healthwatch Enfield

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Enter & View Report

Magnolia Unit, St Michael’s Site, 11 March 2016

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Premises name	Magnolia Unit
Provider name	Barnet Enfield and Haringey Mental Health NHS Trust
Premises address	St Michael's Site, Gater Drive, EN2 OJB
Date of visit	11 March 2016

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Purpose of the visit

Authorised Representatives from local Healthwatch have statutory powers to 'Enter and View' 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 several hospital wards in Enfield where the majority of the patients are elderly. This forms part of a wider project to find out about the experience of frail elderly people both as patients and as users of local social care services. Our visit to Magnolia Unit therefore had a dual purpose: to find out from patients and their relatives about the nature and quality of care in Magnolia Unit itself, and to listen to any comments they might have about care the patients had received in their own homes prior to their stay in hospital.

Executive Summary

We gained a positive impression of Magnolia Unit overall. The service appears to be well-led and managed and staff told us they found the work satisfying and fulfilling. We are pleased to report that we found a great many examples of good practice, which are listed below.

Most of the patients and family carers who spoke to us said they thought the care and treatment was good, although we did hear of some exceptions. The manager responds promptly when any concerns are raised with him; a carer who had made a verbal complaint told us they were very satisfied by the manager's response. Two carers who wrote to us after our visit reported that their relatives had had a poor experience of discharge. When we drew the manager's attention to these instances, he sent us a detailed response and has undertaken to make sure lessons are learned.

Although clinical care and therapeutic treatments appear to be of a high standard, we became aware that some patients who we met were feeling unhappy, and we believe that more attention should be given to ensuring that patients' emotional needs are met, in addition to their physical needs. We found that several patients were bored, as apart from their scheduled therapy sessions there are very few activities available. We recommend that a determined effort is made to increase the number and range of activities, and suggest that volunteers could play a valuable role in this respect.

We have made some recommendations for the management of Magnolia Unit, and since preparing our draft report, which we sent to the management for their response, we have received an action plan setting out how they intend to act on these recommendations. This action plan is included in full on pp.5-8.

We have been very impressed by the positive and constructive way the management and team at Magnolia Unit have responded to the various issues and concerns we brought to their attention, both during and after our visit, and believe this demonstrates that there is good leadership and a culture of continuous learning in this service. We commend the many instances of good practice which we found, and hope they will be emulated by other local providers of similar services where appropriate.

Good practice examples

Person-centred care

- The Magnolia Unit referral form and care planning documents are well-structured, user-friendly and person-centred.
- Patients are invited to set their own goals on admission and are given a personalised schedule of therapies, tailored to their individual needs.
- Patients are encouraged to be as independent as possible, for example getting dressed each day and managing their own medication where appropriate.
- Patients are given a choice about when to wake up.
- Patients are supported to eat food at their own pace; all nurses and healthcare assistants stop their other work to assist patients at meal-times.
- There are regular 'comfort rounds' to check that patients are not in need of any assistance.
- Call bells are always plugged in and placed where patients can reach them easily.
- Patients who have a fall shortly before planned discharge are kept in the unit for a few extra days for observation.
- With the patient's consent, family carers are encouraged to participate in care-planning and review
- Family carers may make arrangements to visit outside standard visiting hours.

Integration

- The integrated, multi-disciplinary approach is well developed; staff from different disciplines have the chance to shadow each other's work.
- Patients have access to a wide range of specialist therapists; staffing of therapy teams is generous.
- Disability aids and equipment are compatible with the equipment supplied by the council for use in patients' own homes.

Staffing, management and culture

- The manager is directly involved in staff recruitment and understands the importance of getting 'the right person'.
- Staff receive regular supervisions and appraisals; staff affirm there is an open culture where they feel free to raise any concerns.
- The manager responds promptly when concerns are reported, and takes action including discussions at team meetings and mentoring of staff where appropriate.

Training

- There is a high level of compliance with mandatory training; all training takes place in working hours and is built into staff schedules.
- Staff have a high level of dementia awareness and the butterfly flag system is in place to ensure patients with dementia or confusion receive appropriate support.

Information

- The patients' information booklet is clear and well-produced.

Recommendations

1. ***Meeting emotional needs:*** *we recommend that more emotional support, either formal or informal, should be made available to patients. (p.13.)*

2. ***Discharge procedures:*** *we recommend that greater care is taken to ensure patients/families are provided with accurate information about imminent discharge, including rules about luggage, laundry etc. Patients/families should be given advance notice of any equipment which needs to be provided in the patient's home. We suggest that patients and/or carers should be contacted a few days after discharge to find out if there have been any problems. (p.17.)*

3. ***Personal information:*** *we recommend that non-clinical information about patients, including their likes and dislikes, former occupation, interests and hobbies, are recorded consistently and used to help staff see each patient as an individual, and to help identify activities and pastimes which might appeal to them. (p.20.)*

4. ***Spiritual support:*** *consideration should be given to contacting local ministers and faith leaders with a view to inviting them to visit more often, and perhaps work together to offer a weekly multi-faith service. (p.21.)*

5. ***Food:*** *we recommend that the food supplier is asked to provide a wider range of cooked menu items in 'small' as well as 'standard' portions, to meet the needs of patients who do not have a large appetite. Patients should be invited to take part in food tasting sessions when new menu items are being considered. (p.22.)*

6. ***Activities and pastimes:*** *We recommend that a concerted effort is made to provide an imaginative range of activities and pastimes, both for groups and individuals. Consideration should be given to employing an activities organiser, full or part time, who could recruit and manage a team of volunteers. Alternatively, additional training could be provided to existing staff. (p.24 and Appendix A, p.33.)*

7. ***Sensory disability:*** *we recommend that with the patient's consent, sensory disability should be flagged on care plans and on the white board in a similar way to dementia and cognitive impairment. Staff would benefit from awareness training in how to identify and meet the needs of patients with hearing or visual impairment. (p.25.)*

8. ***Environment:*** *patients' opinion should be sought as to whether the chairs are sufficiently comfortable, and consideration should be given to replacing them if appropriate. The cleaning routine, including the cleaning of "hidden" areas should be reviewed. (p.30.)*

Magnolia Unit Action Plan August 2016 as supplied by management of Magnolia Unit

Healthwatch Recommendation	Actions	Named person. Action taken	Time frame
Recommendation 1 (p.13) ***Meeting emotional needs:*** *we recommend that more emotional support, either formal or informal, should be made available to patients.*	Review and update present assessment of needs. Provision of palliative care training and supporting assessments in the need for emotional health to enhance staff knowledge, understanding and skills in working with complex care needs.	**Band 7 and 8s** The emotional needs of patients are considered at team level; we have the support of a mental health nurse for patients with mental health needs, anxiety and suspected depression in our patient's population. Emotional health is considered in our assessments and is part of the team's objectives for patients. The palliative care course is managed by Hertfordshire University. Nursing Band 7 lead on the ward.	30 October 2016
Recommendation 2 (p.17) ***Discharge procedures:*** *we recommend that greater care is taken to ensure patients/families are provided with accurate information about imminent discharge, including rules about luggage, laundry etc. Patients/families should be given advance notice of any equipment which needs to be provided in the patient's home. We suggest that patients and/or carers should be contacted a few days after discharge to find out if there have been any problems.*	Develop a two page discharge information booklet about nursing actions on discharge, and therapy contacts . Include voluntary organisations. Consider the possibility of contacting patients after discharge to check if there are any problems.	**Nursing, OT and physiotherapists band 7s** A discharge checklist is already in place and discharges are managed within the team and are discussed at all levels in the team. Normally the patient, their carers and family are involved in the process and the discharge process then becomes a collective approach.	30 October 2016

