healthwatch Enfield

Healthwatch Enfield

Enter & View Report

Parkview House Care Home 20 August 2014

Parkview House Residential Care Home

Enter and View Report

Premises name	Parkview House Residential Care Home
Premises address	12 Houndsfield Road, London, N9 7RQ
Date of visit	Wednesday 20 August 2014

Contents

Purpose of Visit

Healthwatch Enfield Enter and View Authorised Representatives have statutory powers to enter health and social care premises to observe and assess the nature and quality of services and obtain the views of the people using those services.

This was an announced Enter and View visit as part of a planned strategy to look at a range of care and residential homes within the London Borough of Enfield to obtain a good idea of the quality of care provided. We are particularly interested in the interface between health and social care, and want to find out whether care home residents are receiving a good service from local health providers.

The most recent Care Quality Commission (CQC) inspection at Parkview House Residential Care Home, dated December 2013 was a themed inspection focusing on the quality of care provided to support individuals with dementia. This inspection rated Parkview as meeting all standards. The last full CQC inspection was in July 2013 and all standards were met.

Healthwatch Enfield chose to visit this care home because, in addition to the satisfactory CQC reports, we had heard from relatives of some of the residents that they thought the care in this home to be particularly good. We wanted to see for ourselves what the care is like in this well-regarded care home specialising in looking after people with dementia.

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Executive Summary

We were very impressed by our visit to Parkview House Care Home.

Residents appeared to be generally content and at ease; many of them approached us to have a chat during our visit; several of them spoke highly of the staff and told us they felt safe in this environment.

Staff and management appeared to be well-trained to care for people with dementia, and demonstrated good communication skills and a kindly attitude. They seemed to know all the residents well, to be aware of their personal history, and to have a warm relationship with them. We found that residents are encouraged to maintain independent skills where possible.

The accommodation is spacious and well-designed so as to facilitate personalised care for each resident, and to maximise opportunities for residents to move about freely inside the building or to go outside into the garden. Residents also have opportunities to go outside the care home either for short informal walks or on planned outings.

Residents have access to good health care services, and staff make an effort to reduce unnecessary hospital admissions or lengthy stays in hospital, as part of the care home's commitment to continuity of care. Staff are trained to support

residents as they approach the end of life, and most residents are able to die in the home, in familiar surroundings.

Our overall impression was very favourable. However, there are a number of aspects which could be improved, which are listed in our recommendations below.

We hope that other local care homes, and their residents, can benefit from emulating the good practice which we observed at Parkview House.

Recommendations

1. *Activities programme: we recommend that the Activities Manager receives professional training, as well as support from a professional organisation such as NAPA (the National Association for Providers of Activities for Older People).*
2. *Facilitating conversation: we recommend that there is sometimes a quiet environment in the sitting rooms, without the television or radio/CD player on, to facilitate conversation, especially for residents who may be hard of hearing.*
3. *Administration of medication: we recommend that more stringent checks are put in place to ensure that residents always take all of their prescribed medication.*
4. *Signage: We recommend that much clearer signage is put in place throughout the care home, in line with best practice for dementia care.*
5. *Front door and reception area: we recommend that improvements are made to the arrangements for allowing people to enter and leave the care home, so that staff can easily see who is trying to get in or out, and relatives can leave the care home quickly at the end of a visit. Possible solutions include: installing a key pad and giving relatives the code so that they can let themselves in and out; moving the office so the staff have a good view of people entering or leaving the premises, and/or installing an entryphone system with a camera on both sides of the door.*
6. *Hygiene: we recommend that urgent steps are taken to deal with the unpleasant smell in some parts of the care home.*
7. *Maintenance work: we recommend that safety procedures and training are improved to ensure that maintenance work does not compromise the safety of residents, visitors and staff.*
8. *Training: we recommend that the care home's training programme should not rely so heavily on online training, but should also include opportunities for staff to take part in interactive classroom-based courses, so that they can learn by discussion and exchange of ideas.*
9. *Sharing good practice: we recommend that arrangements are made for the staff of Parkview House Care Home to share their good practice in dementia care and end of life care for people with dementia with the staff of other local care homes.*

The Enter and View team

The Healthwatch Enfield Authorised Representatives who took part in the visit were Elisabeth Herschan, Janice Nunn, Parin Bahl and Lucy Whitman (team leader).

