healthwatch Enfield

Healthwatch Enfield
Enter & View Report
Hugh Myddelton House 5 February 2015

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Premises name	Hugh Myddelton House Care Centre
Premises address	25 Old Farm Avenue, Southgate, N14 5QR
Date of visit	Thursday 5 February 2015

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 nursing 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 and nursing home residents are receiving a good service from local health providers.

Hugh Myddelton House was inspected by the Care Quality Commission (CQC) four times between June 2013 and August 2014, and the inspection reports note that there have been concerns regarding staffing, management and record-keeping during this period, and that enforcement action was required on the safe management of medicines following the inspection which took place in May 2014.

Healthwatch Enfield chose to visit this nursing home because of its chequered history of CQC reports and because it has a large number of residents all of whom are extremely frail and vulnerable. We wanted to see for ourselves what the care is like in Hugh Myddelton House and whether the staffing problems which have been noted at this establishment have been resolved.

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Executive summary

We found that much of the care provided at Hugh Myddelton House is of a high standard and many of the staff are greatly appreciated for their kindly attitude and hard work. We were impressed with the manager and noted that she and her deputy demonstrated good understanding of the needs for individualised care planning and were focused on continuous improvements to the home. However, we heard from residents and relatives of concerns about the attitude and competence of some of the night staff, and about the lack of adequate appropriate activities for the complex client group who live in this nursing home. We believe that these are the two key areas where improvements are needed.

We also feel that as there has been a high turnover of staff and managers at this nursing home, and a history of staffing problems which have been noted in a series of CQC reports, the manager and staff of Hugh Myddelton House would benefit from more support from the proprietors, Barchester Healthcare.

Recommendations for the management of Hugh Myddelton House

(These recommendations should be read in conjunction with the response from the manager which appears on pp.29-34.)

1. *Provision of activities: we recommend that renewed efforts are made to appoint an additional properly qualified or experienced full-time activities coordinator as a matter of urgency. Varied and high quality activities should be available seven days a week. The activities coordinators should aim to devise activities to meet the differing needs of residents including younger residents and those who are bedbound. Activities coordinators should not be asked to do personal shopping on behalf of residents. Greater use should be made of volunteers to help with outings and other tasks.*

2. *Use of internet for residents: we recommend that full use is made of the opportunities provided by the installation of wifi and the new Ipad, to offer less mobile residents the chance to take part in interesting internet-enabled activities.*

3. *Opportunities for physical exercise: we recommend that more systematic opportunities should be provided for residents to take part in appropriate physical exercise.*

4. *Opportunities for going out: we recommend that more opportunities are provided for residents to go out on both formal outings and informal trips to the local amenities. It may be necessary to recruit volunteers to assist with taking residents out.*

5. *Photos of staff: we recommend that good quality photos of all staff are displayed on each floor, with their names and job titles clearly written in a large font.*

6. *Accessibility of call bells: we recommend that staff should ensure that call bells are always plugged in and left within easy reach of residents. Additional electric sockets or adaptors may be needed to make sure all necessary electrical equipment can be plugged in at all times. TV remote controls should also always be left within reach.*

7. *Communications skills training: we recommend that all staff receive additional training in advanced communication skills, such as communicating effectively with people who may have dementia or brain damage, and/or impaired sight or hearing. This training should be delivered in a classroom setting with opportunities for reflection and discussion, rather than an online format.*

8. *Equality and diversity training: we recommend that all staff receive expert training in equality and diversity, so that they can explore the challenges and advantages of working in a multicultural organisation, and can discuss sensitive issues in a safe and non-threatening environment.*

9. *Manual handling training: we recommend that all staff receive additional training in manual handling, with an emphasis on techniques for managing situations with residents who are particularly frail in addition to having a condition such as dementia, which may increase the possibility that they will be resistant to receiving personal care.*

10. *Overnight stays for relatives: we recommend that a folding bed or reclining chair is provided for relatives staying overnight when the resident is gravely ill or approaching the end of life.*

11. *Volunteer involvement: we recommend that greater efforts are made to recruit suitable volunteers, perhaps with the help of the Enfield Volunteer Centre, and to offer a range of activities for volunteers to get involved in.[1] For example, volunteers might be able to engage residents in conversation or board games if they are bed-bound, or to help facilitate conversation between residents who are sitting in the lounge together or waiting for their meals. Volunteers might be able to help residents develop their IT skills. Volunteers could help with shopping for residents, and could also assist staff to take residents out on formal or informal trips. Relatives of current or former residents might be interested in becoming volunteers.*

12. *Access to mental health services: we recommend that the manager and staff review the emotional wellbeing of all the residents on a regular basis, and ask the GP to consider making a referral to mental health services for any resident whose mental health appears to be deteriorating.*

13. *Hygiene: we recommend that cleaning procedures are reviewed and urgent action is taken to ensure that any malodours are dealt with promptly.*

14. *Signs and notices: we recommend that all signs and notices are written in a large clear font and placed where they can easily be seen by residents who are seated in wheelchairs.*

15. *Seats for visitors: we recommend that some folding chairs and cushions are purchased and stored centrally for relatives to use when they visit.*

16. *Care home providers meetings: We recommend that the manager attend meetings of the Care Home Providers network hosted by Enfield council, to which all local care home managers are invited. At these meetings she will be able to network with other local care home managers and receive information about support provided by the council.*

[1] **Use of volunteers:** since drafting this report, Healthwatch Enfield has been in touch with Enfield Volunteer Centre and we understand that there are some legal issues regarding the use of volunteers in privately-owned care homes. We are investigating this further and will get in touch with Hugh Myddelton House once we have clarified the situation.

17. *Staff holidays: we recommend that care is taken to ensure that staff holidays are spread throughout the year more evenly.*

18. *Night staffing: we recommend that night staff should be supervised more closely by senior staff, and that consideration should be given to having a manager on duty on the premises at all times.*

19. *Team building: we recommend that night staff should sometimes be rotated with day staff to ensure that the staff team is well-integrated and that the whole workforce benefits from all opportunities for personal and organisational development, including team meetings, staff social events and training sessions.*

20. *Gold Standards Framework: Providing good end of life care is an essential part of the work of a nursing home. We strongly recommend that the home should restart the process for accreditation by the Gold Standards Framework.*

Recommendations for Barchester Healthcare

1. *Support for care home managers: we recommend that Barchester Healthcare should consider investing more resources in Hugh Myddelton House, including offering additional support to the manager and staff to build on progress to date, in order to ensure that improvements to the quality of life at the nursing home can be sustained.*

2. *Terms and conditions for staff: we recommend that in order to attract and retain high quality permanent staff who are keen to make a lasting contribution to the Hugh Myddelton House community , Barchester Healthcare should urgently review the wages, terms and conditions and support offered to staff at all levels.*

The Enter and View team

The Healthwatch Enfield Authorised Representatives who took part in the visit were Elisabeth Herschan, Gillian Edwards, Janina Knowles and Lorna Reith (team leader).

General information

Hugh Myddelton House is a purpose-built 48-bed nursing home, situated in a quiet residential street near shops and transport. The manager, who has been in post since September 2014, is Ms Nicola Phillips.

The nursing home has a 19-bed unit on the ground floor for frail elderly people, a 19-bed unit on the first floor for people with dementia and a 10-bed unit on the second floor for younger people (under 65) with physical disabilities. The manager told us that many of the residents are very old (in their eighties and nineties), and extremely frail; the oldest resident is 99. We heard that the residents in the second floor unit for younger people are mainly those with brain injuries, spinal injuries, progressive MS etc, and that the youngest of these residents is in the thirties.

We were told that there were currently two beds empty, and two residents receiving respite care on a short-term basis. We were informed there was a waiting list for beds. We understand that less than a third of the residents are privately funded, and that the rest are mainly placed by the London Borough of Enfield, with a few from the London Borough of Barnet.

