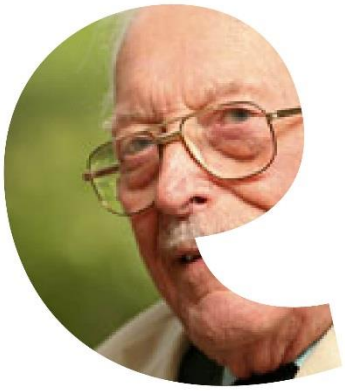
healthwatch Halton



Croftwood Care Home

Runcorn

August 28th 2014

Enter & View report

ACKNOWLEDGEMENTS

Healthwatch Halton would like to thank everyone at Croftwood Care Home for their time and consideration during our visit.

WHAT IS ENTER & VIEW

People who use health and social care services, their carers and the public generally, have expectations about the experience they want to have of those services and want the opportunity to express their view as to whether their expectations were met.

To enable the Healthwatch Halton to carry out its activities effectively there will be times when it is helpful for authorised representatives to observe the delivery of services and for them to collect the views of people whilst they are directly using those services.

Healthwatch Halton may, in certain circumstances, 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. In carrying out visits, Healthwatch Halton may be able to validate the evidence that has already been collected from local service users, patients, their carers and families, which can subsequently inform recommendations that will go back to the relevant organisations. Properly conducted and co-ordinated visits, carried out as part of a constructive relationship between Healthwatch Halton and organisations commissioning and/or providing health and social care services, may enable ongoing service improvement. Healthwatch Halton's role is to consider the standard and provision of local care services and how they may be improved and to promote identified good practice to commissioners and other providers.

VISIT DETAILS

Centre Details	
Name of care centre:	Croftwood
Address:	Whitchurch Way Runcorn Cheshire WA7 5YP
Telephone number:	01928 576049
Email address:	manager.croftwood@minstercaregroup.co.uk
Name of registered provider(s):	Croftwood Care Ltd
Name of registered manager (if applicable)	Mrs Diane Hesketh
Type of registration:	Dementia, Old Age, Physical Disability
Number of places registered:	44

The Enter and View visit was conducted on 28th August 2015 from 10.00am to 12.00pm

The Healthwatch Halton Enter and View Team were:

- Michael Hodgkinson
- Lorna Plumpton
- Irene Bramwell

Disclaimer

Our report relates to this specific visit to the service, at a particular point in time, and is not representative of all service users, only those who contributed.

This report is written by volunteer Enter and View authorised representatives who carried out the visit on behalf of Healthwatch Halton.

OBSERVATIONS

This was an announced visit.

Croftwood Care home is set in a quiet residential area, close to shops and local amenities. The team noted that finding the best route to the home may prove a little difficult, if new to the area, but public transport is frequent with bus stops nearby. The exterior of the home is well maintained, with neat gardens, flower beds and furnished with table and chairs for residents, staff and visitors to use. The home is accessible by wheelchair and has a large car park with adequate car parking facilities including car parking spaces for people with disabilities.

On entering the home, the team noted that a signing-in book with pen was available for visitors to sign in. The main reception area of the home was accessible by key pad to ensure the safety of vulnerable residents. On entering the reception area Healthwatch Halton representatives were warmly greeted by the deputy manager Ann Percival. Ann asked the team to wait in the reception area which was comfortable, clean and clutter free, as the manager was in the process of answering a telephone call. The visiting team noted that employees clocked in and out electronically.

The team used this opportunity to observe the reception area of the home and noted that within the main reception area a Healthwatch Halton Poster was clearly displayed on a notice board, informing staff, residents and visitors of the enter and view visit, should they wish to contact Healthwatch Halton or meet the team during the visit. Healthwatch Halton feedback back forms were also available in the reception area.

The notice board provided clear information and telephone numbers to support individuals in the whistle blowing procedure; a copy of the latest Care Quality Commission Report (following a recent unannounced inspection which recorded 'good in all areas'); a schedule of resident and family meetings; the fire alarm process and zone system and a recent survey undertaken by the management team. The home registration certificate was clearly displayed within the reception area and a visible fire extinguisher in case of fire.

Following her telephone call the visiting team were welcomed by the manager Diane Hesketh, who invited us in to the manager's office, providing the team with the opportunity to discuss the care provided.