Healthwatch Recommendation	Actions	Named person. Action taken	Time frame
Recommendation 3 (p.20) *Personal information: we recommend that non-clinical information about patients, including their likes and dislikes, former occupation, interests and hobbies, are consistently recorded and used to help staff see each patient as an individual, and to help identify activities and pastimes which might appeal to them.*	Captured in OT assessments. Continue to ensure patient needs assessments include: occupation, interests, hobbies and preferences and are shared in the MDT meetings and used to develop person-centred care goals and plans.	**Occupational therapy lead** Patient needs assessments include: occupation, interests and hobbies and preferences and are shared in the MDT meetings and used to develop person-centred care goals and plans.	30 October 2016
Recommendation 4 (p.21) ***Spiritual support:*** *consideration should be given to contacting local ministers and faith leaders with a view to inviting them to visit more often, and perhaps work together to offer a weekly multi-faith service.*	Work with the Trust to identify and engage ministers' support and proactively inform patients of spiritual supports that can be provided.	**Trust lead** At the request of patients staff can contact the patients' choice of faith leader and we will request a visit from them. The Trust has a contract with a local provider for chaplain support to Chase Farm and we will review this to include Magnolia Ward.	30 October 2016
Recommendation 5 (p.22) ***Food:*** *we recommend that the food supplier is asked to provide a wider range of cooked menu items in 'small' as well as 'standard' portions, to meet the needs of patients who do not have a large appetite. Patients should be invited to take part in food tasting sessions when new menu items are being considered.*	PLACE inspection achieves food inspection which includes a patient assessment. Magnolia unit had a PLACE inspection in the spring of 2016; the quality of the food was then described as good. Since the Healthwatch review we have identified that small meals can be ordered; this was not widely advertised in the Trust.	**Nursing staff lead** We have access to Medirest menus which have healthy choices, a choice of meats and fish and chicken in total : 23 main courses,. 6 jacket potatoes. Vegetarian meals are also identified, 3 soups, 8 different sandwiches. 24 desserts. Large and small choices can be also ordered. Additional ethnic meals and pureed foods are available.	30 October 2016

Healthwatch Recommendation	Actions	Named person. Action taken	Time frame
Recommendation 6 (p.24 and Appendix A, p.33) ***Activities and pastimes:*** *We recommend that a concerted effort is made to provide an imaginative range of activities and pastimes, both for groups and individuals. Consideration should be given to employing an activities organiser, full or part time, who could recruit and manage a team of volunteers. Alternatively, additional training could be provided to existing staff.*	A healthcare assistant has been identified to support social activity on the ward and once we have improved access to volunteers this nurse will have protected time to coordinate such activity. Patient Experience Manager to liaise with the identified HCA to support ideas re: social activities / undertake some benchmarking across similar settings as well as identify best practice guidelines.	**Occupational therapy leads** In place at present: Group once weekly Pat dog managed by occupational therapy in place. Once weekly volunteer visits for a social knitting group. Once weekly memory group runs managed by occupational therapy. We are working with the Trust to identify a pathway to identify to appoint and support volunteers. August Donation made for TV in the side rooms. Work in progress to identify funding for TV for other rooms. TVs are in place in the day rooms. Gardening activity managed by occupational therapist. We do have a schedule of events on the wall/available. We are unable to provide newspapers as this is not budgeted, however, we can support patients to purchase newspapers on request.	30 October 2016

Healthwatch Recommendation	Actions	Named person. Action taken	Time frame
Recommendation 7 (p.25) ***Sensory disability****: we recommend that with the patient's consent, sensory disability should be flagged on care plans and on the white board in a similar way to dementia and cognitive impairment. Staff would benefit from awareness training in how to identify and meet the needs of patients with hearing or visual impairment.*	Actioned and in development by two therapists, including training and to look at notices. Develop and support staff skills.	**Occupational therapists are to lead** Some notices are in place for day rooms, bathrooms; notices are above the patient's bed identifying sensory impairment.	30 October 2016
Recommendation 8 (p.30) ***Environment:*** *patients' opinion should be sought as to whether the chairs are sufficiently comfortable, and consideration should be given to replacing them if appropriate. The cleaning routine, including the cleaning of "hidden" areas should be reviewed.*	Ward Manager to ask Trust Infection Control Lead to focus on 'hidden' areas during spot checks to provide additional monitoring and assurance. Review chair comfort.	**Nursing staff lead** Cleaning issues are raised at a number of levels. Monthly meetings are held with the cleaning company Medirest and Estates with completion of regular audits and spot checks three times daily. **Physiotherapy lead** The ward has a variety of chairs which meet Trust and infection control standards. Patients are assessed by therapists for their most suitable setting. Consideration is given to pressure care and comfort. The chairs are part of the ward's standards cleaning schedule, and when the cleaning does not meet expectations there is a recognised escalation process.	30 October 2016

The Enter & View Team

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

General information

Magnolia Unit is a rehabilitation ward based at St Michael's Primary Care Centre, provided by Barnet Enfield and Haringey Mental Health Trust (BEH MHT) as part of their community health service provision. It is described on the Trust website as "a unique inpatient service in Enfield focusing on preventing avoidable admissions to acute hospitals where a patient cannot be looked after safely at home".

There are 28 beds, arranged in four 4-bed bays with 13 individual side-rooms. The majority of patients are female. The unit can take patients over the age of 18, but in practice almost all patients are over 65, and most are over 75. Occupancy levels vary depending on local need, but average about 95%. Priority is given to patients who are registered with an Enfield GP, but sometimes patients who are residents of Barnet, Haringey or Hertfordshire are accepted if there are no suitable places in their home areas. These patients are normally transferred back to their own boroughs as soon as an appropriate place becomes available for them.

The patients we spoke to had been admitted for rehabilitation for a variety of reasons including falls, pneumonia, cancer treatment, complications following heart surgery. We understand that falls and infections are the most common reasons for admission or transfer to Magnolia Unit.
The target length of stay is two weeks, but we were told that the average stay is 26 days. In rare instances, patients may stay for several months.

About one third of patients are admitted from home, referred by the London Ambulance Service, while two thirds are transferred from local emergency departments or as a "step down" from acute care at Chase Farm, Barnet or North Middlesex (NMUH) hospitals.

Staff on Magnolia Unit work within a multi-disciplinary team (MDT) approach. The emphasis is on supporting patients to be as independent as possible. Patients receive nursing care and a personalised programme of therapies which may include physiotherapy, occupational therapy, and speech and language therapy, dietetic support and so forth.

Methodology

A team of four Enter and View Authorised Representatives from Healthwatch Enfield visited the ward and engaged in conversation with patients, relatives and staff, focusing on the following five key areas:

1. Physical and mental health care
2. Personal choice and control
3. Information, communication and relationships
4. The environment
5. Staffing and management

The team also asked patients and relatives if they wanted to comment on any care the patients had received in their own home from care providers or community health services.

A few weeks before our formal visit, two team members had a preparatory meeting with the nurse consultant, Gina Elharch, and the ward manager, Dumsile Mabuza (as the unit manager was on leave). This was because we wanted to find out how the ward is organised, and discuss how to plan the Enter & View visit in such a way that it would not be disruptive to the patients or interfere with their care and treatment. Some of the factual information provided in this report, about how the ward is organised and managed, was given to us in this preliminary meeting.

When the full team arrived for the visit, we spent some time with the unit manager, Mark Cubitt, and spoke with 15 patients, 4 relatives, 2 therapists, 2 healthcare assistants, 1 registered nurse and the nurse consultant.

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

A draft of this report was sent to the management of Magnolia Unit and BEH MHT, to be checked for factual accuracy and for an opportunity to respond to the recommendations prior to publishing. In response they sent us a detailed action plan, as well as some additional information relating to other comments we had made in the draft report. These additional points appear as footnotes in the text.

This report will be published on the Healthwatch Enfield website, and sent to interested parties including the Care Quality Commission and the relevant clinical commissioning groups and local authorities.

Acknowledgements

Healthwatch Enfield would like to thank the people we met at Magnolia Unit, including the unit manager, ward manager, nurse consultant, ward staff, patients and relatives, who welcomed us and whose contributions have been very 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 patients, relatives and staff who met members of the Enter & View team on that date, or who sent us written comments soon after the visit.