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 and management issues

We spoke with 11 residents and either spoke with or received written comments from 8 relatives.

We spoke with the manager; 2 nurses; receptionist; hairdresser; activities organiser; and (more fleetingly) with several other care assistants and nurses.

We found that Healthwatch Enfield posters were on display in reception and elsewhere and Healthwatch Enfield leaflets were available in reception. It was clear that the staff had made sure that residents and their relatives had received copies of our letter announcing our visit. At least one relative had made a particular effort that day to get to the home in time to speak with us. One of the residents had expressed a particular wish to talk to us, and this resident was

pointed out to us. More than one relative had emailed their comments to us in advance of the visit.

On our arrival the manager was in an unplanned meeting about a safeguarding alert which the home had raised regarding a resident who had been discharged from North Middlesex University Hospital (NMUH). The receptionist and other staff were expecting us.

Staff appeared to have been well briefed about our visit. They seemed comfortable with our presence. When asked, they identified residents who they thought could manage a conversation with us, asked the resident's permission, and then left us alone.

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 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 Hugh Myddelton House to be checked for factual accuracy and for an opportunity to respond to the recommendations prior to publishing. We have included her response on pages 29-34, and are pleased to learn that many of our recommendations have been accepted by the management, and are being acted upon.

This report will be sent to interested parties (including Barchester Healthcare, the Care Quality commission, Enfield Clinical Commissioning Group, 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 Hugh Myddelton House, including the manager, 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

Person-centred care

In general, we found that staff appeared to know the residents well and to be delivering person-centred care. Some examples are:

A nurse and a care worker we spoke with both spoke of the importance to them of staying on one floor (rather than being moved around) so that they could get to know residents. Both of them seemed caring and demonstrated knowledge of the needs of individual residents.

When we were looking for a particular resident who had expressed an interest in talking to us, a staff member, who was cleaning a floor at the time, knew exactly who we were looking for and took us to meet the resident. The staff member introduced us and asked the resident politely if they were willing to talk to us.

We understand that there is at least one married couple living in the home who are both accommodated on the ground floor, so that they can be near each other, although they have different needs.

One of the residents said they had originally been given a room on the second floor of the home but had put in a request to be on the ground floor, and had now been moved down. The resident now has direct access to the garden (in their wheelchair) via French doors from the bedroom. The resident's spouse had installed three bird-feeders in the garden outside the window.

Individual care and support plans

We looked at three care plans and folders, which are kept in a cabinet in the nurses' station. We found them to be robust, with up to date information. The initial assessment reflected the personal history, preferences and abilities of the resident. Other people were present at the planning stage and reviews were present in the folder. One of the key workers sat with us whilst we were looking at the files. They were able to tell us the resident's religion (for example this resident attends church on Sundays and the priest comes in sometimes). This member of staff informed us that a Greek Orthodox priest comes in for a Greek resident. One care plan that we saw recorded the resident's wish to be involved in any decision to call an ambulance, as well as a clear decision not to be resuscitated. The folder included this resident's picture, medical records, continence assessment, and assessment of needs, Waterlow assessment (risk assessment tool for pressure ulcers), skin inspection, choking assessment, healthcare reviews and daily log which were up to date. Most residents have DNAR (Do not attempt resuscitation) decisions in place, and Advance Care Plans if nearing the end of life.

The relatives we spoke to all reported being involved in discussions about their family member's care.

Personal histories

We asked a member of staff about residents' backgrounds and she was able to tell us what some of the residents, who had grown up locally, had done in their working life, but said she didn't know this much about all the residents.

Support for residents with disabilities

We were told that many residents have hearing or visual impairments as well as mobility restrictions. There is disabled access throughout the building and we saw various items of equipment (hoists, wheelchairs, strollers etc). Relatives gave us examples of staff knowing about hearing aids and glasses, although one relative reported that some care staff had not fitted the resident's hearing aid batteries correctly on more than one occasion. (We are not sure how long ago these incidents took place.)

Cultural and spiritual needs and preferences

There is a variety of cultural backgrounds amongst both residents and staff, although the majority of residents appear to be white British, and the majority of staff are from different minority ethnic groups. The staff we met appeared to have a good command of the English language.

We understand that there are two south Asian residents at present and that some of the staff speak South Asian languages; family members are also often around to interpret. Relatives of an elderly frail resident with dementia who speaks an Asian language told us the home always ensures that a member of staff who speaks the same language takes this resident for their shower twice a week and washes this person's hair. The relatives said they also appreciated the help from other staff who speak a different but related Asian language, and can communicate at a basic level with this resident.

Choice and control of daily schedule

Staff told us that residents can follow their own personal schedule, (eg when to get up, go to bed, eat etc) and this was confirmed by residents and relatives we spoke to.

Several residents told us that drinks and light snacks are available if they get up in the night.

One of the younger residents who has been in the home quite a while, said that the staff allow residents to choose whether to stay in bed all the time or not. This resident has decided to alternate, one day in bed and one out.

We asked about showers and baths. Staff told us that residents can shower as often as they wish and some do so every day. One resident confirmed that they can choose when to shower. Two residents told us they have two or three showers a week. Staff said they had some difficulties with residents who don't want to bath or shower; they said they try to insist on once a week as a minimum.

Two relatives informed us that in the past personal laundry had not always been returned because the labelling was poor, but said this had improved recently.

A member of staff said there is a smoking area outside and some residents are able

to go there unattended and others are given support to do so. We came across a resident who had just come back inside after a smoke.

Choice of food and drink

The menu looked very good, and residents and relatives told us the food had improved since a new chef was appointed. Special requirements (coeliac, vegetarian, pureed) are met and there are choices on the menu. We understand that two residents are having PEG feeding. We saw a resident who had a cup of tea and portions of fruit (which looked appetising and freshly prepared) mid-morning in their bedroom. We spoke to residents who preferred to eat in their room but knew they could eat in the dining area. We observed that some relatives were helping with feeding.

One relative told us that before the current manager and chef came into post, food was reheated from lunch and given out again at dinner time; this relative said the previous chef did not listen, and did not prepare pureed food as required by the resident; as a result of this, the relative had started coming in twice a day to help with feeding and to check the quality of food offered. This person had raised these concerns with the current manager and praised her quick response to the issues raised. They now had a new chef, the food was good and this relative felt more relaxed.

Another relative said the food is much better than it was; this relative had tasted one meal and said it was "*delicious*".

One resident said the food is fine; "*there's a choice of two things every day*."

There was a large handwritten sign saying that "*X is diabetic and should not be given any sugar.*" This resident told us their blood sugar level is checked every day and they are not on any medication for diabetes at the moment.

A staff member told us that some residents can be very fussy about the visual appearance of their food. Having chosen something they may decide they don't like the look of it. The chef will then, apparently, provide them with something else. This staff member confirmed that the chef makes an effort to provide food to match personal preferences and dietary and cultural requirements.

Choice of planned activities

We found that the range and availability of activities appeared to be very limited. Two residents and several relatives told us that there is a shortage of activities.

We were particularly concerned about the lack of activities for the younger residents on the top floor, and for the large number of residents who are bedbound.

There is currently only one activities coordinator who works part-time (Thursdays, Fridays and Saturday mornings). One relative said there has not been a full time activities coordinator "for a long time", and another relative said, "There has not been a full complement of activities staff at the home since January 2011." This relative said, 'As far as I am aware, other than the occasional entertainer there are currently no organised activities on Sundays to Wednesdays.' Another relative told us that there used to be a lot more outings than there are now, because

currently only one member of staff - the maintenance man - is qualified to drive the minibus.