Discussions included the frequency of buses to the home. The manager informed the visiting team that the home is near a bus route and that buses run every twenty minutes which is useful for both visitors and staff. Diane told the team that at the time of the visit the home was not running at full capacity and that there were currently 42 residents being cared for of which 3 were in hospital. 6 residents are on respite care. She further explained that eighty percent of residents have regular visits from friends and family

members, whilst residents whose families live a long distance away from the home are kept updated through emails and phone calls.

Diane explained that that there are six qualified staff on duty throughout the day and five qualified staff on duty during the night, with the home having little or no turn over of staff. Diane said that both she and the Deputy Manager had been employed at the home for over twenty five years. The home had been transferred from the local council to the private sector and currently employs six members of staff who were originally Halton Borough Council employees.

Discussions included the level of services that the home delivers. Diane explained that they offer a diverse range of services, which includes respite care, day care services palliative care and permanent residential care. Some residents have been diagnosed with dementia and have complex care needs; the home engages with the memory-recall services. The staff have a broad range of skills, and all staff have undertaken mandatory training, which is documented on a training matrix that is retained.

Staff have also undergone training in the '6 Steps End of Life' Care Programme and have regular moving and handling training. They have access to distance learning programmes, however, E-learning is currently restricted due to the care home only having two PC's at their disposal and these are in constant use.

Diane explained that care plans are in place for all residents which are reviewed regularly. A member of the team enquired about external services provided to the care home and was told that call times for external services varies, as referral and charting actions is a long process and that the process for respite care takes longer, whilst external agencies regard falls as not urgent.

The manager was very open in her discussions with the visiting team regarding falls and explained that all incidents are recorded and if a fall is not witnessed the staff have to record the incident as an accident. Diane discussed the colour coded risk analysis supported by a plan showing the locations of the falls that the home undertakes to identify types, times and location of falls to try and identify patterns and triggers. Diane explained that the risk analysis has identified a possible trigger for some residents who are mobile, who wake in the early hours of a morning tired and needing the toilet.

The visiting team discussed hospital admission and discharge procedures and Diane gave the team an update on their participation in a pilot study facilitated by the Warrington Hospital Discharge Liaison team, which involves a yellow form and file that a carer or family member takes to the hospital with the resident on admission.

The file contains all the information needed to help health professionals understand the resident's needs. Prior to discharge the yellow form should be completed and returned with the resident to the home and should outline their current health status and any changes to medication. However some residents had been sent back to the home without the yellow form, or an incomplete one, and this required staff liasing with the ward to

get the completed form, and to date, only one doctor has filled in a form for a resident returning to the home following discharge.

Diane highlighted how Warrington Hospital has sent residents back to the care home by taxi after midnight as the resident had not been admitted. Diane said she felt this was not only costly but inadequate as the resident may need someone with them when travelling back to the home.

Diane told the team that staff cannot always accompany the residents, who are vulnerable adults, to hospital and that the duty of care lies with the ambulance service once the patient is transferred into their care. On admission, the duty of care is then transferred to the hospital trust. Diane gave a scenario of a staff carer being told she could not leave the hospital until the patient had been assessed. She felt this was unjustified as staff also have a duty of care to residents in the home.

Discussing the administration of drugs, we were told that this is undertaken by a senior care assistant. Diane explained that on admission to the home they ask residents and family members what medication they are currently taking, insisting that residents only take medication prescribed by medical professionals, as sometimes residents arrive at the home with un-prescribed medication that has been provided by friends and family members. Staff found that the health of residents sometimes improved when they were taken off un-prescribed medication.

A Senior Care Assistant highlighted some of the problems staff experience, including how prescriptions are ordered monthly but were not always fulfilled. To demonstrate her point the carer produced a prescription list that had been ordered three weeks previously which the home was still waiting to receive. The carer expressed her concerns explaining that as medication is ordered monthly this becomes problematic when a patient is discharged from hospital back to the home with only one week's supply of new medication. The carer highlighted that this system needed to change as it is not compatible with the monthly re-ordering system in place. The delay is from the GP to pharmacy.

To try and rectify the situation, Diane explained that the home changed from a pharmacy in Halton to a pharmacy in Stockton Heath, as this pharmacy has a team who deal directly with care homes. The carer maintained that sometimes the hospital does not inform the home of medication changes and felt that hospital staff needed to write down the changes, to inform the home.

Residents should have their medication reviewed on a six monthly basis, however, some GP's are reluctant to review medication when visiting the care home. The team enquired whether residents can stay with their own GP when moving to the home and the manager said that Runcorn residents are able to keep their own GP. However GP's of Widnes residents are reluctant to cross the Bridge so those residents are mostly registered with Runcorn surgeries.