Key Area 1: physical and mental health care

To find out whether patients' physical and mental health needs are met

Do patients feel well looked after, and do relatives/family carers feel the care on the ward is good?

We heard many enthusiastic comments about the staff and the care they deliver, and patients reported they felt safe on the ward.

A patient who had arrived on the ward the night before told us that she was very pleased with the care so far. "I can't fault it at all. They're all so friendly, it's really good." She said everything had been explained to her and her exercise programme was going to start on Monday.

Other comments included: "They look after you well here. On the whole they're very nice, very kind." "They do a marvellous job." "The nurses are kind." "They do seem to take good care of you here."

However, some patients expressed reservations. One patient said, "They're very kind here, but there is a shortage of staff. But that's financial, isn't it?" Another patient said, "They're very kind here, most of them," but added, "Some of them are a bit rough, they twist you over." Another patient told us: "One or two carers were caring and gentle but some were rough and pull you about. One made me lose my balance in the bathroom and I nearly pulled her over." Other comments included: "One or two are not nice". "Some nurses not exactly marvellous." (See also the comments about compassion and dignity on p.19.)[1]

One lady said she had reported a nurse to the manager and he had responded promptly and effectively and she was happy with the outcome.

Two relatives told us their mother was being well looked after and that she had improved with the support given on the ward.

Nursing and medical care

Nursing care is led by the nurse consultant and the unit manager who is also a senior nurse. Patients are carefully screened before admission, and not all referrals are accepted; it is important to ensure that patients are well enough to benefit from rehabilitation and do not have medical needs, such as a need for intravenous antibiotics, as this would indicate that the patient should be treated in an acute ward.

The nurse consultant is responsible for admitting and assessing patients, prescribing medication, organising investigations such as scans, x-rays and blood tests and initiating the patients care. The nurse consultant is able to prescribe oral antibiotics if required.

Medical care is provided by a GP who attends every day, Monday to Friday; in the evenings and over the weekend, medical cover is provided by the Out of Hours service, currently Barndoc.

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[1] *Comment from management: "The nurse described as 'a bit rough' was identified, the issue discussed in supervision, and an action plan is in place."*

On admission, patients are allocated a side-room, which helps with infection control and gives time for a thorough assessment of individual needs and a risk assessment. When this stage is complete, patients are moved to other parts of the unit if appropriate.

The manager mentioned that special care is taken to ensure that patients have the correct mattress for their comfort and to prevent pressure sores. We heard that mattresses have a limited lifespan and are regularly replaced.

Specialist rehabilitation services

All patients receive a tailored programme of specialist therapeutic interventions. There are three occupational therapists and three physiotherapists, plus a technician for each service, on the ward team. Speech and language therapists, based next door in Cedar House, are also available, as is a continence nurse. Physiotherapists and occupational therapists were present throughout our visit, working with patients. The manager told us that the initial core assessment is developed by different therapists depending on the individual needs of each patient. The therapists set objectives and goals for improvement; the whole team are made aware of these, and progress is discussed at the weekly team meeting.

Patients we spoke to confirmed that they were receiving physiotherapy sessions and said that they were beneficial. One said, “The exercise has helped.” Another patient told us, “The physio here has been good.” This patient had a session every morning and was using the exercise bike to strengthen leg muscles which had not been used for a couple of months due to hospitalisation for medical issues. This patient had become weak, but was regaining the ability to walk.

One patient expressed disappointment that there were no physiotherapy sessions at the weekends.[2]

Throughout their stay in Magnolia unit, patients are encouraged to be as independent as possible, and to have control over their care. For example, they may be allowed to manage their own medication once they have had an assessment, in which case they are given a key to their own medicine cabinet. Patients are expected to get dressed every day rather than staying in their night clothes, and we observed that all the patients using the day room were fully dressed. They are served breakfast in bed to start with, but once they reach a certain stage in their recovery, they are invited to join the breakfast club, which entails getting up and dressed and making their way along the corridor to the dining room.

Staff told us that they often witness patients growing in strength and confidence and getting back their mobility during their stay at Magnolia.

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[2] *Comment from management: “For the last two winters, up until April 2015, Magnolia unit had commissioned funds for additional resources at weekends, including Occupational and Physiotherapy. We have a proposal in mind, for Magnolia unit to move to having a six day therapy service involving the recruitment of additional staff for this and a consultation of existing therapy staff to work weekends. We will develop and review this proposal via our operational management group.”*

Access to specialist mental health/dementia support

We found that there is a high level of awareness about the special needs of patients with dementia. A nurse we spoke to confirmed that all staff receive training in dementia care. We heard that community mental health and psychiatric liaison staff can provide assistance for patients if required, and will attend team meetings where appropriate. If patients appear to need a cognitive assessment, a referral is made to the memory service.

However, some of the patients we met appeared to be experiencing emotional distress. One patient, who was in very low spirits, confided: "I pray each day for the good Lord to take me. There's no point in growing old."

Another patient said, "I can't look after myself any longer." This patient had a relative who was looking into residential care on their behalf, but had not received much help as to how to choose a care home. We gave the patient information about the Carers Centre, to pass on to the relative. The patient appeared very sad and quite anxious about the prospect of moving into residential care.

Another patient was concerned because they were experiencing some language and memory problems. "I can't express myself properly… I used to be quite fluent."

We gained the impression that a number of patients were feeling sad or fearful about facing the future, and it appeared to us that in some cases, despite excellent clinical care, perhaps insufficient attention was given to recognising and meeting patients' emotional needs.[3]

Recruiting volunteer "befrienders" and providing a wider range of activities and pastimes, as suggested on p.18 and in Appendix A (p.27), would be one way of helping to support patients' emotional wellbeing.

Recommendation 1

Meeting emotional needs*: we recommend that more emotional support, either formal or informal, should be made available to patients.*

Good nutrition and hydration, and help with eating if necessary

We observed lunch being served to eight patients sitting together at a large round table in the pleasant day room; all were able to feed themselves. They were

[3] *Comment from management: "Emotional needs assessments are undertaken by nurses, and therapist, the patient's emotional health is a significant factor in their rehabilitation. Magnolia unit has an ICT link with a Community mental health nurse, who attends the weekly MDT meetings. All of the patients have an assessment of their cognition and if needed, a depression screening assessment is performed. We are forging links with Enfield carers to support patients on discharge. We recognise that some staff need additional training in regard to supporting patients psychological needs, and for this we are working with the Trust to develop a HCA and RGN training programme to capture customer care and the patients experience. Additionally we are working with the training team to access palliative care training for staff. The therapy team have added an additional question about mood in their assessments."*

served and assisted by a nurse and a healthcare assistant. We noted that patients were all eating at their own pace and were not expected to eat the same courses at the same time. They were all offered water and later, tea. We also saw four patients eating meals by their bedside, all managing without help. We were told that the red tray system (alerting staff that the patient may need help with eating) was in operation, but did not observe this; we saw red trays being used for storage on bedside tables.

Is intake of food and drink monitored?

We were told that all patients' food and fluid intake are monitored carefully on arrival for the first two days; after that, monitoring continues if required.

One patient told us they had been in a number of different hospitals over the past three months, and had lost a lot of weight. This patient, who was expecting to be discharged the following week, had not seen a dietitian or been offered any supplements in Magnolia.[4]

Record keeping of falls, accidents and incidents

The majority of patients in Magnolia Unit are there because they have previously had a fall. All falls which take place on the unit are carefully monitored and reviewed; the aim is to build patient confidence.

Records of falls were on display on the general board. The manager said that all falls were recorded on the Datix database, and there is always a follow-up assessment to ensure patient safety. If a patient has a fall shortly before they are due to be discharged, the MDT will reassess the patient's needs, and if necessary will delay the discharge for a few days to monitor any after effects. The unit has additional sensory mats in the 'high dependency' areas of the ward.