We were told that other activities are provided by other members of staff, and the manager told us she is trying to recruit another full-time activities coordinator so that activities can be provided seven days a week.

We met the activities coordinator who told us she usually organises outings for Thursdays, to places such as garden centres or Kenwood House. She can take up to 3 residents at a time on outings, assisted by the home's maintenance man who drives the minibus (apparently the only staff member qualified to drive the vehicle). She told us that most residents are now so frail that the maximum time for a trip out is probably 1½ hours. She said that previously trips might have been longer but now many of the residents had been there for a long time and their health had deteriorated, so that overall there was a much higher level of need than before.

More than one relative confirmed that compared to a few years ago, more of the residents are extremely frail, which means it is harder to provide enjoyable activities and social stimulation for everyone.

Residents from the top floor told us that the activities coordinator did their shopping for them but this wasn't an opportunity to go out. This was also mentioned by the relative of a resident on a different floor, who said the activities coordinator "spends most of her time shopping on behalf of residents and /or on outings with perhaps just 1 or 2 residents".

We think it is inappropriate for an activities coordinator to be running errands, which is something that could be done by a volunteer, rather than facilitating actual activities for residents to join in with.

There was a reminiscence session taking place when we arrived in the morning and a number of older residents were participating. The room where the reminiscence group was taking place was crowded and a larger space would have been more appropriate and comfortable. The activities programme indicated that these reminiscence sessions take place once a month. It also indicated that there is a monthly visit by two music therapists.

In the afternoon there was a singer entertaining about a dozen residents on the ground floor. We spoke briefly with the singer beforehand. She told us that she would be delivering a range of songs including Beatles and music theatre.

Some relatives mentioned that their family member enjoyed attending singing and dancing sessions. A member of staff and a relative spoke positively about a Christmas meal. One resident told us there was bingo but this wasn't something this resident enjoyed.

The home has a hairdresser who comes once a week. We met her and she was interacting warmly with three residents who she clearly knew well. We had also seen her earlier with different residents, so her service is well-used and popular. One relative said the hairdresser would come to bed-bound patients if asked.

Recommendation 1
Provision of activities: we recommend that renewed efforts are made to appoint an additional properly qualified or experienced full-time activities coordinator as a matter of urgency. Varied and high quality activities should be available seven days a week. The activities coordinators should aim to devise activities to meet the differing needs of residents including younger residents and those who are bedbound. Activities coordinators should not be asked to do personal shopping on behalf of residents. Greater use should be made of volunteers to help with outings and other tasks.

Meaningful occupation when not taking part in planned activities

This seemed quite limited. There were books and videos/DVDs available and we saw residents with newspapers and puzzle books but we saw nothing else. All residents have a television in their bedroom, but care staff sometimes leave the remote control out of their reach. On two occasions when we were talking to residents in their bedrooms, they had to ask us to pass them the remote to turn the TV off.

The activities coordinator told us that the home has recently installed wifi and there is an iPad for residents to use.

One relative, on their own initiative, was exploring the availability of IT courses for their family member who needed something to occupy the time.

Recommendation 2
Use of internet for residents: we recommend that full use is made of the opportunities provided by the installation of wifi and the new Ipad, to offer less mobile residents the chance to take part in interesting internet-enabled activities.

The manager said that staff facilitated activities with residents who are bedbound but we did not see evidence of this. As far as we could tell, bed-bound residents' interaction was only with their own visitors and with staff. Some relatives apparently spend time every day with their family member, and provide company. Apart from staff checking they were okay on a regular basis it didn't appear that bedbound residents had any other interaction and the only 'activity' was the TV.

We spoke with one elderly resident who was sitting in an armchair in their bedroom on the first floor unit for people with dementia. This person told us they prefer to eat in their bedroom and are not interested in joining in activities – especially not bingo or outings to shopping centres. This resident said they preferred reading the newspaper to reading books. There was a selection of family photos on the bedroom wall and this resident appears to have regular visits from family members.

Another resident told us they are not interested in socialising in the home. This person said (not unkindly) that *"most of the people are mental…and don't speak clearly"* so they prefer to be on their own. We saw a modest-sized flat screen TV

on the wall in this resident's room. This was on when we arrived but the resident turned it off to speak with us.

One of the younger residents told us the wifi coverage in the home is good. This resident does not have any concerns about the home, indicating that the staff have made an effort to accommodate this person's lifestyle. This resident said they can get up when they want, eat when they want, meet up with friends, listen to their chosen type of music, and they did not expect to find others in the home with similar tastes and interests. This resident goes out of the home to meet friends and has been given the entry/exit code so is free to come and go, as long as they sign in and out. The resident seemed happy with this arrangement.

One resident that we spoke to said they had previously stayed for short visits in another facility, and had not been happy there, but was happier here at Hugh Myddelton House. This person said they do not socialise much in the home, or have any particular interest in doing so.

The examples given above illustrate the challenge of providing enjoyable activities and creating a sociable community for such a disparate group of people, of different ages, different physical and mental abilities and different tastes.

However it is to be hoped that once another activities coordinator has been appointed, more residents can be enticed to leave their bedrooms and to enjoy taking part in activities with each other. Volunteers could also be recruited to help provide activities with those who need one to one attention.

Opportunities for exercise

Quite a number of residents are not mobile but we saw others walking about inside the home. We did not see or hear mention of exercise activities. One resident on the top floor had exercise equipment in their room which we were told was to help them build up their strength.

Recommendation 3
Opportunities for physical exercise: we recommend that more systematic opportunities should be provided for residents to take part in appropriate physical exercise.

Opportunities for going out
We heard from some relatives that they take their family member out from time to time. Another relative mentioned a recent outing to St Albans. However, we were concerned that some of the residents we spoke to who could have gone out had not done so. Some residents are apparently reluctant to take up opportunities to go out and it seems the home might do more to encourage and support them.

Recommendation 4
Opportunities for going out: we recommend that more opportunities are provided for residents to go out on both formal outings and informal trips to the local amenities. It may be necessary to recruit volunteers to assist with taking residents out.

Can residents bring their own furniture?
Residents can bring their own furniture with the exception of beds.

Pets
Pets may visit but not stay in the home; some relatives had brought their dog with them, and told us that their family member liked to see the dog, as did other residents. One resident was missing their cat.

One relative was investigating whether the organisation Pets as Therapy could start to make visits to the home. We understand that the nursing home has already contacted this organisation, and are on the waiting list.

Key area 2: communication and relationships

Interaction between residents and staff

All staff we spoke to came across as kind and compassionate. All interactions between staff and residents that we witnessed were courteous and respectful; residents were addressed by name and treated with dignity and kindness. We got the impression that staff were accessible. There was no sense of rushing about; there was an air of calm about the place which would make it easier for people to talk to staff.

One of the relatives told us that the day carers and nurses who work on the ground floor are "excellent". This relative said that all staff, including the maintenance man, reception staff, cooks and cleaning staff, and the manager know this person's family member very well and treat the resident "kindly, with great patience and respect".

The home does not display named photos of staff, but on each floor was a board displaying the names of all staff on duty that day including the manager, deputy manager, nurse, team leader and care staff. All the staff wear uniforms and name badges but we were not always able to read these.

Recommendation 5

Photos of staff: we recommend that good quality photos of all staff are displayed on each floor, with their names and job titles clearly written in a large font.

Two residents who we spoke to also expressed some anxiety about not always being able to summon staff. One resident said, *"The staff are fine, providing I can get in touch with them, they will do anything…"* The resident has to *"get the cord and press the button"* and it is not always within reach. The resident might simply want to get hold of the TV remote control, which has also been left out of reach, and then the resident would have to wait until someone is passing their bedroom, or comes to check up on them. This person said they would shout for assistance if necessary.