General Information

Parkview House is a purpose-built home in Edmonton which provides personal care and accommodation for up to 45 frail older people with dementia care needs. The home is divided into five 'clusters' each accommodating nine residents. This approach is known as 'small group living'.

The home is situated in a leafy cul-de-sac opposite a park and a school. We were told that: all 45 rooms are occupied; nearly all residents have dementia; two have additional or other mental health conditions. A block contract from London Borough of Enfield Adult Social Care funds all the places. Most residents are on permanent placements but occasionally someone comes in for respite.

The Registered Provider is Sanctuary Care Limited, who took over the care home from 2Care (part of the Richmond Fellowship) in 2013. Most of the existing staff members have worked at Parkview House for some years and were transferred under TUPE arrangements from the previous provider. The Registered Manager is Jenny Goddard who has been in post since February 2014.

Methodology

During our visit, the team of four Enter and View Authorised Representatives made observations, and engaged in conversation with residents, relatives and staff focusing on the following five key areas:

1. Personal choice and control
2. Communication and relationships
3. Access to good healthcare
4. The environment
5. Staffing issues

During our visit we spoke with the manager Jenny Goddard, one other member of staff (as well as some brief conversations with other staff members), 10 residents and 5 relatives.

This report has been compiled from the notes made by team members during the visit, and the conclusions and recommendations agreed amongst the team after the visit. The recommendations for Parkview House management also appear in boxes at the appropriate point in the report, close to the relevant pieces of evidence.

A draft of this report was sent to the manager of Parkview House to be checked for factual accuracy and for an opportunity to respond to the recommendations prior

to publishing. However, we have not received any response from the care home. This report will be sent to interested parties (including Sanctuary Care, the Care Quality Commission and the London Borough of Enfield) and will be published on the Healthwatch Enfield website.

Acknowledgements

Healthwatch Enfield would like to thank the people who we met at Parkview House, including the management team, staff, residents and relatives, who welcomed us warmly and whose contributions have been valuable.

Disclaimer

This report relates to the service viewed on the date of the visit only, and is intended to be representative of the views of the residents, visitors and staff who met members of the Enter & View team on that date.

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Key area 1: Personal Choice and Control

Individual care and support plans

The team were given access to two individual care plans. These were very large lever arch files containing detailed and comprehensive information which appeared to be up to date; monthly reviews were dated as having been undertaken in the past month. The needs, abilities and wishes of the residents were reflected in the care plans. We were told that the plans are drawn up during the induction period, within the first few weeks after admission, and include advance care planning for the end of life. We were informed that every resident has a designated keyworker and co-worker.

Personal histories

We were told that care workers undertake life story work with the residents and it appeared that staff members were aware of the personal histories of the residents. When asked what she enjoyed doing, one resident replied, "To do with the past." We saw a 'memory box' outside some residents' rooms, containing photos and items of significance. There is the option for residents to have a photo of themselves on their bedroom door to help guide them to their room. We were told that residents received a gift and have a party on their birthdays.

Choice of planned activities

A number of planned and informal activities are included in the published activities programme such as making life story booklets, painting, sing-along, hoopla and darts, lotto, armchair exercises, reading club and 'individual choice' sessions. An external organisation, Mobility London, comes in to provide some of these activities. Some activities take place in the communal areas of the individual clusters and some take place in the central activities room. During our visit we saw residents doing jigsaw puzzles that had large pieces.

We were told that attempts are made to understand the requirements of individual residents to enable them to make their own choices and do something that feels worthwhile. It appeared that one resident uses a laptop and we were told that the home provides wifi. We were told that some residents enjoy helping out with daily chores although we did not observe any resident carrying out a task-based activity. Pets are allowed, but no current residents have a pet.

Not all residents seem to find the activities which are offered appealing. One resident's relative told us that there were activities but their family member does not want to participate. Another resident told us that there is "nothing for me to do."

A hairdresser was at the care home on the day of our visit, and we were informed that she comes every week. There is a room designated as the hairdressing salon and many residents are weekly customers. Several residents said that the hairdresser was "very good" and indicated that they love having their hair done; one resident who did not seem able to communicate verbally showed us that she had had her nails polished and seemed delighted with this. The hairdresser told us that she was seeing 19 clients that day. She said she loved coming and it was "very rewarding". Residents pay extra for the hairdressing service. They have a small

'personal allowance' to spend on hairdressing and toiletries and are helped by staff members to manage their money if needed.