Efforts made to ensure dentures, glasses, hearing aids etc. do not go missing, and are in use.

We asked about safekeeping of items such as dentures and glasses. The manager said that the staff team were aware of this issue and took care to ensure that items didn't go missing; he also said that if they did, the matter was addressed urgently. He told us that two sets of dentures had been lost in the past few years, and replacements had been funded by the Trust.

We met one patient with severe hearing impairment whose hearing aid had gone missing when she was in another local hospital. She could not hear normal conversational speech, but we found it was possible to converse with her by speaking very close to one of her ears. When we asked if her hearing aid was being

[4] *Comment from management: "Magnolia unit carry out weekly MUST (malnutrition universal screening tool) assessment on patients. We have an agreement with the dietician that we action the first line of intervention, including supplements for patients and food and fluid monitoring, when a patient then fails to gain weight or have more complex needs then a dietician referral is made."*

replaced, she said her relative was “working on it”. The lack of hearing aid was having a major impact on her wellbeing, as she was unable to take part in conversations with staff or with other patients and was feeling bored and isolated.

Discharge procedures

The manager explained discharge procedures in detail, and said that discharge planning starts as soon as the patient is admitted. Much of the discharge process is organised by the occupational therapists. The unit aims to help patients to regain as much independence as possible, and this process starts with regular assessments; when the patient has made sufficient progress, an OT will visit a patient’s home to assess the viability of a successful discharge and whether any adaptations are needed; this is followed by a joint home visit with the patient to test readiness for discharge. This was confirmed by a patient who had a home visit booked for the following week with the expectation that, if all was well they would return home the week after.
We were told that similar equipment is used in people’s homes and on the unit, so if patients and families learn to use a hoist or other piece of equipment they will be familiar with it after discharge. (We have found that in other local hospitals there is sometimes a discrepancy between the equipment used on the ward and the equipment supplied by the local authority to people’s homes, which can cause problems.)

Patients usually arrange their own transport home and are picked up from their bedsides. If needed, the patient will be provided with some basic food on discharge, including a sandwich to help with the transition. The manager said that normally medication is delivered prior to discharge as the unit has its own pharmacist and medication is sent from St Ann’s Hospital every day before 3pm. If medicines are needed earlier for any reason, the unit will arrange for a taxi to deliver them.

If there is concern about the timing of a discharge, the bed is held for the patient for a short period until there is confirmation that the patient has settled back at home. For example, if such a patient is discharged on Friday, the bed will be held till the following Monday. It was acknowledged that some patients do return to the unit; this was more likely to be someone who lives on their own.

We were told that carers and relatives are involved throughout this process, and that a family/carer meeting is held prior to discharge, to ensure that there is agreement about proposed action.

We met two patients who were hoping to go home the following week and one patient who was waiting for transfer to a care home. None of these patients seemed very clear about what was going to happen. One was waiting for a relative to arrange private home care and did not know whether she would be entitled to any financial support. A second person had been told a careworker would visit her every morning, but did not know exactly what they would do for her. The third patient was unsure about how to choose a care home.

Although the discharge procedure as described to us sounded very well-organised,

two family carers wrote to us after our visit, to tell us that their relatives' experience of discharge had been very poor. We forwarded their concerns (anonymised) to the unit manager, who replied in detail, expressing his regret for the problems that had been encountered, setting out clearly the procedures which should have been followed, and noting any action to be taken to try to ensure similar situations did not arise again. He pointed out that without being given the names of the patients involved he could not investigate to see what had gone wrong in these particular instances, but indicated that the team would endeavour to learn from these examples.

One family carer (Carer A) wrote: "On discharge, concerns by family dismissed totally. The visit by the OT was pointless, I could see that all she wanted was to push for discharge; the welfare of that patient was not a priority - making that bed space available was more important. Needless to say, we struggled badly a week into discharge with no help or any follow up in community."

Another family member who wrote to us (Carer B) told us that the discharge process had not gone at all smoothly. This relative lives many miles away from London, and was not able to be present at the discharge, but had tried to make sure everything was satisfactorily arranged in advance. The relative said that:

- The ambulance arrived an hour early, and the patient was "hassled" to "hurry up", so the driver "could get to his next booking", so the patient missed her lunch. A sandwich was provided but in the rush and confusion, the patient did not eat it.
- The ambulance driver refused to take all the patient's luggage, although the relative had been expressly assured that "all her luggage" would go home with her. The driver left behind a bag of clean clothes and sent her home with two bags of dirty clothes.
- Because of the earlier departure time, the patient arrived home an hour earlier than expected, and "it was sheer chance" that someone was present when she arrived.

Carer B told us that there were also significant problems with continuity of care for this patient after discharge:

- The patient was discharged without her discharge notes, and it took 12 days before they were sent to the patient's GP, who was thus unable to review her medication.
- The patient was discharged without a handover book for the domiciliary care assistants; this did not arrive till the following week.
- The family were told that a social worker would accompany the care assistant on their first visit, but this did not happen.
- The care assistants complained that there was no microwave or key safe, but no one had informed the family that these items should be provided.
- There was no contact from the community physiotherapy and OT teams until the patient had been at home for five days, leading to a significant interruption in treatment, setting back the patient's recovery.

Carer B added, “Better information for families in advance would avoid a lot of these problems, explaining what sort of things should be provided e.g. a key safe, a microwave if that is expected, and what might happen. I was unaware for example that the enablement team was separate from the carers.”

When we drew these issues to the attention of the unit manager, he provided a detailed reply to each of the above points, which we have forwarded to the informants.

While there were operational reasons for some of the problems encountered by Carer B and her relative, it would appear that in this instance, communication with the family both before and after the patient was discharged was poor. Some useful information was not provided, while other information was inaccurate. Ward staff need to bear in mind that the relatives of some patients live many miles away and may not be able to play an active part in the discharge process, such as collecting their relative and all their luggage. Family members may also be completely unfamiliar with what to expect from domiciliary care workers, and what the care workers will expect in return.[5]

Access to social worker

The manager said there were good links with the team of three social workers, one of whom attends the weekly team meeting to discuss care packages and post-discharge arrangements. It became apparent that several patients we spoke to were unaware of social worker involvement in decisions about their care and discharge. It may be helpful to alert patients to the involvement of social workers in decisions about care, and to facilitate a meeting with a social worker for those patients and families who would like it.[6]

Recommendation 2

***Discharge procedures**: we recommend that greater care is taken to ensure patients/families are provided with accurate information about imminent discharge, including rules about luggage, laundry etc. Patients/families should be given advance notice of any equipment which needs to be provided in the patient’s home. We suggest that patients and/or carers should be contacted a few days after discharge to find out if there have been any problems.*

[5] *Comment from management: “We welcome the comments made by Healthwatch. Action to develop a booklet for patients and their families on discharge. Magnolia unit has a booklet in place about the service with key staff and services identified. The Trust is reviewing and updating the Trust complaints leaflet.”*

[6] *Comment from management: “We welcome the comments made by Healthwatch. Social services are not based on the unit and different social workers are involved in our patients’ care; as a result this changes the traditional dynamics of the social worker and patient relationship. Action to develop a booklet for patients and their families on discharge.”*

Repeat admissions

Some patients are re-admitted to the ward after they have been discharged, usually following another fall or infection. We heard that there are some who return quite frequently, and this tends to be those who live alone.

