healthwatch Havering

Enter & View

Ladyville Lodge

Fen Lane, North Ockendon,
Upminster RM14 3PR

7 February 2018

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.

The Premises

As the team arrived at the home, they noted that arrangements were being made to take three residents to Romford, a regular occurrence; another resident was being collected by ambulance to attend a hospital appointment.

The entrance was welcoming, with many notices on display, about a variety of topics, including the Healthwatch poster advising of the visit. As well as facilities for the staff to sign in via a fob system, there was a visitors' book and a device for staff, residents and visitors to provide feedback to the parent organisation on a number of topics. The device had been designed to identify which category the person providing feedback was in.

Along the corridor to the manager's office there were large displays of photos of various events that had taken place. The manager's office, however, was not very well sign-posted and was some distance from the entrance. The team were met by the manager, who advised that she had been in post for six years and was fully CQC registered. In her absence, responsibility for the home lay either with her deputy or the clinical lead but she advised that she was contactable by telephone on a 24 hour/365 day basis. She also advised that the parent organisation (Four Seasons) had offices in the grounds. In reply to an enquiry about recent publicity about financial problems, the team were told that a restructure had been developed and agreed and that there was no longer a problem.

It was noted that the Environmental Health Department had awarded the kitchens a '5 star' rating and inspection of the kitchens found them

to be clean and tidy. All items were stored appropriately. Stocks appeared to be rotated and opened items in the fridge were dated (although this best practice did not appear to be applied to opened items in the freezers).

The design of the laundry prevents a 'clean and dirty' system being operated but otherwise it appeared to be well organised. It was noted that an area of the flooring was split. We were advised that an additional washing machine was awaited.

The team noted that there were photographs at the windows in the hall.

The grounds are very large with some areas of woodland. Given the time of year the gardens close to the home are very well cared for.

Care

At the time of the visit, there were 34 residents in the home – of whom 14 were receiving residential care and 20 nursing care; more residents were due to be admitted shortly. Some residents were living with dementia. A dog belonging to a member of staff was a regular visitor and was clearly much loved by staff and residents.

The manager confirmed that the home offered palliative care as well as respite and short stay care, and that all new admissions were assessed, by either herself, her deputy or the clinical lead. Residents were accepted subject to room availability. Short stay residents had booklet-style care plans, which included all relevant information but were not quite as comprehensive as the care plans for permanent residents, which were, clearly, all-encompassing.

In terms of palliative care, the team were advised that the Havering palliative care specialist was involved as well as the local hospices. In response to a question about caring for residents with communication difficulties, the team were told that there were no residents with complete hearing loss, all staff attended a dementia awareness course

and the team were told of plans to introduce a dementia framework programme. Hand signs were used for communication with a number of residents, and families were very helpful.

Multi-denominational religious services were held on a monthly basis and a local priest could be called upon if any resident wished to take communion. There was one Muslim resident who, the team were advised, had expressed no religious preferences other than diet.

The manager told the team that she monitors all falls and analyses any patterns that are discovered. Risk assessments are reviewed on a regular basis and residents are referred to the home's GP if this is deemed necessary for referral to the Falls Clinic. The GP service is provided by Health 1000, which holds a weekly surgery. Details of residents to be seen are provided prior to the clinic. The service provided is regarded as very good by the home.

Generally, the 111 service is used unless there is clearly an indication that a resident requires to go to hospital (e.g. for attention to a head or hip injury etc).

Medication is stored in dedicated lockable cabinets in a locked, dedicated room where there is also a Controlled Drugs cupboard which is secured to the wall. Controlled Drugs are checked between each shift change. The CQC noted that there was a problem with temperature control in this room and the team were told a portable air conditioning unit had been purchased to solve this. A few residents in the dementia unit have covert medication, which has been approved by the GP, families and the pharmacist. No residents self-medicate. Several residents take warfarin and have INR levels checked by the pharmacy or the GP. The pharmacist carries out 6 monthly audit checks. MAR charts, care plans and risk assessments are monitored on an ongoing basis and are reviewed monthly.

Access to physiotherapy services is obtained through the GP but is usually only available for new admissions. Opticians attend every 6 months or more frequently if required. A chiropodist attends every six

weeks and the dental service is provided as and when required by the local authority.

As has been noted, residents are weighed monthly or more frequently If concerns about weight loss are noted. MUST charts are used to identify areas of concern and food charts are also used to help monitor this. Some residents require pureed food which is prepared by the chef who has had appropriate training. Many residents require feeding and this was observed during the course of our visit. Additionally, fluid charts are in use to ensure residents are hydrated, particularly where residents have UTIs and are prescribed antibiotics.

Residents are offered showers/baths as and when requested. All taps in bathrooms etc have appropriate heat controls. The team noted one bathroom where the wash hand basin requires lever taps.