We were told that there are opportunities for going out such as visiting the local Age UK day care centre (staff told us this is "absolutely excellent") and participating in outings such as an upcoming day trip to the seaside. The poster advertising the trip said that relatives were welcome to join the outing. One relative we spoke to was disappointed that their family member was not included in the trip, apparently due to safety concerns.

Most residents have relatives or family friends visiting them on a regular basis and they are encouraged to support activities at the home.

There is a full-time activities manager who is a fairly new member of staff. We were told that she has not been professionally trained for this role, but is being mentored by a more experienced colleague.

Recommendation 1
Activities programme: we recommend that the Activities Manager receives professional training, as well as support from a professional organisation such as NAPA (the National Association for Providers of Activities for Older People).

Meaningful occupation when not taking part in planned activities

Some residents were sitting in the communal lounge of their cluster. In most of the clusters the TV or radio was on, or there was music playing. This may discourage conversation, and may not suit all the residents. Some of the residents we spoke to were hard of hearing and they appeared to struggle to maintain a conversation in the communal areas.

One resident said that sometimes there was a bit too much music in the sitting room. This resident had been sitting alone and seemed sad when the Healthwatch team member left to talk to other people.

Recommendation 2
Facilitating conversation: we recommend that there is sometimes a quiet environment in the sitting rooms, without the television or radio/CD player on, to facilitate conversation, especially for residents who may be hard of hearing.

Another resident said that they appreciated being left alone some of the time without being forced to socialise. This resident said:

> "The people are very nice here. They are very obliging. I like it very much. People are friendly without being gushing. They mind their own business. I have got my own room and it's nice and warm and comfortable. I'll recommend this place wherever I go."

During our visit, one resident, accompanied by their relative, came into the activities room and played the piano with great skill. We were informed that this resident used to play the piano for their church.

We saw residents walking about inside the care home, which can help them maintain their mobility, and going into the garden, which can stimulate their senses and help them to feel connected to the natural world.

We were told that residents are encouraged to go out of the care home (accompanied by a member of staff) on short walks to the nearby park, the local shops and café and the local day centre. Staff told us that some residents could walk to the GP surgery at the end of the road.

Choice and control of daily schedule

The residents appeared well cared for and reasonably clean and tidy. We saw that residents were able to express their individuality through their dress and chosen activities, and we were told that residents can follow their own personal schedule. A staff member informed us that residents are free to get up when they like, have breakfast in their own time and are able to spend their time as they like. We were told that one resident is brought a cup of tea in bed before they get up. We saw many residents walking about and moving freely around the care home. One resident said: “I can go out in the garden when I like.”

Another resident said that they like to go out into the garden for some “quiet time”. We could see that residents are free to walk to the different clusters of the home to visit residents and staff when they feel like it, and we were told that they can have their dinner in one of the other clusters if they wish.

Choice of food

The menu we saw appeared to be varied with choices available every day on a four weekly cycle. We were told that food is bought from a central supplier but is all freshly prepared and cooked on the premises. Arrangements are in place to cook for those with special dietary requirements and/or feeding needs. Residents are able to eat when and where they like but it seemed most joined in with the communal meal time. Staff members told us that breakfast is prepared in the small kitchen in each cluster, but cooked breakfasts could be ordered from the main kitchen if desired.

Several residents said they enjoyed the food. Residents’ comments on the food include:

> “It’s simple; it’s tasty, not greasy. They’re generous with the helpings.”
>
> “The food is nice with not a bad choice.”
>
> “The food is not bad and I get enough to eat.”

Cultural and spiritual needs and preferences

Care home management and staff appeared to be aware of the needs of residents from diverse backgrounds, and we saw an ethnically diverse staff team on the day of our visit. We were told that individual and cultural needs and preferences, for example for food, spiritual support, or communication in a particular language, are noted on admission. Current residents appeared to be predominantly white English, although we met some residents from other ethnic groups. Staff members

reported examples of adjusting meals to meet religious preferences. We were told that some staff are able to communicate with residents in community languages such as Polish, and that the care home draws on the council's interpreters for residents whose language is not covered by existing staff.

We were told that a weekly inter-faith service is held to help meet the spiritual needs of residents and that specific arrangements are made for those who want other religious services. For example there is a visit to Mass for a Roman Catholic resident, and a member of staff who is Muslim assists with Islamic festivals and rituals.