End of life care

Staff on Magnolia Unit do not normally expect to provide end of life care, as this is a rehabilitation ward, but occasionally they admit a patient who suddenly takes a turn for the worse and palliative care is needed. In such cases, the community palliative care team is called in to provide specialist support.[7]

Key area 2: personal choice and control

To find out whether the care is truly person-centred

Assessment and care-planning documents

We were given blank copies of a large number of assessment, care-planning and observation tools, including:

- the Magnolia unit referral form
- an initial assessment tool to decide which areas need a specific action plan e.g. falls, communication, breathing difficulties etc.
- a detailed falls assessment tool
- a suite of forms for tissue viability/pressure sore prevention and care
- observation charts including: behavioural chart, neurological observation, weight chart, food chart, fluid balance chart, blood glucose chart etc.
- a 'safe rounds checklist' to be ticked off, including: call bell at hand, bed table by patient, anything needed, pain, comfort, warmth, offer toilet, check pad etc.
- a self-medication guidelines pack.

The **Magnolia unit referral form** is clearly set out and user-friendly; it requires quite a lot of detail as it is used to assess whether or not the patient will benefit from a stay in the unit. When completed it provides a large amount of information under key headings including: key contact details; reason for admission; current medical issues; current medication; sensory impairments; cognitive assessment/ issues; mobility/functional level (with detailed assessment sheet); and social/home information. The person making the referral is asked to confirm that the patient "is medically stable for admission to Magnolia". We regard this referral form as an example of good practice.

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[7] *Comment from management: "Magnolia unit has an education intention to develop staff knowledge and skills around end of life care; we are presently in dialogue with the trust training team, the North London Hospice and Hertfordshire university to support staff development, in order to improve the patients experience and perhaps in the future be able support patients with end of life care rehabilitation needs."*

The **self-medication guidelines pack** contains clear instructions for the patient and also a detailed assessment of how well the patient can manage key tasks, with or without help, such as “able to read labels and directions on medication”, “open and remove a tablet from a blister pack”, “pick up a tablet from a table/counter”, “able to swallow tablets” etc.

The team have also created their own clerking form for use if an out of hours doctor is called in to see one of the patients overnight or at the weekend.

Both staff who we interviewed confirmed that they had robust handovers and care plans to refer to.

Generally speaking, the care-planning and observation tools which we saw were clearly set out and user-friendly, requiring an appropriate level of detail; taken together they indicate a person-centred approach, based on each patient’s specific needs.

Do the individual care and treatment plans reflect the needs, abilities and wishes of the patients? Are patients and their families involved in drawing up the care and treatment plans and in reviewing them regularly?

The nurse consultant talked through with us how patients are assessed on admission to the unit and how the care plans and records described above are filled in. Each patient is asked about their individual goals during the initial assessment, and progress towards these goals is reviewed and recorded at regular intervals. Family carers are usually keen to be involved in the care-planning and review process and their participation is welcomed.[8]

Are staff aware of the personal histories and individual needs and preferences of the patients?

Efforts are made to ensure that staff know patients and their likes and dislikes, for example, whether they prefer cups to mugs. The HCA said, for example, that in the initial assessment, the patient is asked whether they want to get up early or late. She said that if a patient likes a ‘lie-in’ this is accommodated. Key information is recorded on a white noticeboard behind patients’ beds.

However, we noted that individual needs and preferences were not always known about or met. For example, we met a patient who said her main pleasure was reading; she was unable to hold a book for any length of time, but had not been offered a book stand. Another patient told us she would like to choose some books from the book case in the day room, but as she is in a wheelchair she could not

[8] *Comment from management: “Care planning involves patients; we expect patients’ involvement, yet recognise that more work needs to be done to ensure the care plans are truly patient-focused.”*

reach the books. No one had engaged with her to find out that she would like to have a look at the books which were available.[9]

We asked one patient if the tea she was drinking, which was very milky, was how she liked it and she said no. She would prefer weak earl grey tea with a slice of lemon, but she said, "I can't ask for that."[10]

It seems that some of the patients are reluctant to ask for anything which might make their stay at Magnolia more pleasurable, because they 'don't want to be a nuisance'. Staff may need to be more proactive in asking patients about their preferences, as small comforts such as having a cup of tea 'just how you like it' can make a big difference to a person's state of mind, and can help to speed their recovery.

It might be helpful to use a tool such as 'This is me'[11] to record basic personal information – including particular preferences, past occupation, hobbies and interests, etc. - about each patient. Although it was originally designed for people with dementia it can be used more generally (or could easily be adapted), to help staff see at a glance what is important to each individual, and therefore assist in making care more person-centred. This type of tool can also be useful to prompt conversations with the patient on topics which interest them, such as football, opera or the country where they were born.[12]

Recommendation 3

***Personal information**: we recommend that non-clinical information about patients, including their likes and dislikes, former occupation, interests and hobbies, are consistently recorded and used to help staff see each patient as an individual, and to help identify activities and pastimes which might appeal to them.*

Are cultural needs and preferences identified and supported?

We met a diverse staff team, and they told us that where staff have additional language skills these are used to support patients if appropriate. Interpreters are booked if required.

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[9] *Comment from management: "The books on the Magnolia unit have been donated; accessing volunteers may be able to assist with a mini library service / attracting further book donations. Patients will frequently choose to read a magazine of their choice, procured by family. The bookcase is five shelves high and the low levels are accessible to wheelchairs, on such shelves we now have games and popular books, staff can assist with the higher shelves."*

[10] *Comment from management: "It is worth looking at the demand and need/cost for a wider range of teas available for patients to increase their choice of refreshments."*

[11] https://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=399

[12] This could lead to more detailed life story work, whereby the patient, their family members and a trained volunteer or staff member work together to create a scrapbook or memory box recording and celebrating significant aspects of a person's life. See: ***Reminiscence and life story work: a practical guide*** by Faith Gibson, 2011, Jessica Kingsley Publishers.

We were told that patients are able to arrange for spiritual or religious support and this is facilitated by the unit if requested. The manager said that though they did not have an allocated priest, patients' families often arrange for their own representative to come and visit. However, one patient told us she would like to see a Roman Catholic priest because it would be "comforting", but that hadn't been suggested or offered to her.

Recommendation 4

Spiritual support: *consideration should be given to contacting local ministers and faith leaders with a view to inviting them to visit more often, and perhaps work together to offer a weekly multi-faith service.*

Good choice of food, meeting individual dietary requirements and preferences?

Food is provided by Medirest. We received a copy of the menu which appears to offer quite a wide choice of dishes, identified with a system of symbols to indicate that they meet particular preferences or requirements, for example: diabetes, "healthier choice", "higher energy", "softer", "vegetarian", gluten-free. Halal and kosher meals are available on request. We heard that patients who have been transferred from other local hospitals, where food is also provided by Medirest, have grown used to the options on this menu and would welcome a change.

A three course meal is available at both lunchtime and in the evening, with lighter options such as soup or sandwiches also available at both times, to suit patients who are used to having their main meal at lunchtime or dinner time. Patients are encouraged to eat together in the dining room if possible; otherwise they are served with their food in bed or by their bedside. We were told that at lunchtime all nurses and HCAs stop doing other work and make themselves available to help serve the food and drink, and assist those who need help with feeding.

The unit has a housekeeper present four days a week. She collects patients' food orders and makes sure they receive what they have ordered; this is done by HCAs on other days. On the day we visited, the housekeeper was not on duty. We heard that she provides feedback to Medirest about the food provided and will always let Medirest know if the food is unsatisfactory.

The food received mixed reviews from the patients. One said the food is "tasty"; another said it was "tasteless". One told us the lunch was "lovely". One patient said, "Normally the food is not too bad, but today was the worst ever. I wasn't given a choice." Another patient said, "The food is not always up to scratch," and added that the food was not presented in an attractive and appetising way.

Several patients told us the portion sizes were far too big, and we saw that a lot of food was left on plates and was thrown away. It appears that the same size portions are provided for males and females of all ages, throughout the Trust.[13]

[13] *Comment from management: "The quality of the food is assessed by Medirest, raised in monthly Environmental meetings with Medirest. Recently the ward passed a PLACE inspection, which included a peer assessment which included patients' advocate; the assessment incudes the taste of the food. The menu has also been updated and includes small portions; however this was not*

Food is available in between meals on request, and relatives can bring in food for patients. There is no facility to heat it up, but there is access to a fridge for storage. Fish and chips are a popular treat.

