healthwatch Shropshire

Enter & View Visit Report

Details of Visit

Service Name and Address	Ellesmere Community Nursing Home, Trimpley Street, Ellesmere, SY12 0AE
Service Provider	Ellesmere Community Care Centre Trust
Date and Time	Monday, 26th September, 10.15am – 1.45pm
Visit Team (Enter & View Authorised Representatives from Healthwatch Shropshire)	3 Healthwatch Shropshire Authorised Representatives

Purpose of the Visit

To observe the quality of care and treatment experienced by service users in this care setting in relation to Dignity, Choice & Respect

Disclaimer

Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experience of all service users and staff, only an account of what was observed and contributed at the time.

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Context of Visit

Healthwatch Shropshire gathers information on people's experiences of health and social care services and there are times when it is appropriate for Healthwatch Shropshire to see and hear for ourselves how services are provided. These visits are called Enter and View and always have a purpose.

Enter and View visits are done by a team of specially trained volunteers called Authorised Representatives (ARs). These volunteers are not experts in health or social care and report only on what they see and hear during the visit.

Healthwatch Shropshire was asked to visit Ellesmere Community Nursing Home by the manager of the home.

Enter and View visits can be announced, semi-announced or unannounced. This was a semi-announced visit and the manager at Ellesmere Community Nursing Home was told that the visit would take place but not the date or time.

What we were looking at

- We looked at how the care team respect the dignity and individuality of the residents.
- We looked at opportunities for residents to be involved in their care and whether they are encouraged to make choices. This includes choice of food and activities, and being able to personalise their own space.
- We asked residents about their opinions of living in the home, including how good the food is, the care they receive and the activities they enjoy.

- We spoke to staff about the initial and on-going training and support they receive. We asked them how they demonstrate care and respect for the dignity of residents.

What we did

We were met by the qualified nurse in charge on the day, who explained the staffing and care practices to us and showed us around the home. We then spent 2 hours talking to residents and staff. As most residents were in their rooms, each person was asked if we could visit them in their rooms. During the visit we were able to speak to four of the residents, as well as two people staying for respite, a carer, two qualified nurses and the cook. At the end of the visit we provided some initial feedback to the nurse in charge.

What we found out

The home

Ellesmere Community Nursing Home is on the first floor of an older building (previously Ellesmere Cottage Hospital) with a separately run Day Centre downstairs. The Nursing Home provides accommodation for up to nine residents for short, long and respite stays. The nurse told us that two beds are reserved for emergency respite care. On the day we visited there were seven long term residents and two people occupying respite beds.

The nurse explained that although the home does not take residents who already have dementia, they do continue to care for residents who go on to develop the condition. Most of the current residents are from the local area with one person having moved to the area to be close to family. All residents currently have family to support them.

There are seven single bedrooms and one shared bedroom with two beds. Three rooms have en-suites, the rest have wash basins. We observed that, due to the nature of the building, the bedrooms are all different in size and layout. The nurse showing us around told us that the rooms can, if necessary, be provided fully furnished with bed, reclining chair, chests of drawers, small tables, wardrobe space and a TV.

In the residents' lounge we saw that there was a TV and a music keyboard. There were five armchairs, four of the same design, around the sides of the room. We noted that this was not enough chairs for all the residents to be seated in the lounge at the same time. We did not see any footstools in the room. There was a large space in the centre of the room. Three hand bells were put on the table close to residents sitting in the room so that they could call for help. We noticed a delay in providing the bells for a couple of the residents.

We saw two hoists in the main corridor and we were told by staff that these were moved into the dining room at night to charge.

We were shown inside a locked medicine room with a locked cupboard and a locked trolley. We were told the medicine file is kept in this room.

There is a small garden for the use of the residents although we did not visit this. When we asked if the garden was used much, staff told us the current residents were 'not into gardening'.

We found the home very light and bright, particularly the lounge and dining rooms. Decoration is plain but clean. Pictures on the walls in the communal areas are a bit small and uninspiring.

We saw one communal bathroom which was clean, tidy and bright.

The nursing station was centrally positioned and was neat and well organised with useful information on display.

- **Access to the home**

The Nursing Home is reached by two sets of stairs and a lift. One set of stairs can only be used during the day through the Day Centre on the ground floor. There is a locked entrance door to the Nursing Home at the top of the stairs with a bell for entry. The other set of stairs has a locked door at the bottom monitored by closed circuit TV in the staff office so that people can be let in directly to the home from the car park. This is the main entrance when the Day Centre is closed. The Day Centre is run separately and there are no obvious signs either inside or outside to indicate how to enter the Nursing Home for anyone unfamiliar with the building.

