care staff employed:	**83**
Number of management staff employed:	**5**
Number of support/admin/maintenance/activities staff employed:	**8**
Number of visitors per week:	**100+**
Number of care/nursing staff spoken to during the visit:	**3**
Number of management/admin/reception staff spoken to during the visit:	**2**
Number of residents spoken to during the visit:	**7 + 1 relative**

The team were welcomed by the manager, who advised that she had been manager at the home for 15 years. There had recently been a change in the management structure of the home so that there were now 3 full time care managers and one part-time care manager. The home manager and the three full time care managers provided cover for the home all times during the days with the manager providing on-call cover by telephone on an over-all basis. The three full time care managers carried out day-to-day management of the home and liaised with each other, the manager and care staff on a regular basis. The

part-time care manager, who worked a 21-hour week, carried out ad hoc duties including night checks at various times of the night, the most recent of which had been carried out 2 weeks before the visit.

The Premises

The entrance to the home was welcoming and there were a number of posters on show. There were no unpleasant smells here (but some were noted in other parts of the home).

The home had 94 beds but, at the time of the visit, only 76 were occupied, as a rolling programme of refurbishment was being carried out. The two maintenance assistants were carrying out the redecoration and, in addition, carpets, furniture and curtains were being replaced. It was noted that, although recommended in a previous visit, there was still no distinction between door frames and walls; whilst appreciating the aim of seeking a homely atmosphere, considering that the corridors were long, the team felt that such contrast would be of considerable benefit to residents living with dementia. The team also considered that coloured toilet seats, also recommended for this client group, would be beneficial.

There were two rooms which could accommodate two residents/couples if required.

Following its refurbishment, the Environmental Health Officer had awarded a 5-star rating to the kitchen. The white goods in the kitchens were in good condition and there was a functioning dishwasher. Staff in the kitchen were not, however, wearing full protective clothing and the team members visiting the kitchen were not offered protective clothing before entering the kitchen area. The team were also concerned to note that the home's cat had its bed in the laundry.

At the time of the visit, the home's IT system was only available to the manager and the care managers/administrator as there was concern about its security. However, progress was being made towards the

installation of a system which would enable hand-held devices to be used by all staff.

The gardens were neat and tidy and safe and accessible for residents. It was noted that there was no permanent shelter (sun or rain) in the gardens - only tables and parasols – and no larger shaded areas which would benefit residents. There was a pond which appeared neglected; the team were advised that the fish in it had been eaten by herons. The team considered that, should it be felt unwise to restock the pond, it could be filled in and converted to provide a covered sitting area.

Care of residents

Almost all residents were living with dementia.

All admissions to the home, whether for respite, short stay or permanent were subject to assessment. A care manager visited all prospective clients in hospital and those living in the community were invited to spend a day at the home so that a full assessment could be carried out. Exceptionally, the home will take emergency admissions without an assessment if necessary; the manager advised that the quality of social worker assessments had improved to such an extent that the lack of assessments for emergency admissions was no longer a problem.

Picture books and pictorial signs were provided for residents with communication difficulties and, recently, when there had been a Russian resident, it had been possible to communicate with him through staff who spoke Lithuanian (which used to be part of the former Soviet Union).

When asked how many residents ate their meals in their beds/own rooms, the manager reported that some residents chose to dine in their rooms while there were about 6 who were confined to bed (as they were receiving end of life and palliative care). All other residents were encouraged to sit at tables in the three dining rooms in the home

that, between them, could provide sufficient accommodation for all residents. Residents who dined in their own rooms were closely monitored. The dining room in the newer part of the building was clean and pleasant but it was noted that there were no menus on the tables. or on the wall and no apparent stimulation. There was a notice board at the end of the room depicting a tea dance, entertainers and details of a cockney evening for which tickets could be purchased by visitors.

A couple of residents' partners visited daily at meal times and dined with their relatives; no charge was made for the food, but they were invited to make donations to the home's amenity funds.

It was noted that jugs of drinks were available in the lounges and drinks were being offered to residents. Additionally, it was confirmed that a tea trolley went around, mid-morning and mid-afternoon.

Rather than have an individual key worker scheme, the home had key worker teams. Under this system, staff would be allocated to units on a permanent basis and, therefore, got to know all residents on their unit which, the manger considered, provided better rapport with the residents, e.g. some staff were better able to encourage residents to participate in activities, have baths etc.