Recommendation 5

Food: *we recommend that the food supplier is asked to provide a wider range of cooked menu items in 'small' as well as 'standard' portions, to meet the needs of patients who do not have a large appetite. Patients should be invited to take part in food tasting sessions when new menu items are being considered.*

Activities and pastimes

We found that apart from scheduled therapy sessions, there were few activities or other opportunities for enjoyable ways to spend the time.

Several patients told us they were very bored. One said, "There is a lack of anything to do from now (lunchtime) till the lights go out at 10.30. It's boring."

A patient who wrote to us said that on one occasion the patients "were taken to the dining room and left there for three hours with nothing to do and no explanation."

The lack of activities means that it is a 'long day' for patients, and those in side rooms can feel lonely. One patient told us she had asked to be moved into the main ward so that she could be closer to other patients for company.

We were told that patients have a weekly social meeting, which has included craft work, discussions about current affairs, reminiscence etc. There is a very popular 'pets as therapy' scheme, whereby patients can pat a dog who visits once a week; patients told us how much they enjoyed this. The manager told us that there used to be a knitting group run by a volunteer, which had been popular. There also used to be another volunteer who would run errands for the patients such as buying newspapers for them, but this volunteer was no longer available.

On the day of our visit, some of the patients had been attending a reminiscence session in the day room before lunch was served. Two of the women sitting at the lunch table had not been able to take part in the group discussion however, because one is very deaf and the other is not fluent in English. Their individual needs were not being met by this activity, and in fact it may have served to exacerbate existing feelings of boredom and isolation.

The radio was on in the day room during the lunch time, but no one appeared to be listening to it. It was tuned to radio 3, and the music being broadcast was rather esoteric classical music. One patient said she liked this music, but all the others who were sitting at the table agreed that they would prefer to listen to radio 2.

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widely advertised. We are also aware that patients on numerous medications and with pre-existing disease can have an altered taste."

There are televisions in the two common rooms, but patients said they could not always agree which programme to watch. No TVs are provided in the side rooms and bays. Patients are allowed to arrange for a personal TV to be brought into a side room, but this is only possible for those patients who have relatives/carers who can arrange this. (While we were there, we found that one patient had a TV balanced rather precariously on a chair in her room. We asked the staff to provide a table for her, and they responded very quickly and efficiently. The patient was impressed with their prompt response.) One patient commented that it would have been nice if there was even a radio in the rooms.

Watching favourite films or TV programmes together can be an enjoyable and sociable activity, and it would not be difficult to create a 'film club' or an 'EastEnders' club, for example, whereby patients are encouraged to leave their rooms and spend time together during the evening.

One patient said that a relative brings in the newspaper each evening and the patient reads the paper the following day and does the crossword "to keep the mind active".

Although there are books, games and a piano in the day room, it appeared that these valuable resources were not much used. Volunteers with a variety of talents might be able to provide a range of enjoyable and stimulating activities on a group or one-to-one basis. Patients should be asked what kind of activities they would like to take part in. Patients or their family members may have a particular skill they would like to share with the other patients during their stay, for example, playing the piano.

Absorbing activities which are well-suited to individual patients' interests and abilities can lift the spirits and play an important part in restoring patients' confidence and motivation and contributing to their overall rehabilitation.[14]

Delivery of a wider range of activities might be facilitated by recruiting an activities organiser, or alternatively, by additional training so that the existing workforce are supported to facilitate activities themselves.[15]

[14] The Alzheimer's Society's ***Fix Dementia Care: Hospitals*** report highlights as good practice the approach at Kingston Hospital where "the hospital runs therapeutic activity sessions for patients with dementia every day, including painting, listening to music, craft, knitting and jigsaw puzzles. These sessions are led by hospital staff along with a group of trained dementia activity volunteers." https://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2907

[15] In an article about delivering activities in care homes, Sylvie Silver, Director of the National Activity Providers Association (NAPA) suggests that all care staff should be upskilled so that they can facilitate worthwhile activities as well as delivering care. "We need to skill up the whole care workforce so they recognise that activities are integral to person centred care." Although the requirements of a rehabilitation ward are different to those of a care home, this idea merits consideration.
http://www.carehome.co.uk/news/article.cfm/id/1560721/benefit-of-having-meaningful-activities-in-care-homes-is-huge-says-director-of-napa

Recommendation 6

Activities and pastimes*: We recommend that a concerted effort is made to provide an imaginative range of activities and pastimes, both for groups and individuals. Consideration should be given to employing an activities organiser, full or part time, who could recruit and manage a team of volunteers. Alternatively, additional training could be provided to existing staff. A list of suggested activities is included as Appendix A on p.33.*

Key area 3: information, communication and relationships

To find out about communication and interaction between patients, staff and relatives

Kindness, compassion, human warmth, respect and dignity

Most patients who spoke to us were very complimentary about staff. "They treat me like a queen," said one. "Everything I want done, they do for me."

We observed that patients were treated in a warm, kind and respectful way by all types of staff including domestics, nurses and therapists, and this was confirmed by the patients we spoke to. We observed a nurse knocking on the door before she entered a patient's room. The healthcare assistant (HCA) who spoke to us said she had a lot of interaction with patients, and often thought, "How would my mum like to be treated?" when working with patients.

The manager also mentioned that there are regular 'comfort rounds', when patients are asked if they need a drink or to go to the toilet, and staff check that they are comfortable.

However, according to two separate written statements we received from relatives of patients who had spent time in Magnolia Unit, some members of staff had refused to assist patients to the toilet. One of these relatives wrote: "On one occasion at night she called staff to take her to the toilet but they refused to help her, saying it wasn't part of their job. When I reported this the next day I spoke to a very concerned healthcare assistant who said that was wrong and said he would mention it to the nurse in charge. His concern was genuine and reassuring but his attitude was not universal."

When we alerted the unit manager to these two comments, he replied: *I was sorry to read about the relatives experience and that we did not respond in an appropriate manner as would be expected. This issue will be picked up directly with the whole team via team meetings and individual supervision so everyone is aware of the concerns raised… We would agree with you that these patients' experiences you have raised are unacceptable, particularly if staff are putting patients into a position where by the patient feels degraded in any way. I would encourage the complainants in these incidences to contact me so that we can establish the facts of these incidents and so that appropriate action can be taken with staff… I am also in the process of arranging a refresher training session with*

the Trust's Patient Experience team to explore with the staff team how we can improve gathering patient and family/carer feedback and support people to give feedback whether it is via face to face communication, the Patient and Carer survey or a formal complaint.

Understanding amongst staff of how to communicate with people with dementia or other communication difficulties

Although staff appeared to be well-trained and confident to look after and communicate with patients with dementia or confusion, there appeared to be less awareness of how to communicate with and meet the individual needs of patients with hearing impairment. We observed a nurse administering medicine to a patient who had lost most of her hearing; this patient was however able to hear in one ear if the person speaking to her spoke very close to this ear. The nurse approached from the side where the patient has no hearing, and said quietly, "I'm going to give you your medication now." The patient had no way of knowing what the nurse had said, and the nurse did not check to find out whether she had been heard or not.[16]

Recommendation 7

Sensory disability*: we recommend that with the patient's consent, sensory disability should be flagged on care plans and on the white board in a similar way to dementia and cognitive impairment. Staff would benefit from awareness training in how to identify and meet the needs of patients with hearing or visual impairment.*

Response time to call bells

Three patients told us there was a good response when they pressed the call bell, but one patient reported that the response was not always prompt.

