healthwatch Havering

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Enter & View

The Willows Nursing Home

(Second visit)

227-229 London Road
Romford RM7 9BQ

24 July 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 Willows. 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:	72
Number accommodated at the time of the visit:	61
Number of care staff employed:	75
Number of management staff employed:	2
Number of support/admin/maintenance/activities staff employed:	5
Number of visitors per week:	70
Number of care/nursing staff spoken to during the visit:	4
Number of management/admin/reception staff spoken to during the visit:	4
Number of residents spoken to during the visit:	7

Care services

The team were met by the manager, who advised that she had been in post for a couple of years and that she was registered with the CQC. She had a deputy manager, and between them they provided 24-hour support for the home - by telephone outside normal working hours.

The breakdown of the care offered for the 61 residents accommodated at the time of the visit was:

Nursing care	23
Nursing with dementia	16

Residential care	22

Many residents were the subject of Deprivation of Liberty Safeguards (DoLs):

Nursing care	5
Nursing with dementia	13
Residential care	22

At the time of the visit, 8 applications for DoLs were awaiting confirmation from Havering Council.

The team were informed that short-term care plans were prepared for residents requiring short period/respite care. Applicants would always be assessed in their homes or hospital, as appropriate, prior to admission. All care plans were kept electronically as well as in hard copy.

In order to promote good communication, easy-read leaflets were available in all bedrooms, including advice on how to make a complaint. The manager advised that, whilst some residents were unable to talk, most were able to read.

While there were no formal arrangements to meet residents' religious needs, a priest visited on a fortnightly basis, a number of church member friends visit and families were able to escort residents to church according to their wishes. Individuals' wishes were noted in care plans.

In terms of staffing, there was a registered nurse on duty on each of the three floors of the home, and both the manager and her deputy were registered nurses. The V-Care agency was the home's preferred agency, and there were currently only 2 night nurse vacancies, for which recruitment was underway. The team were told that the position had recovered from a few months ago when several nurses had left following the departure of the previous manager. Most staff worked 12-hour shifts (8.00-8.00pm/am) but shorter shifts were available from 8.00-2.00 and from 2.00-8.00. Following the recent

CQC report there was a 15-minute handover between shifts to discuss residents' needs.

In terms of ancillary staff, on a daily basis, there was 1 domestic per floor, supervised by a housekeeper who also assisted the laundry assistant, and a full-time maintenance assistant (although the post was vacant at the time of the inspection). All bedding was laundered by an external company and contractors maintained the gardens. Additionally, there was a chef and 3 kitchen domestic assistants.

There were 2 full-time Activities co-ordinators, who worked alternate weekends. A minibus was shared with a sister home, enabling residents to go out on a regular basis.

Special occasions such as birthdays were celebrated by nominating residents to be 'resident of the day', when they can choose their activity and what they have for lunch. A birthday cake was provided and wine was also available.

A number of methods were employed to ensure staff received training appropriate to their roles, including 1-1 training, group training and E-Learning (which could be undertaken on site or at home - although most was undertaken at work); some outside training was also used. Staff were paid for time taken in training.

Palliative care training was provided by an external nurse specialist who attended to train nurses who, in turn, would train carers. This was an ongoing process to ensure that training was kept up to date and did not suffer when individuals left the home to work elsewhere.

It was confirmed that the home did not have a defibrillator and there were no plans to purchase one. Should the use of one (or any other specialist equipment) be advised (by the emergency services), the home had arrangements in place to procure it.

The home had a whistle-blowing policy which was published internally. The owning organisation had an HR helpline and there was a weekly visit from a member of the organisation's HR team.

A meeting with residents had been held in May and one for friends/relatives was held in June. It was hoped to continue these meetings on a quarterly basis.

Quality issues were monitored by questionnaires, care plan reviews and a feed-back form devised by the manager. The website CareHome.uk.com was used in this context and meetings took place on a fortnightly basis. Provider monitoring took place on a monthly basis, following which an action plan was developed (which was shared with Havering Council's Quality Outcomes Team).

Procedures for ensuring good infection control included management monitoring, regular hand washing/sanitising and barrier nursing. In the event of an outbreak the Control of Infection department would be advised and the services of the GP utilised, with the Environmental Health department being advised should food contamination be suspected.