Religious needs were met in several ways - a local catholic lay preacher attended each Tuesday; the local Methodist church provided a monthly Sunday service with a Gospel church attending to sing to residents on other Sundays; and a rabbi visited 1 Jewish resident (who did not follow a kosher diet although the cook tried to provide some meals according to kosher rules).

Although there was an activities chart, due to the nature of the client group, it had to be very flexible. Activities included art, knitting and painting, pie and mash suppers, rock and roll nights and quizzes. At the time of the visit, a song and dance session was taking place in one of the lounges but there was no detailed information about activities.

The activities co-ordinator spoken to said that activities were varied and delivered largely on an ad hoc basis due to the nature of the client group and that every effort was made to include bed-bound residents and respite/short stay residents. Family meetings were held quarterly, and the home had been successful in getting people to attend.

Special occasions were always celebrated with a party, a cake and, often with professional entertainment - 2 professional entertainers were arranged each month. 4-course menus were provided on special days, e.g. Mother's Day and Christmas. Relatives may attend on purchase of a ticket.

The team felt that the manager appeared a little confused about the difference between End-of-Life and palliative care but confirmed that the home operated the Gold Standard framework and also the Weald project. The manager and her former deputy were trained to train. It was not clear whether any staff had been specifically trained in palliative care.

All mandatory training was carried out in the home, with some being bought in. All new carers were enrolled on to NVQ training after 6 months in post; external assessors attended to carry out this training. Staff were paid to attend training but failure to attend could incur a charge.

The home did not have specialist emergency equipment (such as a defibrillator) but it was noted that one resident used an oxygen concentrator for which there was a back-up cylinder in appropriate storage. The team were told that there had been discussion about the provision of a defibrillator, but specific fund raising would be needed for one.

The home had a whistle-blowing policy which was evident on notice boards, but an external anonymous agency was not used. A safeguarding issue had been raised shortly before the visit, when a member of staff contacted the local authority regarding an alleged

unwitnessed fall but the manager told the team that this had been an altercation between two residents, which she had already reported.

Nearly all residents were the subject of Deprivation of Liberty Safeguards (DoLS) and, whilst Havering had significantly improved the turn-round time for DoLS applications, this is not true of other London boroughs who had residents placed in the home, nor of the CCG.

Residents, relatives, outside agencies and staff were all invited to take part in quality monitoring and the directors attended on a daily basis. The fact that the manager carried out her own quality audits was questioned but she advised that this had been approved by the CCG. The team were advised that one director was undertaking NVQ level 5 training and would soon be carrying out audits.

The procedure for control of infection involved the use of protective clothing (gloves and aprons), isolation of residents as far as possible, and hand-cleansing at bedroom doors. Staff who might be infected were instructed to remain away for 72 hours after recovery.

In response to a question about a staff accident book, the team were advised that one was no longer kept. Accident forms were contained in individual persons' files. The manager was aware of the terms of RIDDOR.

A central register was kept for falls. A "measles" chart, whereby incidents were shown on a floor plan, was also kept so that areas that appeared to be problematic were noted and investigated. All unwitnessed falls and injuries were reported to the Safeguarding Team immediately, with a full monthly report also being made. Apparent reasons for falls were also noted, e.g. UTIs, confusion etc.

When asked about the options for 111 or 999, the team were advised that the assigned GP preferred the 111 service to be used but 999 would be called in the event of head injury, suspected heart attack or other obvious injury/suspected fracture. Additionally, family requests to use 999 would also be considered.

A night time inspection had been carried out by the manager and the part-time care manager 2 weeks prior to the visit, when they arrived at 8.15pm and stayed until 6am. Nothing untoward had been reported.

Each of the four units had its own drugs trolley, stored on the ground floor in a locked room where the controlled drugs cabinet was also situated. At the time of the visit, one resident was subject to covert medication with the approval of the GP and pharmacist. No residents were self-medicating. One resident was on warfarin and the pharmacist attended to check INR levels. Medication was given by 2 senior carers and one carer and the round took about an hour on each unit. There was no comment from staff about whether those administering medication stayed with residents to ensure that medication is taken, and tabards were not mentioned.

The North Street practice provided a GP service to the home for which a monthly retainer was paid, in addition to a fee paid direct by the CCG. The GP carried out a weekly surgery and there had been some success in reducing the medication levels of the residents.