Call bells went off a few times during our visit, and the manager explained that in a couple of cases two patients were calling at the same time and where there was a complex need, two members of staff would be involved in dealing with the first patient and this then caused a delay for the second. He explained that if the call was unanswered for any length of time the pips became more frequent; however, every effort was made to avoid this and all staff responded to call bells. We checked this with staff and they confirmed that if they were walking past they would deal with the patient's needs. However, we noted that one bell rang for

[16] *Comment from management: "We welcome the comments made by Healthwatch. We are addressing this through staff appraisals, their one to one supervision and in planned palliative care and professional development training. The therapy team use a system called HADS to assess sensory loss and the Occupational therapy team have an objective to support staff awareness on sensory impairment, involving patients and staff."*

quite a few minutes whilst the nurse was sitting in an adjacent room doing paperwork.[17]

Response to "challenging behaviour"

In response to a question about challenging behaviour, the manager said they had very few patients with challenging behaviour and so this wasn't a priority for staff training. If a patient became upset, staff would try to calm them down, and would stay with them to reassure them and to monitor the situation so that the patient remained safe.

Information provided to patients and carers

Lots of information is displayed on noticeboards in the corridors, including pictures of all the staff, an explanation of the different uniforms worn by different types of staff, and quotes from patient feedback along with a response from the ward.
We were given a copy of the information booklet for patients, which is attractively produced and clearly set out. It contains a wealth of useful information about the treatment and care available at Magnolia, and the everyday running of the unit. Clear information is given as to how to give feedback or make complaints, with contact details and the names of senior staff. We regard this booklet as an example of good practice.

This booklet is meant to be given to all patients when they arrive at Magnolia. Some patients we spoke to said they had not received a copy, but the manager thought the booklet had probably been taken by family members for reference.

The patients' information booklet provides a lot of information which would be useful for carers, but we did not see any leaflets specifically aimed at carers.

We heard that a representative from the Care Home Carers Group at Enfield Carers Centre can provide advice on choosing a care home if required. However, patients and carers we spoke to did not seem to be aware of the service provided by the Carers Centre Hospital Support Worker, who we understand makes regular visits.[18]

Do relatives/carers feel informed and involved?

We were told that staff are encouraged to get to know relatives and build a relationship with them, as they play a key role in supporting the patient's recovery, and enabling a safe discharge.

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[17] *Comment from management: "We are aware that sometimes the call bell response needs to improved and as a result this is raised in clinical governance meetings and during nursing hand over, encouraging staff to be more prompt with answering bells."*

[18] *Comment from management: Magnolia unit does have carers' information on a poster board near the large day room. The board is updated by Enfield Carers Centre and by staff with additional information provided by local charities and carers groups, including details of the 'Carers Centre Hospital Support Worker'.*

We were told that with the patients' agreement, care plans are prepared and reviewed in discussion with relatives/carers, taking into account the work being done with individuals by the therapists. Carers are allowed to help with personal care if they want to do so and if the patient agrees.

Discharge plans are also discussed and agreed with families where appropriate. Staff at the unit try to manage the discharge process in such a way that disagreements are avoided. There is a recognition that sometimes family members expect different outcomes from patients, and this has to be managed with care.

There is a pleasant visitors' room with tea and coffee making facilities. Visiting time is between 3pm – 8pm on weekdays and 2pm – 8pm at weekends. Requests to visit outside these times can be discussed with the nurse in charge, and we understand that relatives may stay overnight if the patient is receiving end of life care.

Two relatives who spoke to us said they were kept well informed and there was a flexibility in visiting hours which was not the case in the hospital. They said they were involved in the initial assessment which they felt was very thorough.

One patient was anxious regarding visiting hours, as the family lived a long way from London. The manager assured us that it would be fine for visits to occur outside the normal hours and said he would arrange this with the patient and family.

How are patients' and relatives' views taken into account?

We were told that non-nursing staff invite patients and carers to complete a satisfaction survey at the end of a stay.

We were given a copy of the 'BEH MHT carer or parent survey' which appears to have been designed for use with the parents and carers of patients under 18 years of age. We are not sure whether this is the survey used for relatives at the end of the patient's visit to Magnolia Unit. If so, it seems inappropriate to give this survey to the relatives of very elderly patients. This form could easily be adapted for relatives of adult patients, by removing references to parents and guardians.[19]

Response to concerns or suggestions made by patients or relatives

The manager said that the unit received very few complaints, but they were keen to listen and address any concerns which are raised. Only three complaints had been raised in the last year and none of these were upheld. He gave us an example where a carer hadn't been involved in care planning due to the involvement of a more assertive relative; once the issue had been raised it was addressed quickly.

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[19] *Comment from management: "This document described is the Trust document on Meridian, a Trust audit tool. Magnolia unit also captures carers' views post discharge, alongside with cards, and informal feedback from comments from patients in our care and occasional complaints. The Trust Patient Experience Committee is currently reviewing (via task and finish group and in co-production) the service user and carer experience surveys for the Trust, and can consider the Healthwatch feedback within the review."*

Learning from this complaint had now been incorporated into the initial assessment procedures, to ensure the right people are involved. He also told us about one staff member whose approach had been perceived as rather surly, though this was not intentional; he addressed this by developing an action plan and raising the awareness of the member of staff, showing them how to communicate in what the patient would feel was a more friendly way, with suggestions for rephrasing comments, maintaining eye contact etc.
We were impressed by the response which we received from the manager with regard to the written comments from relatives which we forwarded to him after our visit; it appeared to demonstrate a genuine determination to take relatives' concerns seriously and to take action to minimise the likelihood of similar problems arising in future.

Key area 4: the environment

To find out whether the physical environment is pleasant, clean, comfortable, safe, facilitates movement and good interaction between people

Magnolia Unit is purpose-built and has been well-designed to make it easy for people with impaired mobility to get about safely and conveniently – for example, there are wide corridors and doorways. The building is bright and airy, with plenty of natural light, is kept clean and tidy, and is maintained in good decorative order.

Communal accommodation

There is a large day room with a mixture of easy chairs (including extra wide chairs) and round dining tables and dining chairs for patients to eat together. There is a TV/radio which was tuned to radio 3 during lunch; there was also a piano in the corner, but it did not appear to be in regular use. There is a toilet adjacent to the day room. One of the patients told us that the chairs in this room make her back ache.

There were several break-out areas and none appeared busy. There was also another day room with a television, and a quiet room adjoining this.

There is a large well-equipped gym (shared with out-patients from the community), and an OT kitchen for patients to practise activities of daily living before being discharged. There is also a kitchen for visitors with coffee, tea and biscuits available.

Bays and bedrooms

There are 4 four-bed bays and 13 individual side-rooms. We understand that on arrival patients are placed in side-rooms so they can be checked for MRSA etc. before being moved into the bays. The team can adjust the mix of patients in bays and side-rooms to ensure all patients are in single sex accommodation.

The bays are large (they were originally designed for six beds) which means there is room for visitors, equipment etc. and patients do not feel too crowded. Curtains round the beds are made of disposable material.

Each bedroom has a lockable cabinet to house individual medication to facilitate patients self-administering their medicine where possible.

A patient commented that their bed was comfortable but said the bedside chair was not so good: it was hard, with no head rest.

Call bells

We noted that call bells in bedrooms and bays were plugged in and were placed within easy reach of patients. There was a portable call bell on the table where we observed patients eating their lunch.

Bathroom and toilet facilities

All but four of the side-rooms have en suite bathrooms with toilet, basin and bath/shower. There are also communal shower rooms and toilets. All the bathrooms we saw were very well-equipped with aids such as hoists, raised toilet seats, grab rails etc., and looked and smelled clean and fresh. The bathrooms are large enough to comfortably accommodate a nurse or healthcare assistant giving assistance to a patient.

Cleaning

The unit looked clean and we saw domestics cleaning floors and surfaces.

However, one patient who contacted us after being discharged commented: “The floor in the middle of the ward was mopped and cleaned several times a day, but the areas under and round the beds were left for two weeks or more. You could see the bits still there.”[20]

Signage

Signage in the unit is large and clear and appears to be dementia-friendly.