We were told that residents have access to healthcare services such as chiropodists, dentists, opticians and a hairdresser is available for residents. Diane explained that staff often support residents attending hospital visits but there are costs incurred by residents when taxis are needed to travel to appointments.

Discussions on continence services highlighted that the quantity of pads per resident often proved inadequate and that more pads were needed for frequent users as the continence service does not take into account illness and infections when residents need more pads. The manager told the team that a further difficulty arose when the brand was changed without consultation as a new brand did not protect the dignity of residents. Further issues developed from the change and it took a while before stocking issues were resolved. The manager told the team that the home now has two months' worth of pads delivered in one order, which proves difficult to store, and they have no option but to store them in the garage, but this is perceived as a fire hazard.

Activities provided by the home were highlighted with the manager saying that they have, on average, six trips a year and an annual tea party. The home had secured funding from *Richard Shacklady* to pay for two coaches, with a tail lift for wheelchair users, and Diane mentioned a recent trip for residents to visit the Albert Dock and Liverpool Museum. Staff support residents on a voluntary basis during the trips.

Diane said that staff encourage local schools to engage with the home. Also there has been an opportunity to fundraise through putting on a Christmas party for the pupils. Croftwood offers work experience to both Widnes and Runcorn secondary school pupils, which consists of one day a week over a period of six weeks, where pupils engage with residents and contribute to the general running of the home. This has now been extended to young people with a learning disability, offering two days a week to gain skills and experience in a care home setting.

The visiting team were then given the opportunity to speak to residents, staff and visitors. No issues were raised by staff with regard to the residents' abilities to engage with the team.

The dining room was clean and uncluttered and tables were being set in preparation for lunch. The team noted that overall the appearance of the home was clean, well-lit, uncluttered and carpets were clean and unworn. The general atmosphere was warm and welcoming.

The temperature in the home was comfortable although one team member thought that the dining room area was a little too warm. The team noted that interaction between the manager, visitors, staff and residents were very positive, but that some residents sat alone unoccupied or asleep. Activities for residents were displayed on a notice board with the use of pictures and words.

Grounds and buildings were wheelchair accessible throughout the home. Corridors and communal areas were clean and uncluttered on both the lower and upper floor levels. A lift was available and in use at the time of the visit. A visiting team member visited the

first floor kitchen and noted that the kitchen was clean and was told by kitchen staff that residents have a daily choice of meals. The menu was displayed on the dining room wall and included pictures of what was on offer.

Water jugs and tumblers were available for residents to access drinks, during our visit. Throughout the home residents names were visible on resident's room doors to aid orientation. A covered smoking area was available for residents on the upper floor on an outside balcony and there was also an outside covered smoking area on the ground floor.

Members of the team chatted with residents, family members and staff in the main lounge, and a smaller quieter lounge and dining room off the main lounge area. Some residents welcomed the opportunity to discuss the care and support they received. However, what has to be taken into consideration within the context of this report is that some residents appeared to lack the capacity to understand questions asked by the Healthwatch Halton authorised visitors. This is reflected in the comment 'I have been here about 6 months but I do not know why I am here and why can I not go home?' A member of staff commented 'Residents are well looked after and trips are available if the person can walk without too much difficulty'.

The collated responses of residents overall was very positive and reflected the manager's discussions with team members. (See Appendix 1.)

On leaving the home the team thanked the staff, residents and manager for answering all our questions and showing us around the home.

SUMMARY

At the time of our visit the residents of Croftwood appeared to be happy and well cared for. The home environment appeared clean and uncluttered and staff were friendly warm and welcoming. Residents, family members and staff shared their views and experiences of the care provided which was predominantly very positive.

RECOMMENDATIONS

1. Engage with Healthwatch Halton when issues arise such as delays in medication or reluctance to review medication as highlighted in this report.
2. Encourage staff members, residents and visitors to complete Healthwatch Halton feedback forms.
3. Liaise with Warrington Hospital to look at any possible issues regarding discharge of residents, particularly at night.

APPENDIX 1

The following comments contain responses from residents and family members. The comments have been collated under a number of themes.