Recommendation 6

<u>Accessibility of call bells</u>: we recommend that staff should ensure that call bells are always plugged in and left within easy reach of residents. Additional electric sockets or adaptors may be needed to make sure all necessary electrical equipment can be plugged in at all times. TV remote controls should also always be left within reach.

We observed nothing that suggested any compromising of privacy and dignity, and saw no signs of residents not being happy, or being afraid of staff.

However, we heard from a number of residents and relatives that there had been problems with staff attitudes in the past, and several relatives told us of current concerns about the attitude and competence of night staff (and some agency day staff).

Several residents and relatives told us the night staff don't make any effort to communicate with them. One relative described the night staff as offhand. Two different sets of relatives spoke of night staff not introducing themselves to either the resident or the relative.

One resident who has dementia had complained about rough treatment from the night staff a year ago, although their relative said it was difficult to know whether this was true or not.

One relative said that their family member had described the night staff as "rough", and said that at night the resident often does not have their hearing aids, spectacles and false teeth in place and is therefore unable to communicate with the staff.

One relative was very concerned because their family member tended to fall asleep in awkward positions and places, for example on the commode; the relative was not convinced that the night staff always took the trouble to move the resident into the right position. Another relative said a staff member had informed them on one occasion that their family member had not been correctly positioned in bed by the night staff.

Relatives of another resident were more positive, and said that night staff always checked their family member's blood sugar, would ring if there was a problem, and would call again, either to report an improvement or deterioration.

One of the residents we spoke to reported no problems with night time care or attention.

Communicating with residents who may have dementia or other communication difficulties, and response to challenging behaviour

We asked one staff member whether they had experienced any difficulties with residents not being cooperative, for example when staff were delivering personal care. The staff member replied that there were some residents whose behaviour

could be challenging occasionally but that they had had training to deal with this, including how to try and avoid residents becoming upset or agitated in the first place.

One nurse told us it was sometimes difficult to communicate with some of the residents with dementia, but said staff were patient and at times would come back later if, for example, it was proving difficult to get them to take medication.

One relative said they thought that staff needed more training in how to communicate with residents who are deaf, for example, being sure to look directly at the resident when speaking to aid lip reading. This relative also said staff did not always understand the importance of fitting hearing aid batteries correctly.

We heard of some tensions between residents and some of the staff, which appeared to be due to failures of communication. We were told that some residents found it hard to understand some of the staff who have quite strong accents and speak quite fast. We also heard that when residents complained that they felt intimidated when members of staff raised their voices, some of the staff justified this by saying this way of talking was part of their culture. Given that communicating well with residents who may have multiple disabilities including dementia, hearing loss and visual impairment is a vital part of the job, and that the cultural and linguistic backgrounds of the staff may be very different from those of the residents, it appeared to us that staff would benefit from training in cultural diversity and communication skills.

Some relatives told us they were generally confident about the current day staff but had concerns about night staff and their inability to communicate sensitively.

The manager told us of a safeguarding alert which had been raised when a resident who has advanced dementia, arthritis and extremely fragile skin had suffered severe bruising, apparently at night. We were also told about this incident by a relative of the resident concerned, who showed us photos of the bruises. It appeared that the bruises had not been caused by deliberately abusive treatment, but by careless or inept manual handling. This incident led to two of the staff being suspended, and being given further training before being reinstated.

We heard that the same resident had later experienced torn skin when being handled by day staff. The relative told us that the response from staff was that the resident had been ‘flailing about’ when they were trying to put socks on. The relative commented that it didn’t seem to have occurred to staff to leave the socks and try again later.

From the reports we heard about the attitude and competence of some staff, we wondered whether all staff are fully aware of good practice in terms of a) communicating with people with dementia, and b) successful manual handling of residents who have extremely fragile skin.

People with dementia may also have other disabilities such as visual impairment or hearing loss, in addition to memory loss and confusion, and may become agitated and uncooperative if staff take them by surprise (especially in the middle of the night) and do not explain clearly, each time, who they are, and what they are

about to do, when delivering personal care. This can then lead to a tussle, which can result in physical harm to a very frail person.

Recommendation 7
Communications skills training: we recommend that all staff receive additional training in advanced communication skills, such as communicating effectively with people who may have dementia or brain damage, and/or impaired sight or hearing. This training should be delivered in a classroom setting with opportunities for reflection and discussion, rather than an online format.

Recommendation 8
Equality and diversity training: we recommend that all staff receive expert training in equality and diversity, so that they can explore the challenges and advantages of working in a multicultural organisation, and can discuss sensitive issues in a safe and non-threatening environment.

Recommendation 9
Manual handling training: we recommend that all staff receive additional training in manual handling, with an emphasis on techniques for managing situations with residents who are particularly frail in addition to having a condition such as dementia, which may increase the possibility that they will be resistant to receiving personal care.

Interaction between residents including those who are bed-bound

Many residents are extremely frail, and appear to spend most of their time in their bedrooms, preferring not to come to the dining room for their meals. This means that they rarely interact with other residents, and rely on their own visitors for company. One relative remarked that because only a small number of residents on the ground floor eat in the dining room, the opportunities for these more mobile residents to socialise with other residents are also very limited. If a greater number and variety of activities could be provided, this could create the opportunity for residents to spend more time with each other.

Involvement of relatives and relationship between relatives and care home staff

Staff had clearly formed good relationships with the relatives that we spoke to. Some relatives visit on a daily basis and spend many hours in the home. We witnessed visitors being made welcome and being served drinks and biscuits or cake.

We asked about visiting hours and were told these were open, though they preferred visitors not to come too late (after10pm) as this could disturb other residents. Relatives told us they felt the manager was approachable and they could ask for information and make suggestions. One relative told us they got regular updates, and could report things they had noticed; this relative described good co-operation.

One relative said that before the current manager was in post, they had visited at 11pm one evening to check whether the family member was being cared for at night. The relative then received a letter asking them not to visit after 9pm. This relative said this was not the case now and it was possible to pop in anytime.

We were told that there is nowhere for relatives to stay if a resident is ill.

Recommendation 10
Overnight stays for relatives: we recommend that a folding bed or reclining chair is provided for relatives staying overnight when the resident is gravely ill or approaching the end of life.

We were told that there are meetings for residents and relatives, and were shown minutes of the last meeting which was held in December. Six residents and eight relatives attended, and staffing issues were the main focus of that meeting.

The manager had also held a cheese and wine evening to introduce herself and plans to hold similar events in the future in order to strengthen the relationship.

When asked, two sets of relatives we spoke to said they would recommend Hugh Myddelton House to others.

Response to residents' and relatives' concerns

Several relatives told us that concerns they had raised had been responded to satisfactorily by the manager.

We asked one resident what they would do if they felt unsafe or unhappy, and they said they would tell the staff nurse.

However, one resident said they had asked for a pendant or hand held pager to call staff and this had not been provided. Another resident had a problem with their glasses (which needed tightening); although the resident had pointed this out several times, nothing had been done.

Another relative told us that they had complained to numerous managers over the past few years about the unacceptable lack of activities at the care home, but that there had been no improvement in the situation.

Involvement of volunteers

The manager said she would welcome more support from suitable volunteers, but has found in the past that applications are often from very young people who only want a short period of work experience, and she does not believe this to be helpful to the residents.

We discussed approaching Enfield Volunteer Centre for help in recruiting more suitable volunteers, and the manager said she would contact them.

Recommendation 11

Volunteer involvement: we recommend that greater efforts are made to recruit suitable volunteers, perhaps with the help of the Enfield Volunteer Centre, and to offer a range of activities for volunteers to get involved in. For example, volunteers might be able to engage residents in conversation or board games if they are bed-bound, or to help facilitate conversation between residents who are sitting in the lounge together or waiting for their meals. Volunteers might be able to help residents develop their IT skills. Volunteers could help with shopping for residents, and could also assist staff to take residents out on formal or informal trips. Relatives of current or former residents might be interested in becoming volunteers.