There are some residents who are bedfast and who require regular turning and charts, including lung, pressure areas and leg ulcers, are in place to monitor this. The tissue viability nurse (TVN) is contacted as soon as any concerns are raised. Currently 1 resident has a grade 4 pressure area which is healing. This is being monitored by the TVN.

When asked, the manager said that she had few problems with hospital discharges but was concerned when residents were returned to the home inadequately dressed and, sometimes, during the early hours (although the home has a rule that re-admissions should not be accepted after 5pm, the home shows flexibility about this. There were no reported concerns about medication.

Staff

Shift times were 7am-7pm or 7am-1pm and 1pm-7pm. The manager confirmed that, as far as possible, there was flexibility to cover childcare arrangements. There was a nurses' handover between each shift, for which staff were paid. A registered nurse was on duty at all times. There had recently been a recruitment drive and it was anticipated that a number of staff - nursing and care - would be

commencing once documentation/DBS had been obtained. Thereafter the only vacancies were for a part time day nurse and one night-nurse. An on-line agency was also used, who were able to provide regular staff.

There was a nurses' station between 2 lounges with adequate viewing so that the nurse could see into both lounges. The manager reported that, at times, there were only 1 or 2 residents in the lounges, as many residents preferred to socialise in the dining room; it was therefore deemed more appropriate for the nurse to monitor the lounges from the station where she could summon assistance if necessary. The team noted that there were call points at intervals around the building.

Staff meetings were held in a bi-monthly basis, with weekly clinical meetings and 'flash' meetings on an ad hoc basis. Meetings with relatives were also arranged on a bi-monthly basis.

In addition to care and nursing duff there are 4 cleaners, 3 kitchen staff (a chef and two assistants), one maintenance assistant (30 hours) and a full-time gardener.

Additionally, there is a full-time activities co-ordinator who normally works Monday to Friday but who attends on Saturdays for special occasions. Activities encompass a number of activities including days out, special days and support groups. These were evidenced by the large photographic displays. All special occasions are celebrated.

Training for staff is through e-learning, with some face-to face elements. End of life care is supported by St Luke's and St Francis hospices. Staff may undertake training on duty or at home and are paid for doing so. When asked how this is monitored, the manager advised that there are random checks and one-to-one sessions to ensure that staff have carried out the training and have understood the programmes. Training also included the use of the defibrillator and it was confirmed that all appropriate staff had been trained in its use.

Details of the home's whistle blowing policy are displayed around the home and this is also discussed in supervision, with staff being advised

that they can approach Social Services and CQC if they feel that their concerns are not taken seriously within the home.

In terms of domestic staff, it was felt that 4 cleaners to carry out all the homes duties as well as laundry duties was insufficient and, when the team spoke to the cleaning staff, they indicated that that they would like an additional member of staff. However, the manager said that she had offered extra hours but these had been turned down. It would seem that individual staff members would prefer additional staff to working extra hours but would appreciate an extra member of staff.

During the visit, staff seemed relaxed and happy in a very informal atmosphere and all were engaged in care activities.

Other matters

In terms of quality audits, the machine in reception through which anyone can provide feedback has already been mentioned. In addition, the manager has an iPad to aid in audits, which include Health & Safety, Weight loss, maintenance checks, bed rails, risk assessments, PIN Nos. etc. Provider monitoring reports are received on a monthly basis and are addressed immediately they are received. The manager advised that she had carried out a night inspection in December and had found nothing untoward.

The adverse comments in the most recent CQC report had been challenged as it was felt that although the home did not regard itself as perfect, some of the comments were inaccurate:

- Only 1 care plan was found that had no reference to bed rails.
- The control of hygiene report had apparently been due to a member of staff stroking the dog and then proceeding to make tea for the residents - not good practice but also not terribly problematic! Staff have been made aware of this and more hand sanitisers have been installed.
- The apparent lack of PAT testing boiled down to one item where the label had become damaged.

- All staff involved in the serving of food now wear navy blue tabards as the manager feels the this is more appropriate than coloured disposable plastic aprons, and is more environmentally friendly.
- The issue with over-full sharps bins has also been addressed with staff.
- The issue with wheelchair access to toilets has been referred to the Estates department to discover whether other toilets can be made wheelchair accessible. Allegedly, residents prefer to use the one toilet which results in a queue.
- It is accepted that the dining room could be larger and plans are in hand to extend this.

Relatives' views

The team spoke to relatives of two residents, both of whom had been at the home for many years. They said that their relatives were happy in the home and with the care, food and drinks provided. One relative reported that the resident was no longer able to participate directly in activities but enjoyed the entertainers who regularly attend the home.

It was not practicable for the team to interview residents.

Recommendations

1. That the flooring in laundry be repaired
2. That freezer items that have been opened be labelled and dated in line with the good practice applied to items in the fridge.
3. That the taps to the wash hand basin in the ground floor bathroom be changed to lever-type
4. That consideration be given to moving the photographs in the hall from the windows to a central display board, in order both to make them more of a focus point and also to reduce the obscuring of the light from the windows

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 7 February 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.

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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