The lift is operated by staff using a key, which is kept in a locked cabinet. This is the only means of entry and exit from the home for residents and visitors unable to use the stairs. As it opens downstairs into the Day Centre it was not clear to us how visitors unable to use the stairs could access the home when the Day Centre is closed. We were assured that the lift broke down very rarely and if it did, help arrived speedily. We noticed the number for Lift Maintenance displayed clearly over the desk at the nursing station.[1]

Approach to supporting the dignity and individuality of residents

- **New residents**

The nurse in charge told us the manager usually visits a new resident at their home, or in hospital before they are discharged, to assess their needs. Currently there is a waiting list. When a new resident arrives, they and their relatives, if available, are asked about their likes and dislikes and a life history is built up. This information is kept locked together with their medical notes although carers are able to read these notes.

- **Resident involvement in their care planning**

One resident we spoke to wanted to be more involved with decisions about their care but explained that they were frightened to ask in case the news was not what they wanted. They said that they would like to have more idea of future plans to give them 'something to look forward to' and to reduce their frustration.

Choice

- **Daily routine and food**

One resident told us: 'I am able to please myself. I can get up and go to bed when I want. I can lie on the bed all day if I want to or I can just walk about.'

When we spoke to the cook, we were told that there are fixed menus covering three weeks with two options, a meat and vegetarian one at each meal, although

[1] Following the visit the Enter & View Officer for Healthwatch Shropshire contacted the Registered Manager to ask for details of the home's fire escape procedure. Please see the response received on p.18

we were told by the cook that there are no vegetarians presently resident. Residents make their lunch choices in the morning. Food is pureed for those who prefer or need that option.

The cook told us that residents can ask for items that are not on the menu and they explained that one resident had requested a simple lunch of scrambled egg, which the cook had provided. We were told by the nurse that residents eat their breakfast in their rooms. Lunch and dinner are served in the dining room or in their rooms if they prefer. More people choose to eat lunch in the dining room than choose to eat dinner there. Many residents like a light meal, such as a sandwich, in their rooms at dinner time. Morning and afternoon teas/snacks are served between meals and cake and biscuits are also available.

One resident said that 'the food is very good and suits my tastes'. Another said: 'I can't complain about the food, it is very good'.

- **Activities**

One resident we spoke to said they liked sketching, reading and writing poetry and told us that they had published some poetry before they came to live at the home. They had been encouraged to sketch and read by staff but the staff did not seem to be aware that they wrote poetry.

We observed that there was a white board on the wall in the lounge with a list of regular activities, showing the day on which they happened. These were:

  - complementary therapies
  - exercise (every Thursday)
  - hairdressing (weekly)
  - visit from vicar (first Wednesday of every month)
  - the music man (Saturday monthly)
  - activities (locked in nurses station)

The staff told us that Easter and Christmas activities take place with the residents helping to make the decorations. The only activity we saw was a box of 'Quoits' in the lounge. When we asked if there was an activities coordinator we were told there wasn't and there were no plans to have one as the decision had been made that it was the responsibility of all the staff.

When we asked the residents about activities the most popular activity was a weekly exercise session by someone who visited to lead this activity. One resident told us that they really enjoyed singing but it was not clear to us if this was an activity available to residents. Another resident really enjoyed playing the keyboard but said they didn't do this very often as they didn't want to disturb other residents. One resident said they were bored and would like more activities. We were told there were no activities in an afternoon or evening and quite often the residents returned to their rooms. One resident said they liked to knit, read and watch TV.

The residents we spoke to about it told us that they could go out with family whenever they wanted to and that family were freely able to visit them. Two residents were asked if they would like to be taken out more on visits and trips. One resident said: 'Yes, but the staff are very busy'. The other resident said: 'Yes' but 'they don't take us anywhere'. One resident had asked to go out last week and had been taken out to the garden.

Although some residents were not concerned about the lack of organised activities or lack of opportunities to do more, we did hear that some residents were not as happy. One person who had been used to walking a lot felt very constrained but also acknowledged that this might be due to the terms of their respite care and due to necessity rather than choice on the part of the staff.

We asked the staff if anyone talked to the residents about new activities or events coming up shortly. We were told this sometimes happens but usually such activities are not actively promoted by staff. Instead leaflets are left on display for family and residents to view. For example, leaflets promoting a coffee morning had been left on the counter next to the signing in book so that relatives had a chance to notice them and take one.