End of Life care planning

We were told that residents and families are inducted into the centre over a six week period and are given time to think through future options. These include Advance Care Planning, Lasting Power of Attorney and DNAR (Do Not Attempt Resuscitation). We were informed that these are reviewed regularly.

The care home has been awarded the Gold Standards Framework with beacon status for end of life care. (See page 12 and Appendix on page 17.)

Key area 2: Communication and Relationships

Communicating with residents who may have dementia,

Staff appeared to have a good understanding of how to communicate with people with dementia or other communication difficulties, and dealt with individuals with care and patience.

Relationships between residents and staff

We found a general atmosphere of respect, kindness, compassion and warmth.

We observed staff members interacting with residents in a friendly way and calling residents by their first name whilst serving food and drink. We noticed that there was considerable scope for conversation and communication between residents and staff. One resident said of the staff: "They make an effort to talk to you."

We observed that a maintenance man addressed a resident by name as the resident made their way out into the garden and made sure that the resident was all right. We were assured that staff members keep an eye on this resident, who often goes into the garden alone.

Staff appeared to be sensitive to dignity and privacy. A 'dignity tree' has been created and is displayed in the hall. This is a large painting of a tree, with post-it notes stuck on the branches, where residents, relatives and staff members have expressed their thoughts about being treated with dignity.

We were told that some residents had lived at Parkview House for a long time. One resident said, "I've been here a long time. I like it. I love you all."

Several residents approached the members of the Enter & View team spontaneously to talk to us. One resident told a member of the team: “I love you. You’re so lovely.” This gave us the impression that these residents felt safe and at ease.

Response to challenging behaviour

We were told that staff make every effort to support residents who display challenging behaviour and that strategies are in place for dealing with this. Residents at Parkview usually stay there till the end of their life. However, we did hear of one case where it was found that a resident with a dual diagnosis could not be satisfactorily cared for at Parkview House; after a discussion with the family, this resident was eventually transferred to another facility where more specialised care could be provided.

Relationship between relatives and care home staff

We were told by one relative that relatives can be involved in a family member’s care if they want to, and we saw that some relatives had come to help with their family member’s lunch.

There is a family noticeboard which includes key information for residents and their families, including the residents’ information guide, activities programme, menu for the week, prices for hairdressing, a poster about the upcoming outing to Southend-on-Sea, and key policies such as the complaints procedure etc. We were given copies of leaflets which are made available to families, including the Gold Standards Framework leaflet: ‘A guide to achieving the best quality end of life care for service users and their families’; an ‘information leaflet for families when a loved one passes away’, and the official Sanctuary Care Complaints and Compliments booklet.

The manager seemed keen to listen to residents’ and relatives’ views and we were told that they aim to deal with emerging issues informally; however, an effort is being made to capture information about feedback and ‘low-level complaints’. If the manager was not on duty, we were told that the deputy manager would always be available to discuss issues with relatives.

Two relatives told us that if there was an incident, such as their family member having a fall, they were contacted quickly.

Some relatives told us that when they raise concerns with the staff, the staff respond in a positive way. However, one relative told us that following a recent incident, they feel that they have not been involved in their family member’s care.

One relative told us that one of their parents had previously lived in the care home, and after their death they had arranged for the other parent to come to live there. This indicated to us that the relative was very satisfied with the care their parents received.

Involvement of volunteers

Apparently at present only one volunteer is involved in helping at the care home. We were told of plans to develop the involvement of volunteers.

Key area 3: Access to Good Healthcare

Hydration and eating

Water was freely available, and we were told that residents were given ice lollies during the warm weather. Jugs with drinks were available in the dining rooms and the menu looked well balanced. We observed one resident being given assistance to feed, and noted that the staff member seemed to be doing this in an appropriate way.

We were told by a relative that their family member enjoys the food and eats well, with the care home providing the resident with aids for eating such as a rimmed plate.

Access to GP services and regular health checks

The manager told us of excellent support received from the local GP practice at Forest Road Primary Care Centre, which is situated close by. The centre also provides other services such as blood tests. Almost all the residents are registered with this GP practice and have a named GP there. (Residents may choose to remain with the GP they were previously registered with, if that GP is based nearby, but this does not apply to many residents.) We were told that the local GP practice holds monthly 2-3 hour long meetings with a multi-disciplinary group, including senior care home staff, to discuss residents' healthcare needs in detail, and there are regular medication reviews.