Accommodation

- *'Living here is the next best thing to my own home'.*
- *'I am not happy here, better if some people were in an asylum'.*
- *'I really like it here'.*
- *'I can have visitors anytime. My daughter visits and everyone is welcome including young children'.*
- *'I have a big box of medicine but it is difficult to store them as there is not enough storage room. Couldn't something be done about that? It's the same with the continence pads there is no room to store them'.*
- *'I like living here, it's ok they look after you'.*
- *I have been here for about 6 months, but I do not know why I am here. Why am I here'?*

Nutrition

- *'The food is alright'.*
- *'We do get a choice, if I do not want what is on the menu I can have something else, like tonight it is fish but I do not fancy fish so I will have something else'.*
- *'We can have drinks when we want, you only have to ask and the girls will get it for you.'*
- *'You do get a choice of meals.'*
- *'There is a limited choice of food'.*
- *'The food is very good and I am given a choice'.*
- *'I have breakfast and dinner in the main dining room and my tea in my own room'.*
- *'The meals are nice if you don't like something they will make you something else, you only have to ask'.*
- *'Yes you can get a drink when you want. They are very good that way if you need something'.*

Staff

- *'The girls are lovely honestly.' The staff are very nice.*
- *'The night staff are as nice as the day staff, they look after you that is the truth'.*
- *'If I am in my room of a night and I ring the buzzer the staff come very quickly. They are there straight away'.*
- *'It is excellent, the girls are so kind'.*
- *'The girls are brilliant they always talk to you and ask if you are alright'.*
- *(Relative) 'They are brilliant here they look after everyone they are really marvellous'.*
- *'One of the carers before she left gave me this brooch, and crocheted this blanket for me they are all really kind and helpful'.*
- *'Most People are friendly'.*

Personal Care

- *'I can have a shower when I want'.*
- *'The staff help me get dressed, I cannot reach my clothes but I choose what I want to wear'.*
- *'They help me get washed and put my slippers on'.*
- *'I get my hair done by the hairdresser who comes in'.*
- *'The staff help me to get dressed and washed'.*
- *'I can get a shower when I want one and the girls help me to shower'.*
- *'Residents are well looked after here'.*

Activities

- *'I do not like activities I like to watch telly in my room '.*
- *'There are lots of activities going on but I cannot really join in as I cannot see very well'.*
- *'I cannot go out in the sun as this damages my skin, so I don't really go in the garden'.*
- *'I went on one trip to the café on the school bus but this was spoilt as we had to pick the school children up so I had to come back by taxi and it took three people to help me get into the taxi and I was not happy the way I was handled'.*
- *'After dinner I like to stay in my own room and listen to music'.*
- *'I used to crotchet but cannot do this now due to my declining eyesight'.*
- *'My son bought me an I pad but I can't use it because of my hands'.*

- *'It is too cold to go in the garden but, it can be used during the day'.*
- *'One resident plants flowers in the garden'.*
- *'I am 90 and having a birthday party tomorrow'.*
- *'I would like to go out but they do not take me'.*
- *'Trips are available if the person can walk without too much difficulty'.*

Access to Healthcare

- *'The GP comes in to see me if I need them'.*
- *'We have the chiropodist coming in to do our feet, who is very nice'.*
- *My optician came in to see me two weeks ago regarding my new glasses'.*
- *'I have a chiropodist who visits me. He is quite good actually'.*
- *'The girls will go with me to the hospital'.*

APPENDIX 2

The Dignity Factors

Research indicates that there are eight main factors that promote dignity in care. Each of these Dignity Factors contributes to a person's sense of self respect, and they should all be present in care.

1. Control and choice in practice

- Take time to understand and know the person, their previous lives and past achievements, and support people to develop ‘life story books’.
- Treat people as equals, ensuring they remain in control of what happens to them.
- Empower people by making sure they have access to jargon-free information about services when they want or need it.
- Ensure that people are fully involved in any decision that affects their care, including personal decisions (such as what to eat, what to wear and what time to go to bed), and wider decisions about the service or establishment (such as menu planning or recruiting new staff).
- Don’t assume that people are not able to make decisions.
- Value the time spent supporting people with decision-making as much as the time spent doing other tasks.
- Provide opportunities for people to participate as fully as they can at all levels of the service, including the day-to-day running of the service.
- Ensure that staff have the necessary skills to include people with cognitive or communication difficulties in decision-making. For example, 'full documentation of a person’s previous history, preferences and habits’ can be used by staff to support 'choices consistent with the person’s character’. (Randers and Mattiasson, 2004).
- Identify areas where people’s independence is being undermined in the service and look for ways to redress the balance.
- Work to develop local advocacy services and raise awareness of them.
- Support people who wish to use direct payments or personal budgets.
- Encourage and support people to participate in the wider community.
- Involve people who use services in staff training.