There was a collage displayed on the wall showing photos of past events but few of the present residents were in them and we could only find details of group events that had taken place over a year previously. Residents who mentioned going out seemed to be recalling events that had occurred a while ago. For example a resident mentioned that 'I used to really enjoy waltzing at the Town Hall'. A canal trip was remembered by one resident but this was more than a year ago.

- **Personalising the residents' space**

Residents can bring small pieces of furniture and electrical equipment which is PAT tested in the home. They can bring a chair if it is considered suitable. It is more difficult to bring a bed as they need to be adjustable to suit health and safety requirements. All residents we visited, except for those staying for respite, had personalised their rooms to some extent with pictures, photos and ornaments.

One resident, when asked if they would have liked to have brought more with them, explained that a relative had moved into their house so they were quite happy to leave things in the house.

A carer we spoke to mentioned that dogs were allowed to visit and to spend time in the communal lounge too.

- **Access to phones/computers for communication**

When asked about the residents' access to computers, the carer we spoke to explained that no current residents use a computer. A former resident who used the computer was provided with an easy to use keyboard. Staff use the internet to find out information for residents if asked. One resident had a mobile phone and told us the mobile signal was good; they frequently spoke to their family. It was not clear to us if there was a landline for use by residents.

Residents views of living in the home[2]

Comments from residents included:

'I feel contented'

'I have no complaints. Although I am concerned, the home looks after me very well'

'Very happy here'

'They are wonderful'

'I feel very lonely'.

[2] The concerns of one resident quoted were shared with the nurse in charge with the resident's permission.

Conversations with staff

Staffing and shift patterns

We were told that the current manager had started just over a year ago and has made quite a few changes. Examples are:

- better management and handling of pharmacy supplies with a monthly ordering system in place
- a new lockable drugs trolley has been purchased and is being used
- improved sharing of information between staff
- a more organised training programme
- individual activities files
- making sure patients records are kept locked away
- new chairs for the lounge
- the use of duvets instead of blankets and sheets.

In addition to the manager, there are seven qualified trained nursing staff, two qualified Bank nurses, 12 carers, two cooks plus one assistant to help as needed, two housekeepers and a person to do administration.

There are three shifts within 24 hours. There is always one trained nurse per shift, sometimes two. They operate a 3-2-1 rota for carers; three carers in the morning, two in the afternoon, one at night.

- **Training and support**

All new staff, nursing or carers, undertake shadow shifts and have a wide range of training, including: Fire and First Aid, Manual Handling, Infection Control, Adult Safeguarding, the Mental Capacity Act. Training is refreshed regularly for all staff. Some courses are now being held in the home.

On the day we visited, we spoke to two qualified nurses. One had just started and was shadowing the other for a month. This nurse told us that this was week three of the shadowing period and they felt that their introduction to the home had been very good.

The carer we spoke to had been at the home for 18 years and felt suitably supported by the management. They said that carers tend to stay though recently there had been some new faces due to staff retiring.

We were told that the manager tries to do annual reviews of staff. The staff we spoke to said they did not feel stressed.

- **Communication between staff**

Staff handover sessions take place in the lounge after every shift. A diary is kept for key information each day and a communication book is used to pass important messages between staff.

There are monthly staff meetings with separate ones for nursing staff and carers. The manager is always asking for feedback from staff.

- **Communication between staff, residents and their families**

Each resident has a named nurse and named carers. There are meetings with family members every three months although the families can speak to the staff at any time.

We asked how they got feedback from residents and family. We were told that when they leave they send thank you cards.

- **Procedure for handling complaints**

When we asked about a complaints procedure we were told that complaints were rarely received but when they were, they were written down. There did not seem to be any formal procedure and nothing was available in writing for visitors and residents to view. We asked if a complaints book was on display and were told not but all staff will listen to and help with complaints.

- **Access to health and other services**

There is good GP support as there is a surgery next door. A call in the morning results in a visit around lunchtime. Most residents continue to see their own dentist. An optician and a chiropodist visit. The hairdresser comes in weekly if required. We were told that no-one wanted to see the hairdresser on the week of our visit.

Observation summary

During the visit one member of the team carried out an observation in the communal areas. A total of five residents and four members of staff were observed during the visit.

Much of the care given to residents in the communal area of a nursing home is routine and continuous. It cannot easily be broken down into separate actions. The numbers are therefore indicative only and it is the overall picture which is significant. During this period of observation the AR noted that staff were always on hand in communal areas during our visit. They did not appear stressed and worked calmly and carefully. They talked to residents and each other with some banter.