We were told that the GPs are "very proactive". Home visits are provided if necessary. One resident told us that she sees the doctor whenever she needs to. She said: "He certainly comes when I ask, and occasionally comes off his own bat."

It is the policy of the care home to try to avoid unnecessary hospital admissions, and in many instances staff contact the GP to attend urgently at the care home, even in the case of apparent mini-strokes, rather than calling for an ambulance. We were told that the GPs are sympathetic to this approach and will always attend when an urgent request is made.

During our visit we witnessed a relative finding some medication – a large tablet – lying on the table in their family member's bedroom. This incident raised a concern that the care home staff do not always ensure that residents take their prescribed medication.

Recommendation 3
Administration of medication: we recommend that more stringent checks are put in place to ensure that residents always take all of their prescribed medication.

Access to mental health services

We were told that access to mental health services was offered through the residents' GPs.

Access to other health services

We were told that that a local optician visits regularly to provide eye tests, that referrals to hearing clinics are made as required, and that residents have access to dental and chiropody clinics and speech and language services. We heard that hearing aids and dentures are well-maintained, and that there are good relationships with community services and social workers.

Access to hospital services

If emergency admission to hospital is unavoidable, the care home sends a leaflet with the resident explaining to hospital staff how the care home will support the resident during their stay (eg by calling regularly and visiting if possible) and requesting that the resident should be discharged back to the care home once their condition has stabilised. This initiative is specifically designed for individuals with dementia, as it is known that they may experience distress during a prolonged stay in hospital; it is part of the care home's commitment to continuity of care for residents who have reached the later stages of life.

End of life care

Parkview House Care Home has adopted the Gold Standards Framework approach to end of life care. We were informed that all staff members have undergone training in end of life care skills, and Gold Standards Framework with Beacon Status was awarded to the home in 2013. (See Appendix page 17)

The care home staff are supported by the district nurses and the community palliative care team in providing end of life care for residents. We were told that in almost all cases, residents who move in to Parkview House stay there until they die. From time to time this is not possible: for example, one resident had been admitted to hospital as an emergency after a stroke and had died the same night.

Key area 4: The Environment

Parkview House occupies a bright and airy purpose-built building arranged on two floors. It is divided into 5 clusters or units, providing accommodation which does not feel institutional. Each cluster has nine single en-suite bedrooms opening out onto a communal sitting room, with a dining room and a small kitchen used for making breakfast and snacks.

There is a large, wide entrance hall with plenty of natural light, where we saw residents walking about and sometimes sitting down for a chat. The ground floor and first floor are connected by a sloping walkway, so residents do not have to go up and down any stairs.

The laundry room and main kitchen are on the ground floor; meals are cooked in the main kitchen and served in the dining rooms in the clusters. There is a large activities room on the ground floor which is used for communal activities, staff training and fundraising activities. This activities room is kept locked when not in

use. It contains a piano and a 'snoezling cart' (used for sensory stimulation) but we got the impression that the snoezling cart is rarely used.

Since the recent takeover of the home by Sanctuary Care, we were told that there have been major improvement works done in renewing the boiler, lighting and fire safety systems.

Accessibility

The care home is fully accessible for disabled residents and is designed in such a way as to maximise the opportunities for residents to maintain their mobility for as long as possible.

We noted 'Orientation Boards' in each cluster displaying the date, month, season and weather for residents' information. A list of residents with their named key worker and co-worker is displayed in each cluster.

We were told that none of the residents is blind. We were not made aware of any special arrangements for people with visual or hearing impairment.

Signage

Good signage is an important feature in a care home specialising in care for people with dementia as they may easily become disorientated. However, we observed that the signage at Parkview House is poor, and we did not find it easy to find our way round the home. Many of the doors in the home look the same and it was not clear where the door led to. We also observed that the signs for male and female toilets in the communal areas were small and difficult to see. People with dementia cannot always decipher or recognise the symbols which are usually used to designate male and female.

We were told that internal redecoration is going to be undertaken with a designer who is trained in dementia-friendly interior design.

Recommendation 4
Signage: We recommend that much clearer signage is put in place throughout the care home, in line with best practice for dementia care.