Please see note 1 on p.4.

Key area 3: access to good health care

Hydration and eating

All bedrooms we looked into had water jugs and cups/glasses. A nurse showed us the fluid charts.

We were told by several residents and relatives that meals had improved with the new chef. We saw two members of staff feeding residents, who were not rushed. Drink was offered during the meal. We also saw that some relatives helped to feed their family members.

Care for bedbound patients

Staff told us they do hourly checks day and night for bedbound residents, and these checks are recorded in the 'red book' (though we didn't see this).

Specialist nursing services

One relative praised staff for spotting a pressure ulcer at an early stage.

The manager reports that there is good support given to residents by specialist nursing teams in particular the CHAT (Care Home Assessment and Treatment) team, The Palliative Care Team and the Tissue Viability Nurse Specialist. Staff also spoke highly of these teams.

Access to GP services

All the relatives and residents we spoke to knew the GP and confirmed that there was a weekly visit every Wednesday. This was appreciated.

The manager told us that the nursing home has a good relationship with a local GP, although the practice staff are not always helpful. Unfortunately the timing of the GP visits (at 9.30am) conflicts with the busiest time of the day for the nurses and care staff, when residents are receiving personal care. The manager is planning to discuss with the practice manager whether the timing can be changed.

Access to dentists, audiology, opticians, footcare etc

We were told there is access to dental services if needed. Some relatives told us that their family member had had two teeth out and this had been done on site. Residents and relatives confirmed that eye checks are done annually. We were told that staff are aware of residents who have hearing aids/glasses, and that residents with suspected hearing problems are referred in the first instance to the GP. Relatives told us of two residents who had been seen by the chiropodist.

One resident told us their teeth had not been checked for a long time.

Access to mental health services

The manager told us of one elderly resident who has recently become very upset and anxious, for no apparent reason. The manager was unsure of the process for referring a resident for a mental health assessment.

Recommendation 12

Access to mental health services: we recommend that the manager and staff review the emotional wellbeing of all the residents on a regular basis, and ask the GP to consider making a referral to mental health services for any resident whose mental health appears to be deteriorating.

Access to hospital appointments

Staff told us that they go with residents to hospital appointments, and staff cover is arranged as these visits can take a long time. We understand that sometimes the home uses its own vehicle for patient transport.

Admission to and discharge from hospital

No problems were reported to us by residents or relatives. However, the manager told us about two recent discharges from North Middlesex University Hospital (NMUH) which had been problematic, where patients had been discharged to the home without their medication or without their discharge letter, or had arrived in the evening when it was too late to get errors corrected until the next day. One of these unsafe discharges was the subject of the safeguarding alert which had been raised by the home and which was being discussed by the safeguarding team when we arrived for our visit.

Staff told us that the home aims not to admit more than one person per day, and not to take admissions on a Friday. This was the ideal but didn't always happen.

End of life care planning and support

We were told that Advance Care Planning is done when residents are approaching the end of life. Some staff have been trained in how to use syringe drivers, but this training needs to be repeated frequently due to the lack of opportunity to use this skill on a regular basis, and to staff turnover.

See recommendation 20 on p.27.

Key area 4: the environment

Hugh Myddelton House is a pleasant modern building situated in a residential street, adjacent to a synagogue. The home is clean, bright and airy, well-decorated and pleasingly furnished. Lighting is good throughout.

Communal areas

"Memory Lane" is the corridor on the first floor, which has specially designed decoration and signage recognising that residents have dementia. This is a Barchester initiative. On this corridor, there were photographs (both recent and from the past) of the residents on their bedroom doors, and pictures on the bathroom and toilet doors.

There was a strong smell of urine on the first floor corridor.

Recommendation 13

Hygiene: we recommend that cleaning procedures are reviewed and urgent action is taken to ensure that any malodours are dealt with promptly.

We noticed that many of the notices pinned up around the home, including the activities time table, were presented in a relatively small font. On the ground floor the room numbers and hand-written names of occupants were relatively high up on the door so they might be difficult to read from a wheelchair.

Recommendation 14

Signs and notices: we recommend that all signs and notices are written in a large clear font and placed where they can easily be seen by residents who are seated in wheelchairs.

The corridors and doorways are wide, making them easily accessible for wheelchairs and mobility scooters, and the nursing/staff stations are appropriately sited.

The communal rooms are comfortably furnished with colour coordinated curtains, carpets and upholstery, all seemingly clean and in good condition; there is a mix of chairs, sofas and space for wheelchairs. In one of the lounges the television was on, and two residents were watching the programme.

The dining room we saw on the first floor contained three round tables, each with three chairs, set out in café format. In one corner is a kitchen area with a sink, kettle, toaster, microwave and storage cupboards. We were told that residents can use these facilities if they are able and, as the nurses' station is directly opposite, staff can keep an eye on them. These facilities are mainly used by staff to prepare drinks and snacks for residents who require food and drink outside of meal times.

Bedrooms

The bedrooms we saw were quite small and there was little space for relatives to sit, especially if the resident was bedbound and couldn't move to a communal area. One resident's relatives had brought in a folding chair to sit on while visiting.

Recommendation 15
Seats for visitors: we recommend that some folding chairs and cushions are purchased and stored centrally for relatives to use when they visit.

In one bedroom we visited, there seemed to be only one electric socket. A sensory pad for falls had been plugged in and the call bell had been disconnected and left on the windowsill. The resident's relative, who was present, was not sure if the call bell was reconnected at night time. This resident was concerned that even when the call bell was plugged in, it was not always possible to reach it.

See recommendation 6 on p.15.

Bathing and showering facilities

The bedrooms we saw each have an en suite toilet and washbasin, and we were told that a few rooms have en suite showers.

On the first floor we saw two shower rooms and a bathroom. We were told that most of the residents prefer taking a shower to having a bath.

We were told that the manager is applying for funds to adapt the bathroom.

Access to outdoors

There is a small garden to the front of the building, with some tables and chairs. To the rear, accessed by French doors, is a garden containing a number of tables, chairs and benches that looked to be in good condition. Both gardens have mature shrubs, and appear to be well-maintained. The rear garden, which had brightly coloured bunting at the time of our visit, looked like a pleasant place to sit, and we were told that it is frequently used in good weather. (It was cold and wet on the day of our visit.)

Entry and exit to the building appeared to be secure. When we arrived we had to ring the bell and a receptionist came to open the door for us. Each of us then signed in before we progressed through a second key-protected door to the main reception area. We were able to take lifts from each floor up to the next, but the stairway, downwards lift journeys, and doors to exit the building, were all protected by number pads.

Maintenance

On the morning of our visit one of the lifts was out of order. Staff told us it had happened the previous day and the lift engineer was due, as the company was on a seven-hour call-out limit.

Key area 5: staffing and management

Management and leadership

At the time of our visit, the present manager had been in post for five months. When she started, in September 2014, she was the third manager the home had had in that calendar year. Residents who had lived in the home for some years and their relatives mentioned the frequent changes of manager. One relative said she thought there had been ten managers over seven years. This relative said that the current manager is "very pleasant and capable" but that some of the managers in the past "have actually caused nothing short of mayhem, causing staff to quit, and upsetting residents and their relatives."

The residents and relatives we heard from seemed to feel in general that the current manager had had a positive impact on the home. Several of them told us that she is approachable, that she had been responsive to concerns they had raised, and had made positive changes (the new chef being a key example). However, one relative commented that the manager seemed to spend a lot of time in the office, rather than out amongst the residents and staff.