The AR also noticed that the home was clean and tidy. The dining-room had pretty cloths on the tables and attractive crockery.

Observation ratings

The AR rated each observation as:

- Positive, showing a high level of compassionate care; or
- Passive, showing good care but little empathy or positive engagement with the patients or their visitors; or
- Poor, showing a lack of care and compassion.

Observation findings

At the time of our visit we observed that residents were sitting in their wheelchairs rather than in the armchairs in the lounge. The wheelchairs were arranged side by side to allow residents to see out of the windows.

Whilst we were there four residents spent a brief time in the lounge, the rest remained in their rooms. Five residents went to the dining room for lunch.

1) General care

A total of 32 observations were made. Twenty-eight were positive and four were passive.

- *Resident-centredness:* Nine observations were made of staff being actively focussed on the wellbeing of a resident. Two observations were of staff being minimally engaged.
- *Food and fluids:* Ten observations were made of staff courteously providing information and support at lunch-time. One observation was passive.
- *Managing pain and distress:* Two observations were made of staff providing care to residents who were feeling tired or unwell.
- *Supporting continence:* Two observations were made of staff responding in a timely and discreet manner.
- *Supporting the small extras a person may need:* Five observations were made of staff ensuring a resident's comfort. One observation was made of an item left out of a resident's reach.

Some examples of positive general care:

- A staff member calling a resident by their name, kneeling down to speak with them and holding their hand.
- A staff member checking that a resident was warm enough or if they wanted the window closing, and checking that the chair was in the right position.
- A staff member smiling, chatting and patting a resident's arm, and getting them a cushion.
- A staff member checking that a resident's clock, water and bell were within reach.
- A staff member promptly and discreetly responding and taking a resident to the toilet and exchanging some banter on the way. Later very quietly asking another resident if they wanted to go to the toilet before lunch.
- A staff member fetching a blanket for a resident, offering a choice of woolly or furry, and checking it wasn't too heavy.
- Staff members gently encouraging residents to eat, anticipating cutlery needs, providing serviettes and warning that some items were quite hot.
- A staff member mashing food to help a resident eat the meal.

Some examples of passive general care:

- A staff member offering to put the TV on but not asking which channel was preferred.
- A staff member feeding a resident too quickly with a spoon.

2) Resident engagement

A total of 27 observations were made. Twenty-five were positive and 2 were passive. Overall the AR observed good quality, warm engagement by staff with the residents.

- *Demonstrating dignity and respect:* Four positive observations were made of staff treating residents as valued individuals.
- *Communication:* Eight positive observations and one passive observation were made of staff engaging in communication with residents.
- *Anticipating care needs:* Five positive observations were made of staff recognising what a resident was about to need and supplying it in good time.
- *Resident empowerment:* Four examples of positive empowerment were observed and one passive example.
- *Participation in care:* Four instances of this were observed.

Some examples of positive engagement:

- A staff member showing interest and talking about a magazine that a resident was looking at.
- Staff members chatting to residents about their families over lunch.
- A staff member asking a resident where they would like to sit.
- Staff members speaking clearly, kneeling down and using residents' first names.
- Staff members introducing ARs to residents and explaining why they were there.
- A staff member knocking on a resident's door and asking if they would like to see a visitor.

- A staff member who was giving out medicines courteously asking residents if they had any pain, needed any paracetamol, and were OK to take it themselves.
- A staff member carefully slipping out of a bathroom so the resident inside could not be seen.
- A staff member asking a resident if they were tired and rubbing their back.

Some examples of passive engagement:

- A staff member answering a resident's question without looking at them.
- A staff member loudly asking the cook what a resident had eaten.

3) Attention to residents' safety

The AR observed no personal care being given, so no observations of hand hygiene and infection control could be made. However, some general observations were made:

- Residents in the communal areas were dressed appropriately and wore suitable footwear.
- The communal areas were kept clean and tidy and, apart from tables and chairs, there were no trip hazards.
- A staff member was observed conscientiously cleaning throughout the home and observing necessary safety practices (e.g. wearing gloves and using a notice to warn that a floor was wet and to take care).

Additional Findings

There are named portrait photos of all the staff grouped together in a frame, on display in the communal area together with similar portrait photos of the Trustees. Some of the Trustees take an active role in the running of the home.

Before our visit we noticed that the Newsletter promoted on the home's web site was dated over a year ago (June 2015) and therefore when we visited the home, we did not see many of the same faces. We pointed out to staff that it gave the impression that nothing much had happened since then.