Front door and reception area

The front door is locked and can only be opened by a member of staff. We were told by relatives that this causes problems. One relative said that at the end of a visit, they need to make a quick exit as delay causes their family member distress. Staff are often busy or working with residents, which means they cannot come to open the front door straight away. Additionally, the front door cannot be seen by staff working in the office, as it is round the corner, which the manager agreed is unsatisfactory.

Recommendation 5
<u>Front door and reception area:</u> we recommend that improvements are made to the arrangements for allowing people to enter and leave the care home, so that staff can easily see who is trying to get in or out, and relatives can leave the care home quickly at the end of a visit. Possible solutions include: installing a key pad and giving relatives the code so that they can let themselves in and out; moving the office so the staff have a good view of people entering or leaving the premises, and/or installing an entryphone system with a camera on both sides of the door.

Communal areas within the clusters

All sitting rooms are comfortably furnished. TVs, CD players and CDs are available for use and we saw magazines in some of the sitting rooms. Four of the five sitting rooms have good natural light, but one only has a skylight and no windows, which makes it rather dark. We observed that this skylight was dirty. We also noticed that one of the sitting rooms has a mirror on the wall and we were concerned because mirrors can sometimes cause confusion and distress for individuals with dementia. One resident informed us that they thought the sitting room and garden were "nice".

We noticed an unpleasant odour in several of the sitting rooms, (which are right next to the dining rooms). In two cases this was particularly bad. This malodour was mentioned in a recent CQC inspection. We were not sure of the source of the odour but noted that there are toilets leading off the sitting rooms and we saw that sometimes the toilet doors were left open; we also thought there might be a problem with the seat-coverings and carpets. We were told that the care home intends to replace the fabric chairs and carpets with more appropriate coverings that can be washed more effectively. The manager has also reviewed current cleaning practice, and training is planned to address this problem.

Recommendation 6
<u>Hygiene:</u> we recommend that urgent steps are taken to deal with the unpleasant smell in some parts of the care home.

Bedrooms
Some residents invited us into their bedrooms and we found that the rooms were spacious and well lit, with an en-suite shower and toilet.

In one bedroom we observed that a window was open which made the room cold. This window was too high for the resident to close without help. The resident opened their wardrobe to get a warmer cardigan, and it was possible to see that all clothes were clean and neatly arranged.

We were told by a number of residents that they liked their bedroom. Residents and families are encouraged to bring personal items to make the rooms familiar

and homely. We observed one resident in their own reclining chair in their bedroom.

We saw a buzzer/alarm on the bedroom wall. We were informed that the buzzer sounds on each floor and in the main office and that calls are responded to within one minute.

Bathrooms, toilets and washing facilities

All bedrooms have en-suite toilet and shower facilities and both floors have a communal bathroom with a hoist.

Access to outdoors

There is direct access from the ground floor clusters to the sensory garden, while the first floor clusters have balconies which look out on the garden. The sensory garden has plants such as lavender which have a distinctive pleasant smell, some artificial grass which is safer to walk on than real grass, and a water feature. The sensory garden is very beautiful and a real asset to the care home. There is a park next door and regular visits to the park are included in the activities schedule.

Maintenance work

During our visit we witnessed a maintenance man standing on a ladder on the first floor landing to replace a light-bulb or repair a light fitting. The ladder was close to a barrier encircling a drop down to the ground floor and was causing an obstruction on the landing. A resident, visitor or staff member could have bumped into the ladder causing the maintenance man to fall or to drop something, putting both him and other people at risk of injury.

Recommendation 7
Maintenance work: we recommend that safety procedures and training are improved to ensure that maintenance work does not compromise the safety of residents, visitors and staff.

Key area 5: Staffing Issues

Staffing levels

We were informed that each cluster has two members of staff on duty between 7am and 9.30pm and one staff member from 9.30pm to 7am. This means that at night there are always five staff members on duty, including a manager at all times. The night manager looks after one cluster but carries a pager in case there is an emergency in another cluster. We were told that the night staff members do hourly checks on all the residents and that the manager does occasional unannounced night checks.

We were informed that shift patterns are under review to align with the requirement of the new owners but are currently 7am to 3pm, 1.30pm to 9.30pm, and 9.15pm to 7.30am. Managers are allocated an extra half hour to help with transition across shifts. We were told that staff members carry mobiles/pagers to facilitate communication.

There are no full time staff vacancies at the home but we were told that there are some vacant hours.

We were told that the care home uses only one agency to cover staff leave and absences, and many of the agency staff have a long-standing relationship with the home and know many of the residents by name.