Security

The entrance to the Unit has doors which open automatically. We were concerned that this might be a security risk and that there was potential for patients with dementia to leave the premises unnoticed. However, we were assured that the front desk was staffed most of the time and that there was little risk of this. The staff said that they wanted patients to feel at home and locking doors didn’t support this. There is careful placement of patients in the ward so that vulnerable and frail patients are placed in areas where it is possible to provide a higher level

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[20] *Comment from management: “We welcome the comments made by Healthwatch. We have the same issue about cleaning under furniture; we raise these issues with the cleaners each day and when a cleaning issue becomes persistent this is then escalated to the environmental group for collective action.”*

of supervision. The manager confirmed that there have been no security-related incidents.

Access to open air

There is a pleasant outdoor space with tables and benches. Staff reported that in good weather they take patients out for fresh air. We noticed that the flower beds were in need of some care.[21]

Recommendation 8

Environment*: patients' opinion should be sought as to whether the chairs are sufficiently comfortable, and consideration should be given to replacing them if appropriate. The cleaning routine, including the cleaning of "hidden" areas should be reviewed.*

Key area 5: staffing and management

We gained the firm impression that the unit is well led and managed, with a calm and orderly atmosphere, and a high standard of nursing care and physical therapies. It was a pleasure to meet a staff team who seem to really enjoy their work and relish ensuring that patients receive good care. One commented: "It's special here." Another said: "I go home after work feeling satisfied; it's a very rewarding job." Patients and carers confirmed that the therapeutic treatment they were receiving was beneficial.

There are about fifty staff, who provide an integrated service: nurses, OTs, physiotherapists and HCAs all work together as a team. Staff told us that all team members are valued equally, whatever their role, and said that their suggestions are always taken seriously. Team meetings are held weekly, and handover is actively managed on a daily basis ensuring that key information is passed on. Staffing has been assessed as meeting 'safe staffing' levels, and the need for an appropriate skills mix on each shift is recognised. We heard that "bank" staff are mostly former (retired) members of the staff team. We understand that most nurses and HCAs work a mixture of day and night shifts, which aids good communication between day and night staff. Staff are allocated to particular sections of the unit, bearing in mind the need to provide continuity of care wherever possible, particularly for patients with dementia, so that they see a familiar face.

The nurse consultant said that although the ward is fully staffed it is a very busy job with no time for staff to chat amongst themselves. She added that demands on

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[21] *Comment from management: "We welcome the comments made by Healthwatch; funding is needed to develop the garden. Where appropriate, funds donated to the ward are made available to support developing the garden and donations from local garden centres could be explored. A porter and occupational therapy staff contribute to the garden and patients participate in garden based therapy/sessions as appropriate. The garden is accessible by wheelchairs, for patients, their family and carers."*

staff depend on the mix of patients at any one time, and how much care they require. Sometimes they have more patients requiring a high level of support, and this can lead to problems if for example, one of the patients has a hospital appointment. If the patient cannot be accompanied by a family member, then an HCA will escort them, using hospital transport; this can leave the ward short of staff. There is some flexibility with staffing levels, and if more staff are needed, a request is made to the Clinical Director or the Director of Nursing at the Trust. The Manager is directly involved in staff recruitment and understands the importance of getting 'the right person'. We heard that there is low staff turnover. It was mentioned that about eighteen months ago, several staff left to progress their careers elsewhere, but the staff who we met were keen to stay. An HCA who we met told us she had worked there for ten years. We were told that one member of staff was away on long term sick leave; otherwise staff attendance was good, and this was displayed on noticeboards.

Staff we spoke to confirmed they had completed their mandatory training. Training is provided by BEH MHT. We heard that most training is delivered on site and is scenario-based, so it is tailored to the requirements of the staff working on the unit. The training was reported as being good, except for the manual handling course; we were told that this has been raised with the Trust and is being addressed. All training takes place during working hours and is built into staff schedules.

All staff have been trained in the 'Butterfly' scheme[22] to identify and support people with dementia, which was introduced two years ago, and the ward has a number of dementia champions. We were told that implementation of the Butterfly scheme is an ongoing process, led by the occupational therapists; team members reflect on their learning and practice and discuss any issues arising in clinical governance meetings.

We were told about a scheme whereby OTs and HCAs had shadowed each other for a day to build up an understanding of each other's roles and contributions to patient care. This is a good example of how to enable an integrated approach.

Staff told us that they feel supported. They confirmed that they have monthly one to one supervision sessions and an annual appraisal which takes place in spring.

A staff member confirmed that feedback is shared if any concerns have been raised, and that in the case of a serious incident, a team meeting would be called immediately. Staff were aware of the whistle blowing policy, but we heard it had not been invoked, as staff felt able to speak openly about any concerns they might have. The manager explained the action he would take and how he would protect the identity of a whistle blower if such a situation arose.

[22] http://butterflyscheme.org.uk/

Conclusion

We gained a positive impression of Magnolia Unit overall. The service appears to be well-led and managed and staff told us they found the work satisfying and fulfilling.

Most of the patients and family carers who spoke to us said they thought the care and treatment was good, although we did hear of some exceptions. The manager responds promptly when any concerns are raised with him and takes action to ensure that the team learns from any reported instances of poor care.

Clinical care and therapeutic treatments appear to be of a high standard, but we believe that more attention should be given to ensuring that patients' emotional needs are met, in addition to their physical needs. We found that several patients were bored, as there are very few activities available. We recommend that a determined effort is made to increase the number and range of activities, and suggest that volunteers could play a valuable role in this respect.

We have been very impressed by the positive and constructive way the management and team at Magnolia Unit have responded to the various issues and concerns we brought to their attention, both during and after our visit, and believe this demonstrates that there is good leadership and a culture of continuous learning in this service.

We look forward to following up within the next six to twelve months to see whether the improvements outlined in the action plan have been successfully implemented and sustained.

Appendix A: Activities and pastimes

We recommend that a concerted effort is made to provide an imaginative range of activities and pastimes, both for groups and individuals. Consideration should be given to employing an activities organiser, full or part time, who could recruit and manage a team of volunteers. Alternatively, additional training could be provided to existing staff. (Recommendation 6)

Ideas include:

- *arts and crafts, knitting, communal singing, puzzles and games, film club, gentle gardening or looking after plants indoors, multi-faith religious service, performances by local schools or amateur dramatic clubs.*
- *make sure not all group activities need verbal communication e.g. arts and crafts and knitting may be more suitable for patients with hearing impairment or those not fluent in English.*
- *try to ascertain what kind of music or television programmes patients would like to listen to or watch. If the radio or television is switched on, check whether or not the patients appear to be enjoying it. 'Make a date' to watch certain films or programmes together.*
- *make newspapers available; make sure patients who want to look at the books in the day room are supported to reach them and choose books which interest them; try to obtain more large print books (for example by asking for donations from the library service).*
- *find ways to give one-to-one time especially for those patients with communication difficulties or sensory impairment.*
- *consider doing Life Story work with all patients who would like to take part, to find out more about the patients as people.*
- *Enfield Volunteer Centre, organisations such as Age UK Enfield and local churches may be able to help the unit to recruit more volunteers. Volunteers could offer group activities, or help by befriending patients who are isolated.*

Appendix B: Patients' and carers' experiences of hospital discharge and domiciliary care

We spoke to one patient, an Enfield resident, who had received treatment at another hospital (outside the borough), and had been discharged with a care package, specifying 3 visits per day. The patient said that they had no idea what help the careworker could give them; when the careworker arrived on the first day, she asked what the patient wanted her to do, but the patient had no idea what help to ask for. This patient's condition had deteriorated immediately and they had been readmitted within 24 hours.

Another patient had received home care from an agency twice a day and found them to be very good, reliable and punctual.

We will bear this information in mind as part of our ongoing work on service users' experience of adult social care services.

healthwatch
Enfield

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

Healthwatch Enfield
311 Fore Street
London N9 0PZ

Email: info@healthwatchenfield.co.uk; Phone: 020 8373 6283

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