There are financial constraints upon the home as it is a Charitable Trust.

Summary of Findings

- The residents were generally very content with the care they received and, even if they were not happy about their circumstances, they felt well looked after. Only one resident we spoke to wanted more information about their care plan.
- The manager and staff ask about each person's likes and dislikes, and try to build up a life history. This information is then locked away with the medical notes.
- We were told that all staff are willing to listen to concerns and complaints from residents or their families. However there was no formal written complaints procedure for residents and visitors to view.
- The most popular activity was a weekly exercise session by someone who visited the home to lead this activity.
- Most of the concerns expressed by residents were about activities. We did not find evidence of any recent group events taking place outside the home. Photographs on the walls are quite old and show former residents enjoying activities. There is no activities coordinator.
- Some families organise trips for their relative.
- On speaking to the residents about activities we found there was a broad range of interests and requirements, both in and outside the home. As a result there might be only 1 or 2 residents wanting to attend a particular event which is likely to mean the event doesn't go ahead.
- Due to the location of the home on the first floor, residents cannot choose to go outside, even to the garden for a bit of fresh air, without asking the staff to let them out.
- Access to the home is not well signposted for visitors, particularly those who cannot use the stairs.

- Most residents spend much of their time in their own rooms. During our visit we did not see evidence that the communal lounge was used very much on a daily basis other than for group activities. There was little in the way of entertainment available, such as books or jigsaws, just the TV or looking out of the window.
- Four of the five armchairs in the lounge were exactly the same offering residents little choice.
- We saw residents sitting in the lounge in their wheelchairs. We noted that there are not enough armchairs for all the residents to sit in the lounge at the same time.

Recommendations

We recommend that:

- Staff make it easier for residents to go outside even if only for a breath of fresh air; and actively encourage them to do so.
- Signs are used to make it clearer how visitors should access the home, particularly those who cannot use the stairs and might want to visit when the Day Centre is closed.
- A formal complaints procedure is introduced, with a written copy made available to residents, families and visitors.
- Staff should be actively encouraged to learn about residents' likes, dislikes and life histories.
- Residents are encouraged to spend more time out of their rooms by making the lounge more inviting.
- Exercise sessions should be offered more than once a week and residents actively encouraged to take part in them.
- One or two staff members should be responsible for developing and coordinating activities for residents.

- There is a broader choice of activities, making better use of opportunities offered off site in Ellesmere so that choices are still available if only 1 or 2 people want to participate.

- Photographs showing current residents should be displayed around the home.

Service Provider Response

Following the visit, the Enter & View Officer for Healthwatch Shropshire contacted the Registered Manager of Ellesmere Community Nursing Home to ask for details of the home's fire escape procedure and received the following response:

- All residents now have PEEP Plans (Personal Emergency Evacuation Plan)
- We are currently purchasing two skid sheets (to assist with possible evacuation of residents that are not mobile)
- We have recently been inspected by Shropshire Fire Service
- All staff have had Fire Training
- Our evacuation plan would be to move the residents into a safe area and we have an agreement with the local Methodist Church that, should a full evacuation be necessary, the church would be a place of refuge.

In response to the Enter and View draft report and its recommendations the Registered Manager has said:

Your recommendations have been noted and I have shared this draft report with staff. It is expressed that the report is concluded following a very short visit, the day to day needs of our residents are changing constantly. However we take on board your recommendations and we have formed a small action group to implement the identified actions. I would like to invite you [Enter and View Officer] to a staff meeting and discuss how you come to the final report and have the opportunity to discuss this process with you.

Acknowledgements

Healthwatch Shropshire would like to thank the service provider, service users, visitors and staff for their contribution to this Enter & View.

Who are Healthwatch Shropshire?

Healthwatch Shropshire is the voice for people in Shropshire about the health and social care services delivered in their area. We are an independent body providing a way for people to share their experiences to help people get the best out of their health and social care services. As one of a network of Local Healthwatch across England we are supported by the national body Healthwatch England, and our data is fed to the Care Quality Commission (CQC).

What is Enter & View?

Healthwatch Shropshire gather information on peoples experiences of health and social care services and there are times when it is appropriate for Healthwatch Shropshire to see and hear for ourselves how services are being delivered: these visits are called 'Enter & View', they are not inspections.

Teams of specially trained volunteers carry out visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows Healthwatch authorised representatives to observe service delivery and talk to services users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies.

Get in Touch!

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