Summary -

Healthwatch Brent Enter and View Reports

The experience of Adult Safeguarding in Brent care homes

March 2018

Summary

This report summarises the Enter and View visits undertaken by Healthwatch Brent from November 2017 to March 2018. The theme of the visits was the experience of adult safeguarding in Brent care homes. These are presented to the Safeguarding Adults Board (SAB) and the Establishment Concerns Group for information and for any further actions that the Board considers that should be taken forward. These visits were undertaken after discussions with the Chair of Brent Safeguarding Adults Board and the manager of Brent Council Safeguarding Team.

Recommendation(s)

a. That the SAB notes the report and recommends any further action to be undertaken.

b. That the Health and Wellbeing Board considers establishing a central portal where all Brent inspections can be accessed publicly (including Enter and View, CQC reports, annual Brent Council customer feedback reports etc.).

c. That further discussions are held between the SAB, Brent Council Adult Social Care, service-users/relatives and Healthwatch Brent staff on whether or how further guidance and information could be provided by care homes to residents and relatives about awareness of safeguarding and how to raise such concerns.

d. For Brent Council to explore ways of disseminating good practice that currently exist in some Brent care homes to all providers in Brent.

e. Brent Council Safeguarding adults team to clarify if there are delays in responding to safeguarding concerns, or delays in providing feedback to referring organisations, and if so, clarify what is in place to reduce these delays.

Background

The national Healthwatch network was established through the Health and Social Care Act of 2012. Through this, each Healthwatch has the legislative right to undertake announced and unannounced visits to health and social care settings for adults.

These visits are carried out by staff and volunteer lay-people and review the quality of care for patients/residents and their friends and relatives. All Enter and View representatives have current DBS checks and receive training for this their role.

The care homes covered by this report were identified by the manager of the Brent Adult Safeguarding Team following a meeting him and the Chair of the SAB.

The most important aspect of Enter and View is that it is intended to add value; the representatives review services from a lay-person's/potential user's point of view and work in collaboration with service providers, residents, relatives, carers and those commissioning services. As such, the visits do not apply CQC or other standards to their review and checks, rather it is an opportunity to reflect on what the setting may be like for a potential resident/patient with an emphasis on gathering feedback on areas that can significantly affect quality of life, such as activities, engagement, food and the levels and approach of staff.

The Enter and View reports are written by the Enter and View team and sent to the care provider to check for factual accuracy and to respond to the report recommendations. The reports are reviewed and authorised at each stage by Healthwatch senior staff, and once finalised are uploaded to the Healthwatch Brent website.

The reports are then sent to Healthwatch Brent CQC Liaison Officer, Andreas Schwarz, who has expressed the team's appreciation for the additional insight that the reports provide.

Overview

During this period, Healthwatch Brent visited five residential homes through announced visits. A summary of the reports is below. Recommendations relate to staffing levels, training, activities and engagement of residents and relatives.

Overall, we found that all of the homes had the basics in place regarding adult safeguarding, including recruitment procedures training, reporting mechanisms and whistleblowing policies. Responses from staff corroborated statements by the registered managers.

We asked about and looked for signs of good practice around 5 safeguarding categories: prevention of physical, psychological, financial, and discriminatory abuse and neglect.

In general, all homes had some record-keeping processes and policies. However, these could be strengthened in some areas. For example, Lee Valley Care seem to have less robust systems for incident reports and did not respond to our recommendation on safeguarding training.

We found that the overall standard of care was appropriate and the homes had processes for key care requirements, such as Care Plans, staff training, and relative and resident engagement.

After making Brent Adult Safeguarding referrals 3 of the 5 homes found the feedback response time to be slow. This surprised them when the concern was straightforward. In one home it created difficulty in terms of knowing what measures to put in place.

Physical
Kenbrook, Parkside and Voyage check for bruising on a daily basis and have detailed records. These three homes range from 52 to 3 residents indicating that such standards can be met in a range of settings. Lee Valley and Tower had significantly less detailed records, although Lee Valley had made a safeguarding referral regarding a physical health risk for a resident.

Psychological
On entering Parkside and Kenbrook one is struck by a warm and homely atmosphere.
The lack of atmosphere and basic human warmth was tangible at Voyage.
Both Parkside and Kenbrook offered a wide range of regular and varied activities and engagement methods. The other 3 homes offered a less stimulating environment.

Financial
We had limited ability to look in any great detail, however we gained responses from staff, families and a few residents to indicate that residents' money was safely managed. An indicator was that residents in all of the homes were well dressed.

Neglect
All of the homes were proactive regarding fluid and food intake and recorded information.
Staff engagement to help to motivate residents with activities was noticeable in all but one.
At Voyage the standard of record keeping and monitoring was very good. However, during our visit to Voyage there was a noticeable lack of engagement by staff.

We did not look at medication as this is beyond the remit of Healthwatch Brent Enter and View visits.

Staffing
3 relatives from Kenbrook wished there were more staff to spend time chatting with residents. Kenbrook informed us of the staffing level management tools used.
Staff retention was cited by some managers as a sign of a good home. 4 homes had a consistent team with only Voyage struggling to recruit a regular staff team.

Staff training
All of the staff that we spoke with in all of the homes had a reasonable awareness of safeguarding and reporting methods. The 4 recommendations we made about staff training were not related to safeguarding.