Staff training

Sanctuary Care have their own training department and the manager of Parkview House said the standard of training provided was very high. She has undertaken an intensive programme of leadership and dementia care training, which is still ongoing, since her appointment in February.

We saw the training matrix for staff which appeared comprehensive, including mandatory courses on health and safety, food safety, first aid, infection control etc, as well as courses on dementia care, communicating with people with dementia and palliative care. We were informed that most of the staff training including dementia awareness is done by e-learning. Some staff commented that they feel that relying on e-learning courses alone is inadequate and does not allow for discussion and sharing of experience.

Recommendation 8
Training: we recommend that the care home's training programme should not rely so heavily on online training, but should also include opportunities for staff to take part in interactive classroom-based courses, so that they can learn by discussion and exchange of ideas.

Residents' and relatives' opinions on the staff

One relative told us of a recent time when they had noticed that the only staff member on duty in one of the clusters was watching the TV and not attending to the residents' needs.

However, comments from residents about the staff include:

> "Personally I think it's wonderful the way they look after us."
>
> "Most of them are all right."
>
> "People here are helpful. It's lovely here."

In answer to the question, "Are the people here helpful?" one resident replied: "Very much so."

Conclusion

From our observations and conversations, we were satisfied overall that Parkview House provides high-quality person-centred care for people with dementia, helping residents to retain their mobility, their cognitive faculties and their independence for as long as possible, and making every effort to support residents at the very end of their life to die in dignity and comfort in familiar surroundings.

Recommendation 9
Sharing good practice: we recommend that arrangements are made for the staff of Parkview House Care Home to share their good practice in dementia care and end of life care for people with dementia with the staff of other local care homes.

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Appendix

The Gold Standards Framework for End of Life Care

The Gold Standards Framework (GSF) is a nationally accredited systematic evidence based approach to optimising care for people nearing the end of life. It is concerned with helping people to live well until the end of life with any end stage illness in any setting.

The leaflet provided by Parkview House Care home when a resident is admitted to hospital near the end of their life defines the goals of the GSF at Parkview House as follows:

1. Providing each individual with the best possible care in their preferred environment until the final stages of life by enabling the service user and their family to have choice and control over how and where their care is provided.

2. Ensuring that the service user's family feel enabled, informed and involved in their care as much as possible and are supported for the duration of their involvement with Parkview House.

3. Clear and collaborative communication between Parkview House, the GP and community services to ensure that care is provided in a coordinated and holistic manner.

Further information about the Gold Standards Framework can be found at www.goldstandardsframework.org.uk

What is Healthwatch Enfield?

Healthwatch Enfield is an independent organisation which exists to represent patients and service users. Our job is to make sure local people's voices are heard by those who design and deliver services. We are part of a national network of Healthwatch organisations.

What does Healthwatch Enfield do?

- Healthwatch Enfield is here to help secure improvements to services such as GP practices, dentists, opticians, pharmacies, hospitals, care homes and day centres.
- We work on behalf of the local community, children, young people and adults.
- We provide information about the health and social care system.
- We collect the views and experiences of local people about health and care services; what works well and what needs to be improved.
- We have formal powers called 'Enter and View' so we can go and see for ourselves how adult health and social care services are working.
- We have a place on bodies like the Health and Wellbeing Board and we attend the Clinical Commissioning Group. This enables us to influence the way services are planned, commissioned and delivered.
- We work with local Healthwatch organisations in neighbouring boroughs because their residents share some services with Enfield residents.
- We pass on information and recommendations to Healthwatch England, to the local Council and the Care Quality Commission.

Further information about Healthwatch Enfield can be found on our website: www.healthwatchenfield.co.uk

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Healthwatch Enfield is registered as a Community Interest Company no 08484607 under the name of Enfield Consumers of Care & Health Organisation CIC.

What is Enter and View?

Healthwatch Enfield has the authority to carry out **Enter and View** visits in health and social care premises to observe the nature and quality of services. This is set out in Section 225 of the Local Government and Public Involvement in Health Act 2007.

Enter and View is part of our wider duty to find out what people's experiences of local health and social care services are, and use our influence to bring about improvements in those services. We can hold local providers to account by reporting on services and making recommendations.

Further information about Enter and View is available on our website: http://www.healthwatchenfield.co.uk/enter-and-view