Enter & View

Beech Court Nursing Care Home

298-304 South Street

Romford RM1 2AJ

17 January 2017

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 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 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, patient or other service-user is not compromised in any way.

The visit

The team found the home welcoming. The lobby was inviting and there were a number of posters, including one advising about the team's visit and the Environmental Health Officer's Scores on the Doors notice (a 5).

The registered Manager had been in post since 2002. She had formerly been midwife and was clearly very knowledgeable. In her absence, a deputy a deputy manager and senior team leaders ensured there would always be a senior person on duty.

There were 50 beds, of which 48 were occupied at the time of the visit. The home offered care for a varied client group, including residents with high dependency or needing End-of-Life care, with 20 beds dedicated to the frail elderly and a further 20 to frail elderly with dementia. In theory, the home would provide care for younger dependent persons but, because the current "youngest" client is aged over 60, the manager said that in practice she would not accept a younger person as she did not feel that this would be an appropriate placement. Respite care was offered on very rare occasions – subject to availability – but this had not happed at all in recent times. Any admissions of this type would be treated in the same way as permanent admissions.

At least 1 registered nurse would be on duty at all times and the rota had a mix of long days/nights and shorter shifts (3 per 24-hour period). The ratio of staff to residents was 1/5 in the morning, 1/6 in the afternoon/evening and at night there were 4 carers and 2 nurses on duty. All shifts were covered in-house and agency staff would never be used. There was a 15-minute handover between shifts to pass on all relevant information.

Most training was on an e-learning basis but some areas, such as Moving and Handling, CPR and customer care, were provided on a face-to-face basis by a facilitator from Head Office (who was on the premises the visit and provided the team with a break-down of training, which showed a 92% completion over all, with just 2 items falling below 90%). The team enquired when and where training was undertaken and was advised there was a mixture of on site and

"at home" provision. Training on site was paid but no recompense was offered for training undertaken at home. In response to a question about what steps were taken to ensure that off-site training was taken and understood by staff, the team was advised that the facilitator would make spot checks.

There were two adverse comments in the last CQC report and the team was advised that the comment about "suitable people" was due to a missing reference for one recruit – this was later found to have been misfiled. The comment about dealing with challenging behaviour was being addressed by employing an external trainer to undertake training of all staff in this aspect of care. It was confirmed that all appropriate staff were now aware of equipment on site and fully trained to use it.

Unfortunately, two co-ordinators who had been well advanced in Gold Standard Framework training for end of life care from St Francis Hospice had left the home but the manager advised that two further members of staff were now undertaking this training with a view to cascading it further down the staff group. The manager was very supportive of the Framework and expressed her relief at the end of "Liverpool Pathway" strategies for end of life care.

There were 41 residents for whom Deprivation of Liberty statements had been submitted. Very few had been confirmed, with some outstanding since March 2015. These have all been re-submitted.

Medication was provided by Britannia pharmacy in Newbury Park. Each floor of the home had dedicated stores for drug trolleys. Doors to rooms had coded locks and there was one dedicated cupboard for controlled drugs which were counted and signed for at each hand over. The pharmacy carried out audits and reviews medication in conjunction with the GP on a regular basis. Several residents were subject to covert medication, which had been authorised by the GP. There were also several residents who were taking liquid medication. No resident was responsible for their own medication, nor were any residents currently on warfarin.

Turning charts were provided for all residents who required turning – on a 2-hourly or 4-hourly basis. The tissue viability nurse would be contacted via the

single point access system as and when necessary. The team enquired about the incidence of pressure areas, and were advised that the biggest problem was with clients discharged from hospital. In line with requirements, all unwitnessed falls and any that resulted in hospital admission were reported to safeguarding although they tended to be few and far between owing to the nature of the client group, with many being confined to bed.

Medical cover for the home is provided by the Lynwood practice and a clinic was held on a weekly basis. This had been set up by the CCG.

Access to physiotherapy was via the GP. Homecare opticians provided a regular service to residents (they would telephone regularly to update any new residents) as did the chiropodist (every 6 weeks) and an NHS dentist (on an ad hoc basis). A hairdresser attended on alternate weeks.

The Waterlow scoring system was used to determine nutrition requirements and residents were weighted on a monthly basis unless there was cause for concern, when more frequent weighing would take place. Approximately 80% residents required feeding and had a pureed diet. Food and fluid charts were completed as and when required.

Showers/baths were offered on a weekly basis as a minimum or as required although some residents refused, in which case full body washes were undertaken. All taps had temperature limiting valves to ensure safe bathing. Temperatures were checked by the maintenance assistant on a monthly basis.

Staff meetings by staff group were held on a monthly basis, with a full meeting which all staff attended on a 3-monthly basis. Meetings with families/friends were arranged by Head Office and took place quarterly.

Whistle-blowing was dealt with by the Manager, with any problems that could not be dealt with locally being passed to the regional manager.

Quality was monitored via audit forms which were available for all visitors and the Manager carries out her own audits. The last Provider Monitoring visit was carried out in November, following which an action plan was completed by the Manager. The next PM visit was due in the near future – they were always unannounced.

There was an Activities' co-ordinator who worked full time Monday-Friday, and on special occasions was available also at week-ends. The Activities Schedule indicated that all activities are sedentary, a reflection of the client group.

The team was advised that all birthdays and special days are celebrated – often with entertainers – with finger food buffets being provided along with birthday/special occasion cakes. The religious needs of residents were provided by a monthly multi-denomination service and visits of local church members.

In response to a question about hospital discharge experience, the team was advised that this was not good. It had been known for patients to be discharged in the late evening and the incidence of pressure sores had been problematic. In addition, the manager had current evidence of inadequate information being provided on discharge and consequent poor response to a request for further information.

The team was very impressed with the home and felt that the manager was effective and efficient, despite the CQC comment that the home required improvement on 3 headings.

The views of residents

Members of the team had an opportunity to speak to a few residents and their visitors (although the nature of their conditions meant that most were not able to be spoken to).

One resident who was spoken to liked living in Beech Court and could not fault the food, confirming that they had plenty of drinks and snacks. Another resident said, with regard to activities, he did jigsaw puzzles and liked quiz shows on television. At the time of the visit, there were not many activities going on.

One resident advised that staff attended promptly when the bell was rung.

All residents have a named carer. Both the residents and their relatives who were spoken to felt that they were involved with decision making.

Residents told the team that they felt treated with dignity and respect and felt safe.

The team would like to thank all staff and residents who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit on 17 January 2017 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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