All falls would be reported to the Council. Each fall would be considered in terms of possible cause - unsafe surface; poor eyesight; UTI; poorly fitting shoes/slippers etc before further actions were taken. Where it was noted that there had been da number of falls without apparent reason, residents would be referred to the Falls Clinic. Sensor mats are provided for dementia patients in order to alert staff of movement.

In the event of emergency assistance being required, 111 would called unless there was a head injury or other suspected bone injury, when 999 would be called.

There had been some problems with discharges from hospital, particularly Queens, when residents had been returned to the home without medication and/or discharge letters. The was unable comment about the work of the Joint Assessment and Discharge Team (JAD).

It was normal practice for either the manager or her deputy to visit hospital to assess new proposed residents or those returning following treatment.

In response to a question about night time inspections, the team were advised that the manager had recently carried out one, spending about two hours on site. It was her intention to continue this practice quarterly or more frequently if need be. She had found nothing untoward on her recent visit.

In the light of an adverse CQC comment about complaint handling, a log had been developed, giving details of investigations and how problems had been dealt with.

The team were advised that there was a handover period of 10-15 minutes prior to shift change, which applied to staff, nurses and at times, the manager.

Medication was stored in dedicated trolleys in a locked facility. Controlled drugs were kept in a purpose-designed drug cupboard and were checked by two members of staff at each shift change. The manager monitored this on a weekly basis. No residents were self-medicating. At the time of the visit, three residents were on warfarin and the District Nurse attended to carry out checks. Two residents had covert medication which had been approved by the GP and the pharmacist, both of whom reviewed medication on a regular basis.

The staff appeared very conscientious about infection control and the procedure for this control was strictly adhered to.

Medication rounds took up to two hours. Staff stay with residents until medication is taken; however, although staff conducting medication rounds are required to wear tabards, none were observed during our visit.

GP facilities for the home were provided by Healthcare 1000, who attended on a weekly basis. *[Note: since this visit, the Havering CCG*

have terminated the Healthcare 1000 service but replaced it by an equivalent arrangement]

Care plans and risk assessments were routinely reviewed on a monthly basis but would be reviewed more regularly if this is deemed appropriate.

The homes availed itself of the services of an optician (especially for new patients), dentist, chiropodist (bi-weekly) and a hairdresser on a weekly basis.

Generally, residents were weighed on a monthly basis but this was increased where there were particular concerns. At the time of the visit, two residents were under the care of the Tissue Viability Nurse. All new/re-admissions were body-mapped on arrival.

There was a 4-weekly cycle of winter and summer menus. These had been developed with the involvement of residents and a comments book was also available for residents/friends and family to make special requests etc. The menu provided alternative dishes and finger foods were provided, particularly for those living with dementia. Relatives were asked to give details of likes and dislikes. Many of the residents required pureed food and six residents required assistance with feeding, and extra assistance would be obtained from activities staff to help in this. Fluid charts were used for residents who were unable to help themselves to drink and who might be at risk of dehydration.

The kitchen was well stocked and spotlessly clean. All white goods were in good working order. The kitchen staff appeared to be working very efficiently as a team, and morale seemed good. Drinks and snacks were always available, and liquids were offered hourly.

All rooms in the home had en-suite showers and residents were encouraged to shower on a daily basis although this could prove logistically difficult. Bathrooms were available for those who did not like to shower and those residents who were reluctant to shower or

bath were encouraged to have all-over washes on a daily basis. Water temperatures were checked on a monthly basis.

Fifteen residents required regular turning and charts were in place to monitor this. Staff were reminded to turn those residents via iPods which contained all aspects of residents' care plans/care required and which were carried by all members of nursing and care staff.

Residents had the choice of going out, either accompanied or on their own if appropriate. A minibus was available when required for group outings, including trips to resorts and other venues.

The activities manager was very enthusiastic, showing the team a room set aside for activities, which could be used by residents at any time they wished. This was very well equipped and inviting. She produced a long list of activities, including baking, flower arranging, manicures, food prep etc. *[Note – the July schedule of activities is appended to this report by way of example].* There was a Resident of the Day scheme, carried out fairly on a rota basis so every resident would be included. The activities room on the ground floor was very well equipped. The activities manager mentioned that she thought it would be useful to have a mural painted on a wall; the team suggested that she consider contacting a local school or college for their assistance.