The manager impressed us with her evident commitment to raising standards in the home. She had inherited a challenging set of circumstances including some unresolved safeguarding issues and a staff body which had been unsettled by the high turnover of managers and other staff. She told us she was aware of a number of outstanding problems but that she needed to manage change carefully in order to build and retain the confidence of the staff, and to maintain a calm and supportive atmosphere for the residents.

We learned that the manager's strongest support is the deputy manager, but unfortunately the deputy has recently handed in her notice so she can work closer to home, so her post has been advertised. The deputy manager told us that in her opinion the home has seen standards rise over the past year.

We learned that the managers of the two large nursing homes provided by Barchester Healthcare in the borough of Enfield, Hugh Myddelton House and Southgate Beaumont, meet regularly and offer each other informal support. This seems to be an excellent initiative.

The manager said she feels well supported by her manager but would like to be in contact with other care and nursing home managers in Enfield.

Recommendation 16

Care home providers meetings: We recommend that the manager attend meetings of the Care Home Providers network hosted by Enfield council, to which all local care home managers are invited. At these meetings she will be able to network with other local care home managers and receive information about support provided by the council.

Given the history of this nursing home, with the high turnover of staff and managers, and some persistent concerns raised in a series of CQC reports, we were surprised to find that the proprietors, Barchester Healthcare, do not seem to be

offering more tangible support and possibly investing more resources. We are aware that other large providers of care and nursing homes offer a more support to managers, including setting up peer support networks where managers from different homes can get together to support each other, and providing emergency and out of hours support across a region.

Recommendation 1 for Barchester Healthcare

Support for care home managers: we recommend that Barchester Healthcare should consider investing more resources in Hugh Myddelton House, including offering additional support to the manager and staff to build on progress to date, in order to ensure that improvements to the quality of life at the nursing home can be sustained.

Record keeping

We looked at the incident report folder which had quite a few entries for January 2015. Incidents included bruising, body maps completed and attacks on staff or other residents. We found that clear reasons for the incident had been recorded, action plans completed, and there was confirmation that the next of kin had been informed. Some of these incidents had been notified and recorded by night staff.

The manager said she had completed all the Deprivation of Liberty Safeguards (DoLS) referrals and was now awaiting approval.

The manager showed us the spreadsheet which she completes monthly for Barchester which includes safeguarding and other incidents, complaints, DoLS records, nutrition and reviews. We understand that Barchester then send her an action plan to complete. A regional manager checks and signs off once completed. Directors of Barchester can dip into this information at any time for their audit records.

Staffing numbers, recruitment and retention

We were told that there are 62 members of staff, including a number who have been working in the home for many years with at least one in excess of 15 years. However, there has been a significant turnover of staff in recent years.

At the time of our visit, we were told that the home was particularly short of permanent staff. We heard that this is partly due to sickness, and to staff holidays being taken at the same time, but also to staff turnover in general. When we visited, there were several unfilled posts including: a unit manager, a night nurse, a second chef and an activities organiser, and we were told that it is proving quite difficult to fill the vacant posts. The deputy manager will also be leaving in the near future. The manager told us that the home is located in a very expensive area for staff to find accommodation. We were also told that it is quite common for nurses from overseas to work in care homes while they are awaiting registration, and then to move on to NHS posts which provide better pay and conditions than the private sector.

Relatives said they felt that the constant changes of staff at all levels unsettled residents, with the lack of continuity.

We heard that agency staff when required are drawn from two agencies.

Recommendation 17

Staff holidays: we recommend that care is taken to ensure that staff holidays are spread throughout the year more evenly.

Recommendation 2 for Barchester Healthcare

Terms and conditions for staff: we recommend that in order to attract and retain high quality permanent staff who are keen to make a lasting contribution to the Hugh Myddelton House community , Barchester Healthcare should urgently review the wages, terms and conditions and support offered to staff at all levels.

Shift patterns and staffing at different times of day or night

The manager said that quite a few residents need two staff in attendance for manual handling; this was confirmed by staff on each floor.

We were told that nurses and care staff work 12 hour shifts from 7.30-7.30 with a one hour break. There is a handover of 30 minutes at end of the shift, which all staff are paid for. This was confirmed by a registered nurse we spoke to, who told us she works a 12½ hour shift, 3 times a week; days vary, but include some weekends. Staff we spoke to said they appreciated the paid handover as this is not the case in all care homes and nursing homes.

A nurse we spoke to showed us an example of a handwritten sheet written up for a resident which would be handed over to the night shift. There is also a verbal handover, although not in front of residents, as it could be intimidating if staff gather round an individual to talk about them.

The manager told us that staff had signed an "opt out" of the 48 hour European Directive. She said that staff would not usually do more than 47 hours per week, but in emergencies had covered extra shifts. These staff had requested extra hours when they were available.

Overnight staffing

We did not meet any of the night staff, so did not have the opportunity to hear their comments. However, a number of things which we were told by the residents and relatives we met, and by the manager, gave us cause for concern.

As noted in section 2, pp.15-17, several residents and relatives commented unfavourably on the attitude and competence of some of the night staff, and there had been at least one safeguarding alert relating to night staff.

We were told that at night there are two care staff on each floor, and two nurses who cover the three floors between them. One relative said they did not feel nursing cover at night was sufficient given the complexity of the client group. There is no manager on the premises at night, but the manager of the home is always on call in case of an emergency.

We were told that there is no rotation of shifts between day and night staff, and we learned that no night staff had attended a team meeting which had been held in the day time. The manager told us she plans to hold another team meeting in the evening. We did not ask about supervision sessions for night staff. The manager assured us that all night staff have received all the training which day staff have had.

We have found that in other similar establishments, there are successful arrangements to ensure that staff are sometimes rotated between night and day shifts, which has the advantage of ensuring that night staff are fully integrated with the rest of the team, and can attend training sessions and supervision sessions which take place during the day.

Recommendation 18
Night staffing: we recommend that night staff should be supervised more closely by senior staff, and that consideration should be given to having a manager on duty on the premises at all times.

Recommendation 19
Team building: we recommend that night staff should sometimes be rotated with day staff to ensure that the staff team is well-integrated and that the whole workforce benefits from all opportunities for personal and organisational development, including team meetings, staff social events and training sessions.

Staff training

We saw a list of training courses provided for staff. Training is a mixture of e-learning and classroom based training, some provided in-house and some by external sources such as the North London Hospice. We heard that the home has recently appointed an in-house trainer. Barchester group has a regional trainer and a business school. They offer a clinical programme for registered nurses, and vocational qualifications at levels 1 and 2 for care assistants. According to the records we saw, at least 2 members of staff have attended external training each month. Barchester has provided sufficient budget to cover this.

The medication policies have been revisited since the last CQC report; all staff have had updated training in the safe management of medicines.

The home has in the past undertaken Gold Standards Framework (GSF)[2] training in end of life care but this was discontinued when the nurse leading this left. The manager hopes to revive this in the future.

Recommendation 20

Gold Standards Framework: Providing good end of life care is an essential part of the work of a nursing home. We strongly recommend that the home should restart the process for accreditation by the Gold Standards Framework.

All staff who we spoke to had attended all the mandatory training and had a NVQ or QCF qualification. One member of staff told us they had recently attended training in safeguarding, first aid, food hygiene and skin care. Two members of staff pointed out a notice on the nurses' station wall inviting staff members to attend a training session on dysphagia (swallowing difficulties). There was a choice of two dates and there appeared to be several names signed up for both. We were told this particular session was not mandatory, although others are. This notice was pinned up in the nurses' station on the second floor as well.

However it appears that not all staff have completed all the training which is provided. On the date of our visit, we saw records showing that 95% of staff had completed induction training, and 97% customer care training, but only 63% had completed the safeguarding training. Overall course completion was 81%.