2. Communication in practice

- Ask people how they prefer to be addressed and respect their wishes.
- Give people information about the service in advance and in a suitable format.
- Don't assume you know what people want because of their culture, ability or any other factor – always ask.
- Ensure people are offered 'time to talk', and a chance to voice any concerns or simply have a chat.

- If a person using the service does not speak English, translation services should be provided in the short term and culturally appropriate services provided in the long term.
- Staff should have acceptable levels of both spoken and written English.
- Overseas staff should understand the cultural needs and communication requirements of the people they are caring for.
- Staff should be properly trained to communicate with people who have cognitive or communication difficulties.
- Schedules should include enough time for staff to properly hand over information between shifts.
- Involve people in the production of information resources to ensure the information is clear and answers the right questions.
- Provide information material in an accessible format (in large print or on DVD, for example) and wherever possible, provide it in advance.
- Find ways to get the views of people using the service (for example, through residents meetings) and respect individuals' contributions by acting on their ideas and suggestions.

3. Eating and nutritional care in practice

- Carry out routine nutritional screening when admitting people to hospital or residential care. Record the dietary needs and preferences of individuals and any assistance they need at mealtimes and ensure staff act on this.
- Refer the person for professional assessment if screening raises particular concerns (e.g. speech and language therapy for people with swallowing difficulties, occupational therapy for equipment such as special plates and cutlery, dietician for special dietary needs relating to illness or condition, physiotherapist to assess physical needs and posture).
- Make food look appetising. If the texture of food needs to be modified seek advice from the speech and language therapist. Not all food for people with swallowing difficulties needs to be puréed. Keep different foods separate to enhance the quality of the eating experience.
- If necessary, record food and fluid intake daily and act on the findings.
- Make sure food is available and accessible between mealtimes.
- Give people time to eat; they should not be rushed.
- Provide assistance discreetly to people who have difficulty eating. Use serviettes, not bibs, to protect clothing. Offer finger food to those who have difficulty using cutlery, and provide adapted crockery and cutlery to enable people to feed them where appropriate.
- While socialising during mealtimes should be encouraged, offer privacy to those who have difficulties with eating, if they wish, to avoid embarrassment or loss of dignity.
- Ensure that mealtimes are sufficiently staffed to provide assistance to those who need it.
- If there are insufficient staff members to support those who need it, introduce a system of staggered mealtimes.
- Develop or make use of existing volunteer schemes to help give support to people at mealtimes.
- Encourage carers, family and friends to visit and offer support at mealtimes.
- Don't make assumptions about people's preferences on the basis of their cultural background – people should be asked what their preferences are?
- Ensure all care staff members, including caterers, have access to training.

- Raise awareness of the risk of malnutrition and the importance of providing good nutritional care.
- Ensure staff has the skills to communicate with people who have dementia and communication difficulties. Visual aids, such as pictorial menus, and non-verbal communication skills may help people to make choices.
- Gather information on the older person's needs and preferences from people who know them well.
- Ensure that centre care staff has sufficient allocated time and the skills to prepare a meal of choice for the person, including freshly cooked meals.
- For residential and day care, implement best practice in food procurement ensuring food is of good quality and is, where possible, local, seasonal and sustainable.
- Carry out regular consultation on menus with people using the service.
- Wherever possible, involve people using the service in meal preparation.
- In residential settings, where access to industrial kitchens is denied, provide facilities for people to make drinks and snacks.
- Ensure that fresh water is on offer at all mealtimes and freely available throughout the day.

Hydration

- Encourage people to drink regularly throughout the day. The Food Standards Agency recommends a daily intake of six to eight glasses of water or other fluids.
- Provide education, training and information about the benefits of good hydration to staff, carers and people who use services, and encourage peer-to-peer learning.
- Provide promotional materials to remind people who use services, staff and carers of the importance of hydration.
- Ensure there is access to clean drinking water 24 hours a day.
- If people are reluctant to drink water, think of other ways of increasing their fluid intake, for example with alternative drinks and foods that have a higher fluid content, (e.g. breakfast cereals with milk, soup, and fruit and vegetables).
- If people show reluctance to drink because they are worried about incontinence, reassure them that help will be provided with going to the toilet. It may help some people to avoid drinking before bedtime.
- Be aware of urine colour as an indication of hydration level (Water UK, 2005); odourless, pale urine indicates good hydration. Dark, strong-smelling urine could be an indicator of poor hydration – but there may be other causes that should be investigated.