Staff had the facility to change into their uniform when they arrived for work.

All bedding goes to outside laundry on a daily basis. Although laundry staff told the team that they were content with their working conditions, the team felt there was inadequate air conditioning as there was only a one stand-alone fan, although they noted that the provision of further fans might cause problems with trailing flexes which might cause safety issues

Call bells were in evidence. They were working and staff responded promptly. Residents did not have named carer.

Staff views

The team spoke to staff who advised that they felt well supported, and had been trained in Dementia, Mental Capacity and DoLS, together with safeguarding training, the procedure of which they fully understood. They told the team that they felt that they had adequate training to look after residents at the end of their lives. Training was regularly updated (on a 6 monthly or yearly basis). Some training was carried out in-house during working hours. There was a yearly appraisal for nursing staff.

Views of residents/relatives

Those spoken to said that that they liked the environment and were happy at the home. When asked about food they said: "sometimes better than others", but on the whole there was plenty of food and drinks. They also they were happy with the range of activities and trips available.

Residents confirmed that the hairdresser attended twice a week for both men and women.

Residents felt comfortable in their surroundings and were treated with dignity, and felt safe, however when asked if they knew how to complain their answer was "no". One lady in wheelchair said she was comfortable but it "could be better". Relatives questioned felt that they were adequately involved in decision-making.

Recommendations

The team do not wish to make any recommendations following this visit.

However, it is suggested that consideration be given to improving ventilation/air-circulation within the laundry as the stand-alone fan there does not appear to be adequate for that purpose.

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 24 July 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.

APPENDIX

Sample activities' schedule – July 2018

July Activity Schedule

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1st *Garden Games *Jigsaw puzzles *One 2 One *Gardening club	2nd *R.O.T.D Tea Party *Current Affairs *Crosswords *Famous Faces	3rd *Room Visits *Current Affairs *Movement to music *Church Service *Flower Arranging	4th *Current Affairs *One 2 One *Gardening club *Music Bingo	5th *Room Visits *Current Affairs *Hairdresser *Manicures	6th *One 2 One *Current affairs *Baking/Food Prep *Gardening club	7th *Room visits *Garden Games *Movie Time Art & Crafts
8th *One 2 One *Current Affairs *Charades *General Knowledge Quiz	9th *R.O.T.D Tea Party *Room Visits *Crosswords *Hangman *Gardening Club	10th *One 2 One *Current Affairs *Flower Arranging *Exercise Tuesday	11th *Room Visit *Current Affairs *Crosswords *Prize Bingo *Gardening Club	12th One 2 One *Current Affairs *Hairdresser *Manicures *Art & Crafts	13th *Room Visits *Current Affairs *Crosswords *Trip to Romford & Local Pub	14th One 2 One *Crosswords *Target Mats *Garden Time
15th *Room Visits *Residents Choice On all floors	16th *R.O.T.D Tea Party *Current Affairs *One 2 One *Conundrum	17th *Current Affairs *Crosswords *Church Service *Flower Arranging	18th *Room Visits *Current Affairs *Anastasia Cole Movement to music	19th *Current Affairs * Hairdresser *Robert Jerome Singer	20th *Room Visits *Crosswords *manicures *Baking/Food prep	21st *One 2 One *Table top games *Puzzles *Scrabble
22nd *Room Visits *Garden Games All floors	23rd *One 2 One *R.O.T.D Tea Party *Southend Day Trip *Table top games	24th *Room Visits *Current Affairs *Reminiscence Quiz *Flower Arranging	25th *Crosswords *One 2 One *Hoy Bingo *Garden Time	26th *Room Visits *current Affairs *Hairdresser *Singer One man Stand	27th *One 2 One *Crosswords *Manicures *Baking/Food prep	28th *Room Visits *Arts & Crafts *Prize Bingo
29th *One 2 One *Residents choice On all floors	30th *R.O.T.D Tea Party *Current Affairs *Crosswords *Word Game Countdown	31st *Current Affairs *Flower Arranging *Exercise Tuesday *Reminiscence quiz				

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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**

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