The manager told us she is striving to ensure that day and night staff have equal access to meetings, courses and training. This is a challenge that she must address in order to remove any inconsistencies in the quality of care delivered over each 24 hour period.

See also recommendations 7, 8 and 9 on p.17.

Staff supervision and support

Almost all the staff we spoke to said they were happy at work and felt supported by the manager.

One of the nurses we spoke to indicated that things had improved under the management of the current manager and her immediate predecessor. In particular, they had listened to staff requests not to be moved from one floor to the other. This nurse said it was much better for staff to stay mainly on one floor so that they could get to know residents well.

[2] See http://www.goldstandardsframework.org.uk . North London Hospice is a regional Gold Standards Framework (GSF) centre offering the 'GSF in Care Homes' training programme. http://www.northlondonhospice.org/education/gold-standards-framework/ .

A care worker who had been working at the home for 8 months, said working for the home was much better than a previous job in domiciliary care, citing the paid half hour handover as an example.

Team work

One of the nursing staff said it was good that the kitchen staff are so helpful. For example, they provide fresh water for residents each day – something which nurses or care staff would otherwise have to do themselves. This facilitates the distribution and consumption of medication. This provided an example of good team work between staff members with different roles and responsibilities.

We heard that the maintenance man helps out in a variety of capacities including driving the minibus for outings and sometimes helping out as a chef. "And he is a very good chef," remarked one of the relatives.

As noted above, we think that more effort needs to be made to make sure the night staff and day staff all feel part of the same team.

Conclusion

We found that much of the care provided at Hugh Myddelton House is of a high standard and many of the staff are greatly appreciated for their kindly attitude and hard work. We were impressed with the manager and noted that she and her deputy demonstrated good understanding of the needs for individualised care planning and were focused on continuous improvements to the home. However, we heard from residents and relatives of concerns about the attitude and competence of some of the night staff, and about the lack of adequate appropriate activities for the complex client group who live in this nursing home. We believe that these are the two key areas where improvements are needed.

We also feel that as there has been a high turnover of staff and managers at this nursing home, and a history of staffing problems which have been noted in a series of CQC reports, the manager and staff of Hugh Myddelton House would benefit from more support from the proprietors, Barchester Healthcare.

Response from the manager of Hugh Myddelton House to the recommendations made in this report

Healthwatch Enfield is delighted that the manager of Hugh Myddelton House has responded so fully to our recommendations, and has taken positive action to implement many of them. In those cases where our recommendations have not been accepted or implemented, we add a further comment.

1. *<u>Provision of activities</u>: we recommend that renewed efforts are made to appoint an additional properly qualified or experienced full-time activities coordinator as a matter of urgency. Varied and high quality activities should be available seven days a week. The activities coordinators should aim to devise activities to meet the differing needs of residents including younger residents and those who are bedbound. Activities coordinators should not be asked to do personal shopping on behalf of residents. Greater use should be made of volunteers to help with outings and other tasks.*

   Response from manager: Since the inspection we have now appointed an activity coordinator to the vacancy. She is currently receiving induction and support to improve the activity experience for all residents, including those nursed in bed. The activity programme now runs across a 5-6 day week with scope for further development with all staff at Hugh Myddelton being supported to maximise every opportunity to provide meaningful interactions with resident during their interventions, so activities are a holistic experience for all. The local Enfield volunteer centre has been contacted and their criteria for allocation of volunteers are for not for profit/charitable organisations, unfortunately. We have had interest from local school 6th form students; however their focus is primarily work experience to benefit their UCAS application and is not long term commitment to the home and residents. We have networked closely with our 'sister' home Southgate Beaumont to share and look at existing successful activities that will enhance our programme to add variety and also will be actions for other recommendations as detailed in this report.

2. *<u>Use of internet for residents</u>: we recommend that full use is made of the opportunities provided by the installation of wifi and the new Ipad, to offer less mobile residents the chance to take part in interesting internet-enabled activities.*

   Response from manager: Wifi now installed in the home – access available to residents and families. The use of a laptop is also available and part of residents' activity programme if appropriate.

3. *<u>Opportunities for physical exercise</u>: we recommend that more systematic opportunities should be provided for residents to take part in appropriate physical exercise.*

   Response from manager: Chair based exercise already part of the activity programme.

   Comment from Healthwatch Enfield: We did not see evidence of opportunities for residents to take part in a variety of types of exercise including walking about (for those who are able). We hope that now the new Activity coordinator is in post, more attention will be given to this important aspect of care.

4. *<u>Opportunities for going out</u>: we recommend that more opportunities are provided for residents to go out on both formal outings and informal trips to the local amenities. It may be necessary to recruit volunteers to assist with taking residents out.*

   Response from manager: This already is part of our programme and is in place. There is a lack of volunteer support as already explained.
   Comment from Healthwatch Enfield: Our conversations with residents and relatives convinced us that at the time of our visit there were not sufficient opportunities for residents to go out. It is to be hoped that now the new Activity Coordinator is in post more informal and formal outings can be arranged.

5. *<u>Photos of staff</u>: we recommend that good quality photos of all staff are displayed on each floor, with their names and job titles clearly written in a large font.*

   Response from manager: Underway to complete and have photos of all staff by beginning of May.

6. *<u>Accessibility of call bells</u>: we recommend that staff should ensure that call bells are always plugged in and left within easy reach of residents. Additional electric sockets or adaptors may be needed to make sure all necessary electrical equipment can be plugged in at all times. TV remote controls should also always be left within reach.*

   Response from manager: Every room has a call bell socket; access to call bells for all residents able to use the call bell is always reinforced for staff, as is TV remote. Call bell leads can be extended length. Electrical sockets are separate and are available for equipment. There are floor/mat sensors that can alert staff to movements if a resident is at risk of falls. Assistive technology can be accessed as appropriate.
   Comment from Healthwatch Enfield: members of our Enter & View team observed in several bedrooms that the TV remote control had been left out of reach of the resident. Two members of the E & V team observed that in one resident's room the call bell had been disconnected and was lying on the window sill. A sensory floor pad had been plugged in to alert staff in the case of a fall, but the resident did not have access to the call bell to request attention. Separately, a resident in another room also pointed out that the call bell was not always left within reach. It appears that staff need to be reminded of the importance of ensuring that all appropriate equipment is switched on and controls are left within easy reach of residents.

7. *<u>Communications skills training</u>: we recommend that all staff receive additional training in advanced communication skills, such as communicating effectively with people who may have dementia or brain damage, and/or impaired sight or hearing. This training should be delivered in a classroom setting with opportunities for reflection and discussion, rather than an online format.*

   Response from manager: Barchester training programmes include classroom based experiential training particularly tailored for dementia and other brain disorder for ALL staff. I have 2 staff embarking on the training

programme for the SoKIND training in May 2015. This will deliver a course of 8 workshops to all staff with a section devoted to communication.

8. *<u>Equality and diversity training</u>: we recommend that all staff receive expert training in equality and diversity, so that they can explore the challenges and advantages of working in a multicultural organisation, and can discuss sensitive issues in a safe and non-threatening environment.*

   Response from manager: An ongoing topic and subject for discussion in group and individual staff meetings and supervision.

   Comment from Healthwatch Enfield: we agree that informal discussions of this nature can be valuable, but believe that on their own they are not sufficient. It is usually helpful for staff to discuss these sensitive topics in a different forum, facilitated by someone other than their line manager, which is why we stand by our recommendation that staff should also receive expert equality and diversity training, delivered in a formal setting.

9. *<u>Manual handling training</u>: we recommend that all staff receive additional training in manual handling, with an emphasis on techniques for managing situations with residents who are particularly frail in addition to having a condition such as dementia, which may increase the possibility that they will be resistant to receiving personal care.*

   Response from manager: The majority of residents in the care home are frail. Barchester training and care plans reflects the fact that residents may be subject to a DoLS and that during personal care residents may resist and be at risk of non-compliance and necessity for staff to be aware of risk of injury during care and transfers.