4. Pain management in practice

- Raise staff awareness that people may not report pain, that it can have a significant impact on dignity and well-being and that it can be identified and treated.
- Enquire about pain during assessment.
- Ensure that night staff receive equivalent training on pain identification and treatment to those working during the day.
- Use assessment guidance to support professionals to assess for pain in people with communication problems.

5. Personal hygiene in practice

- Support people to maintain their personal hygiene and appearance, and their living environment, to the standards that they want.
- When providing support with personal care, take the individual's lifestyle choices into consideration – respect their choice of dress and hairstyle, for example.
- Don't make assumptions about appropriate standards of hygiene for individuals.
- Take cultural factors into consideration during needs assessment.

6. Practical assistance in practice

- Make use of personal budgets to provide people with the help they want and need.
- Help people to maintain their living environment to the standards that they want.
- Tap into or develop local services to provide help for people in the community e.g. gardening, maintenance.
- Make use of volunteers.
- To reduce risk of abuse through people being identified as not coping and subsequently targeted, encourage centre owners and landlords to carry out external repairs.

7. Privacy in practice

- Ensure a confidentiality policy is in place and followed by all staff (including domestic and support staff).
- Make issues of privacy and dignity a fundamental part of staff induction and training.
- Ensure only those who need information to carry out their work have access to people's personal records or financial information.
- Respect privacy when people have personal and sexual relationships, with careful assessment of risk.
- Choose interpreters with the consent of the person using the service.
- Get permission before entering someone's personal space.
- Get permission before accessing people's possessions and documents.
- Provide space for private conversations and telephone calls.
- Make sure that people receive their mail unopened.
- Ensure single-sex bathroom and toilet facilities are available.
- Provide en suite facilities where possible.
- In residential care, respect people's space by enabling them to individualise their own room.
- Consider issues of privacy if a person requires close monitoring or observation.

8. Social inclusion in practice

- Promote and support access to social networks.
- Resolve transport issues so that they do not prevent people from participating in the wider community.

- Build links with community projects, community centres and schools to increase levels of social contact between people from different generations.
- Identify, respect and use people's skills, including the skills of older people gained in previous employment.
- Give people ordinary opportunities to participate in the wider community through person-centred care planning.
- Involve people in service planning and ensure ideas and suggestions are acted upon.

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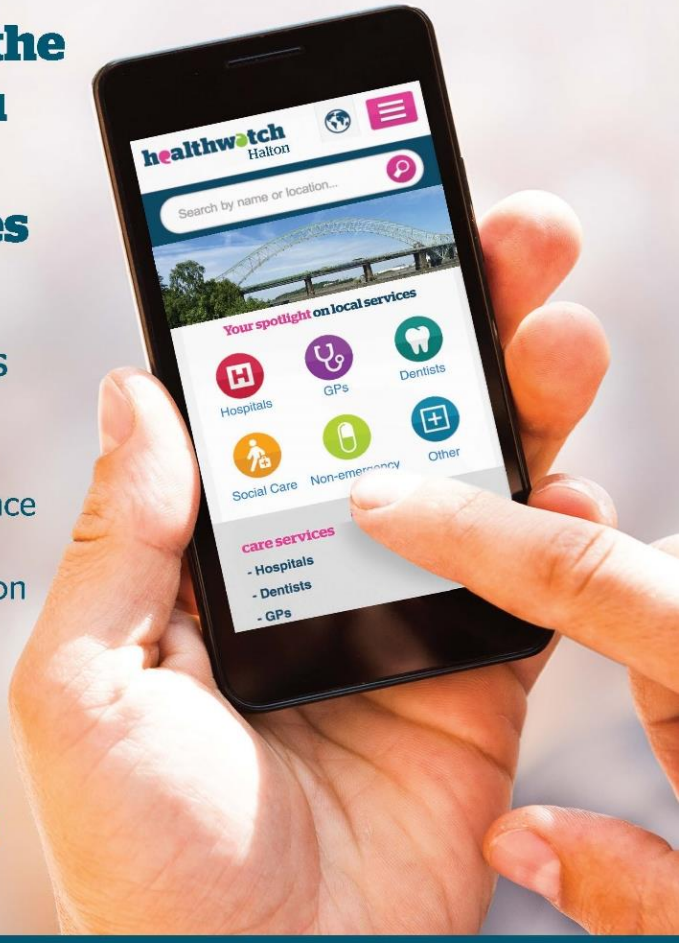

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