Care plans, MAR charts and risk assessments were reviewed on a monthly basis unless there are concerns when this frequency would be increased. Access to physiotherapy was by GP referral; dentist by referral to PA. An optician attended monthly and a chiropodist attended alternate weeks so that all residents were seen in a timely way. A hairdresser attended once a week but residents advised that the staff also washed hair for residents. It was also confirmed that staff respond to call bells, which were all in reach.

MUST assessments were carried out by a senior carer who was non-practising qualified nurse. Insulin was administered to those residents who require it by staff who had had appropriate training. There were currently no residents with pressure area problems, but the home worked closely with the district nurses and the tissue viability nurse to ensure that any problems were dealt with promptly. Charts were kept

for those residents who were confined to bed and required regular turning.

12 residents required a soft diet with a further 6 having pureed foods. Many of them needed assistance/prompting with eating, with 7 needing full assistance.

Residents were weighed monthly and/or when bathed. Bathing was by personal choice. Fluid charts were kept, ensuring that residents had a minimum of 1500ml daily, particularly those who were prone to UTIs.

All taps were temperature controlled, with checking carried out by domestic staff as part of their cleaning duties. Any issues would be reported to maintenance. It was noted that there had been problems with the hot water system as the result of an unresolved a circulation problem.

Admissions/re-admissions from hospital were requested prior to 4pm as residents living with dementia tended to become increasingly agitated after that time and would require close supervision. The manager always arranged for re-/admissions to be assessed but noted that the communication system from the hospital was not as good as it might be.

All residents seen were properly dressed and well-groomed and it was felt that they were treated with dignity and respect. The atmosphere in the communal lounge was happy and TVs and radios were not left on with no-one watching/listening. Residents in lounges were supervised and were chatting among themselves. In the newer part of the building, there was a notice board in the dining room showing details of social events. Food that was being served at the time of the visit was well presented although the pureed food looked rather bland.

Staffing

Four members of staff were provided by an agency on a semi-permanent basis, but most shifts were covered in-house, with agency staff only required for night duties. Shift times were 7.30am-2pm, 2pm-9pm and 9pm-7.30am. Handover was undertaken by the care managers who carried out a walk-round and then cascaded information to care staff as required. Numbers of staff on duty at any one time were subject to the dependency levels of residents. On average, there were 12 carers, 3 senior carers and two care managers in the morning with 10 carers in the afternoons and at night.

In addition to care staff, there were 6/7 cleaners plus a supervisor on a daily basis. The laundry was staffed between 8am-2pm and 5pm-10pm; there were one cook and three kitchen domestics and two maintenance assistants. Four part-time activity coordinators worked from Monday to Friday plus one Sunday per month to help with church service duties and attended at weekends for special occasions.

Staff were seen to be wearing name badges and most were in uniform. None were wearing jewellery, nail varnish or inappropriate footwear.

Staff were not required to change clothing on entering or leaving the building.

Staff views

Staff spoken to felt that they had sufficient support to carry out their duties and confirmed that they had undertaken safeguarding training as well as other mandatory training plus First Aid and caring for people living with dementia. When asked those spoken to felt that they were sufficiently trained to deal with dying residents. Appraisal takes place every six month and training is reviewed/updated every year. There are various means of training, including on a computer and face-to-face with in-house trainers. The manager had confirmed that staff are paid for training but they face a financial penalty if they fail to attend for booked training. Staff said that there is a half hour handover

period before the start of shifts (at variance with what the manager said i.e. that only senior staff member is involved in shift handovers) and that all staff are involved with this. it may mean that the initial handover is then cascaded down to junior staff. Staff spoken to said that they had no concerns.

Residents' views

Residents spoken to said that they were happy at the Lodge and that the food was good, with plenty of choices. One resident, when asked if they got plenty of drinks, replied "not much" - which the team interpreted as indicating that plenty of drinks were offered but refused (it was noted that this lady had dementia and may not have understood the question).

Asked whether relatives felt involved with decision making, residents felt that they did so and that the residents themselves felt safe in the home.

Recommendations

- That menus be provided on dining room tables for the benefit of those residents able to make an informed choice of food
- That consideration be given to replacing toilet seats with a bright colour.
- That further consideration be given to changing the colour schemes, particularly in corridors to ensure that there is contrast between doors frames and walls
- That the replacement of carpet by solid flooring in communal areas be considered

- That consideration be given to providing raised beds for the extension of resident activities and either replenishing the pond or using its site to provide a covered seating area for residents' use
- That consideration be given to providing a defibrillator for the home.

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 19 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.

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**

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