   Comment from Healthwatch Enfield: we heard from several residents and several relatives that there had been concerns about clumsy or rough handling, which had sometimes caused bruising or laceration and in some cases had led to safeguarding alerts. We therefore stand by our recommendation that additional training should be provided for staff. The CHAT team may be able to provide some support in this area.

10. *<u>Overnight stays for relatives</u>: we recommend that a folding bed or reclining chair is provided for relatives staying overnight when the resident is gravely ill or approaching the end of life.*

    Response from manager: Every effort is made to accommodate relatives to support residents when very unwell and they want to spend as much time as possible with their family member. Subject to room availability facilities are offered, and although we do not have a folding bed, items can be sourced as necessary to allow families to spend as much time as they would like on the premises. Arrangements will vary according to circumstances and individual choice.

    Comment from Healthwatch Enfield: we find this response very vague. We were told during our visit that there was "nowhere for relatives to stay". We stand by our recommendation.

11. *<u>Volunteer involvement</u>: we recommend that greater efforts are made to recruit suitable volunteers, perhaps with the help of the Enfield Volunteer Centre, and to offer a range of activities for volunteers to get involved in. For example, volunteers might be able to engage residents in conversation*

or board games if they are bed-bound, or to help facilitate conversation between residents who are sitting in the lounge together or waiting for their meals. Volunteers might be able to help residents develop their IT skills. Volunteers could help with shopping for residents, and could also assist staff to take residents out on formal or informal trips. Relatives of current or former residents might be interested in becoming volunteers.

Response from manager: See response to recommendation 1 for volunteer issues. During relative/resident meetings requests are made for extra support if required and possible. The issue of former family members returning is very individual and needs to be handled sensitively.

Comment from Healthwatch Enfield: since drafting this report, Healthwatch Enfield has been in touch with Enfield Volunteer Centre, and we understand there are some legal issues regarding the use of volunteers in privately-owned care homes. We are investigating this further and will get in touch with Hugh Myddelton House when we have clarified the situation.

12. *Access to mental health services: we recommend that the manager and staff review the emotional wellbeing of all the residents on a regular basis, and ask the GP to consider making a referral to mental health services for any resident whose mental health appears to be deteriorating.*

    Response from manager: Since the Healthwatch visit in February the GM and staff are fully involved with the services of the CHAT team who have enabled access to specialist services to be made available, this is a very valuable resource, and the CHAT team visit the home every time we have a new admission. I have requested that a regular meeting with the CHAT team/GP be proposed in order that we can anticipate and coordinate residents care needs if they change and require more specialist input.

13. *Hygiene: we recommend that cleaning procedures are reviewed and urgent action is taken to ensure that any malodours are dealt with promptly.*

    Response from manager: Cleaning procedures are in place to ensure that the services are responsive. 2 bank staff are awaited to start by the beginning of May; to cover any shortfall due to absence.

14. *Signs and notices: we recommend that all signs and notices are written in a large clear font and placed where they can easily be seen by residents who are seated in wheelchairs.*

    Response from manager: Where information for residents is distributed whether in a public place or minutes from meetings – consideration will be given to those with visual impairment, and adjustments made as required.

15. *Seats for visitors: we recommend that some folding chairs and cushions are purchased and stored centrally for relatives to use when they visit.*

    Response from manager: Refurbishment is underway and further seating is being purchased with will increase available seating throughout the home.

    Comment from Healthwatch Enfield: our recommendation related to the fact that some of the bedrooms are too small to accommodate a visitor's chair on a permanent basis, and therefore a supply of folding chairs which could be kept somewhere else would be helpful for visitors.

16. *<u>Care home providers meetings</u>: We recommend that the manager attend meetings of the Care Home Providers network hosted by Enfield council, to which all local care home managers are invited. At these meetings she will be able to network with other local care home managers and receive information about support provided by the council.*

    Response from manager: Noted and agreed to look at local support as well as the Barchester Regional support provided and the North London portfolio that we have with 9 other homes in our team.

17. *<u>Staff holidays</u>: we recommend that care is taken to ensure that staff holidays are spread throughout the year more evenly.*

    Response from manager: Good admin practice and staff are always encouraged to plan and book holidays accordingly.
    Comment from Healthwatch Enfield: it appears to us that management need to be more proactive in this respect.

18. *<u>Night staffing</u>: we recommend that night staff should be supervised more closely by senior staff, and that consideration should be given to having a manager on duty on the premises at all times.*

    Response from manager: Since the draft report was prepared the whole staff group has received direct supervision regarding the historic issues about night staff that were raised. The meetings were held to ensure both day and night shifts were able to attend – 4 meetings in 2 days. An unannounced night visit has been undertaken by 2 GM's and the plan for unannounced night visits to continue to support the staff and ensure they feel part of the whole team. Particularly to value their contributions and ensure accountability for expectations of quality and performance. Within the staff group currently there are staff who work both day and night shifts, but consideration must be made according to their family/child care arrangements, which was a factor in their decisions to work nights. This is subject to review.

19. *<u>Team building</u>: we recommend that night staff should sometimes be rotated with day staff to ensure that the staff team is well-integrated and that the whole workforce benefits from all opportunities for personal and organisational development, including team meetings, staff social events and training sessions.*

    Response from manager: See response to recommendation 18. Plus Barchester Health and Safety Team now includes staff wellbeing as an issue for engaged and responsive teams. Plans for a programme of sessions for staff wellbeing are being made.

20. *<u>Gold Standards Framework</u>: Providing good end of life care is an essential part of the work of a nursing home. We strongly recommend that the home should restart the process for accreditation by the Gold Standards Framework.*

    Response from manager: GSF programme with North London hospice was in place for HMH for 2014/15. However due to staff changes it was not completed. The funding for this project has now finished. GM to look at local resources and continue with the Care Specialist support from Barchester to ensure positive experiences for End of Life care are maintained for residents

and their families.
Comment from Healthwatch Enfield: we believe that working towards accreditation by the Gold Standards Framework is the most effective way to train staff in End of Life care skills, and that Barchester Healthcare should be prepared to invest in this process. We stand by our recommendation.

Recommendations for Barchester Healthcare

1. *Support for care home managers: we recommend that Barchester Healthcare should consider investing more resources in Hugh Myddelton House, including offering additional support to the manager and staff to build on progress to date, in order to ensure that improvements to the quality of life at the nursing home can be sustained.*

2. *Terms and conditions for staff: we recommend that in order to attract and retain high quality permanent staff who are keen to make a lasting contribution to the Hugh Myddelton House community , Barchester Healthcare should urgently review the wages, terms and conditions and support offered to staff at all levels.*

Response from manager: Barchester GM's have support in relation to Regional and Divisional Directors to whom we report for Operational and home specific issues. The Quality First Initiative for the business is being cascaded by the Senior Management Team to ensure that the reputation of the organisation is based on Quality Standards for all staff to be embedded in our practice. The question of 'the Mum test'[3] is a very good indicator to gauge staff feedback as to the care that they provide for residents in the organisation. Hugh Myddelton is currently undergoing a refurbishment during this month, expected to complete mid May. This will include dining room, bedrooms and en suite areas, communal areas and the lounge on the ground floor. With the next phase to embark on is Memory Lane.

I have shared these findings with Regional and Divisional Directors with whom decisions about strategic issues regarding pay and conditions are made. We have since my appointment made discretionary awards to existing and new staff to improve our competitiveness and retain and attract quality staff. There are ongoing pay rate/competitor analyses in progress.

[3] 'The Mum test' is asking yourself the question: 'Would you be happy if your Mum was living in this care home?'

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