Healthwatch Brent Summary of the visit reports

Location	Service	Main Conclusion and Recommendations	Response
Kenbrook Care Home 100 Forty Avenue Wembley HA9 9PF	Nursing and older people's care and including those with dementia. Capacity for 52 residents.	On the whole, residents and their family and friends informed us that they were satisfied with the care and services provided. However, some comments were made about staffing levels. The E&V team witnessed some good practice and observed well-informed and well-trained staff. However, concerns about staffing levels was raised a number of times by relatives. Both residents (where they had capacity), family members, and staff described the home as a safe place to be, and that they believed that concerns raised were acted upon. 1. We recommend that the staff levels, including floater and night-time staff are reviewed, with staff themselves, residents and relatives, to ensure there is sufficient support for the relatives. 2. It is strongly recommended that feedback is gathered from residents and relatives to ensure that meals and personal care, such as hairdressing, are catered for. 3. For the Manager to clarify the liaison with relatives when having discussions, to ensure that their privacy and dignity is maintained.	1 - Staffing levels are reviewed regularly using a dependency tool and adjustments made where needs reflect a necessary change in staffing levels. 2 - Resident surveys are carried out annually and feedback is gathered in relation to personal care, meals and overall care delivered whilst living in a care home. 3 - On occasions if risk is identified the manager may have to speak to staff directly on the floor to address an issue and prevent harm. Your feedback highlighted areas for further reflections by myself and my team in order to continue to enhance our service and we appreciated this.

Lee Valley Care Home 20 Queenscourt Wembley HA9 7QU	A Residential Care Home for service users with enduring mental health problems and Dementia. Currently there are 7 users.	The residents of the home were well fed and well dressed. The bedrooms were spacious, tidy and well decorated. The residents appeared to be safely cared for and the environment was pleasant. The activities were a diverse and regular. The staff and manager showed a high regard for the safety of the residents. The home appeared to have reasonable safeguarding procedures in place. Regular staff briefings and support sessions should be in place, particularly after incidents so that staff can review the triggers, ways these were handled, obtain support and learn from good practice. Recommendations were – 1. Regular staff briefings and support sessions should be in place 2. Ensure that staff have access to and attend regular safeguarding training and briefings 3. Incidents should also be recorded as soon as possible after they occur 4. Ensure that odours are identified, reported and eradicated as soon as possible 5. Provide posters and information leaflets about the services so that visitors, relatives, family, and staff benefit from having information made more easily accessible.	Manager replied as follows – 1 - No Response 2 - No Response 3 - No Response 4 - Odour was due to recently changing a residents incontinent pads. 5 - Agreed that more posters should be displayed
Tower House Care Home 11-12 Tower Road, Willesden, NW10 2HP	The majority of people at the home are living with dementia. Registered for a maximum of 8 Service Users.	The residents of the home were well fed and well dressed. The bedrooms were spacious and very clean. The manager had a 'hands-on' approach and was very compassionate and attentive to the residents. The home appeared to have reasonable safeguarding procedures. Recommendation was – 1. The home should provide a greater variety of activities so that the resident's interests and needs can be fully met.	1 - The Manger replied that they would implement the recommendation in the report.

Parkside Reeson Care Home 31 College Road, Wembley, London HA9 8RN Tel: 020 89081268 admin@reesoncare.co.uk	Personal care and accommodation for up to 3 young adults with learning and disability.	The manager was highly organised and was supportive of both residents and staff. The staff were very caring and attentive towards the residents. Information displayed for staff and residents was impressive. The home's documentation and record-keeping was very impressive and highly organised. Staff were motivated, well trained and caring. Recommendation was – 1. Staff members that are new to the care home would benefit from training in Autism and Makaton Language.	The report was comprehensive and well documented. 1 - There was no specific response to the recommendation, however in general staff training in this home was excellent.
Voyage 1 Care Home 6 Milverton Road, Willesden London NW6 7AS Email: 6MilvertonRoad@voyagecare.com Tel. 02084591140	Personal care and accommodation for up to 6 adults with learning disability, physical disabilities and sensory impairments.	The home has a very robust system in place for monitoring residents and training staff. The Manager's office was organised and had excellent online tools which were used for record-keeping and training. However, there appeared to be a lack of rapport between staff and residents. Some of the staff observed seem to lack empathy and communication skills towards the residents. The atmosphere in the home was clinical rather than friendly or welcoming. Recommendation for the care home - 1 - Staff should be trained more effectively in - a. Conveying ideas effectively through verbal and non-verbal means b. Developing stronger empathy c. Smiling and using positive body language	• Waiting for response

Responses to recommendations

We are pleased to see the majority of homes responded positively to our recommendations, as detailed below.

Number of care homes visited	5	Number of homes that responded to our recommendations	4 Awaiting 1

Number of recommendations made overall		11
Type of recommendation	**Number of times recommendation made**	**Number of positive responses from care home.**
Staff training	4	1 Awaiting one response
Learning about residents' preferences / activities / providing information	4	4
Staffing levels	1	1
Incident recording	1	0
Odour eradication	1	0

The 5 individual Enter and View reports can be found via this link –
Healthwatch Brent Enter and View Reports

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