healthwatch Havering

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Enter & View

Abbcross Nursing Home
(Second visit)

251 Brentwood Road, Romford RM1 2RL

18 July 2018

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
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What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care in the London Borough of Havering. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff, and by volunteers, both from professional health and social care backgrounds and lay people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups, NHS Services and contractors, and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Occasionally, we also visit services by invitation rather than by exercising our statutory powers. Where that is the case, we indicate accordingly but our report will be presented in the same style as for statutory visits.

Once we have carried out a visit (statutory or otherwise), we publish a report of our findings (but please note that some time may elapse between the visit and publication of the report). Our reports are written by our representatives who carried out the visit and thus truly represent the voice of local people.

We also usually carry out an informal, follow-up visit a few months later, to monitor progress since the principal visit.

Background and purpose of the visit:

Healthwatch Havering is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the welfare of the resident, patient or other service-user is not compromised in any way.

The Management

Beginning the visit, the team met the Managing Director (MD) of the owning organisation and the Manager of the home. The MD had been with the organisation for about five years and the Manager had been at the home for nearly three years. Although her working hours were 8am-4pm, Monday to Friday, she was on call the rest of the time. Her background was in nursing, having previously been a Ward Manager. Both the Manager and the MD spoke openly about the home and were keen to emphasise their concern for residents. The Deputy Manager is not a nurse.

The Premises

The manager's office was situated on the first floor but the team were unable to identify any signage to that effect. There were a number of general information notices which appeared to target residents mainly; but an article about End of Life care, clearly meant for staff, was obviously out of place.

In general, the home was well presented and clean with only a minor evidence of odour in the corridor. The toilets were clean and there was no evidence of limescale build-up. The maintenance assistant is to be commended that water temperatures are checked on a weekly basis, as this is a time-consuming activity. The team were told that, in the exceptionally hot weather at the time of the visit, the mains water supply temperature was higher than normal but the home could do nothing about this. There were signs for hand washing and hand gel

dispensers were available. There had been little change to the previous colour-scheme, with a preponderance of magnolia walls with little definition of doors, but that had been mitigated to some extent by the addition of some pictures, although the team did not think that they served to brighten up the areas, particularly the sitting room, which they felt was a little plain (although the manager subsequently advised that the residents themselves had been instrumental in choosing the colour scheme and were happy with it).

The team noted that medication was stored in dedicated cupboards that were fixed to walls by steel cords but the room in which they were stored was not lockable. Whilst this may not be a CQC requirement, the team felt that having medication cupboards in a locked room was best practice, particularly as the room is close to an external door (to the yard) which is frequently used. Controlled drugs were kept in a dedicated cupboard and locked room elsewhere in the building,

The home's maintenance assistant, assisted by the maintenance assistant from the sister home, were installing new wardrobes in some rooms.

The team were disappointed to note that improvements had not been made to the laundry facility, which had been highlighted as unsatisfactory during a previous visit (but the manager subsequently pointed out that the CQC had not expressed any reservations about the facility); washing machines and the dirty-linen sorting area continued to be located in an extremely small room. Once linen has been laundered, it is transported, on trolleys, along the corridor, outside the main building, across an uncovered area into what appears to be half of a garage-like building (the other half provides food storage) where the tumble dryers and ironing facilities are provided together with sorting baskets and a very small hanging area. Not only was this area too small for purpose, the paint was flaking from walls and ceiling and the team felt that it would be difficult to meet control of infection

requirements, contrary to best practice. The team were told that there was a possibility that adjoining land would be acquired on which a new laundry would be built but there was no guarantee that this would come to fruition.

The team visited the kitchen and were advised that the usual cook had reported sick and that cooking duties were being carried out by a carer who had the appropriate qualifications and covered as and when necessary. The kitchen was clean and tidy, fridges and freezers were well stocked and opened items were appropriately labelled; the team did however notice a quantity of frozen ready meals and convenience foods in the freezer - but the manager has explained that these had been purchased by a particular resident for her personal consumption. The COSHH cupboard was locked. There was nothing stored on the floor in the larder.

The garden areas were user-friendly and were safe and accessible to residents. As a result of then recent high temperatures and lack of rain, the gardens were understandably looking a little unkempt. There was a gazebo for residents' use, when appropriate, and a fish pond.

Staffing

The team were advised that staffing and shift patterns were:

7:30am-7:30pm – 1 nurse and 5 carers

1:30pm-7:30pm – 1 nurse and 4 carers

7:30pm-7:30am – 1 nurse and 2 carers

Extra cover was provided in the 4pm-8pm period if the home was accommodating a higher number of residents living with dementia.

The home had its own bank staff but would call upon agency nurses when necessary. An unannounced night inspection had ben carried out in late June.

All mandatory training is undertaken on-line (with help available in doing so should any member of staff need it), either in work time or at

home; staff are remunerated if training is undertaken in their own time.

The Manager regularly meets the staff and goes through all policies and procedures with them. Staff meetings take place bi-monthly, where concerns can be raised. If the Manager has problems she goes first to the MD (or in his absence, to the Proprietor).

Policies and proceedings for the home and its sister home (Upminster Nursing Home) are reviewed and updated bi-monthly by the two Home Managers and the MD.

A Whistle blowing policy is in place, which staff are made fully aware of.

In addition to a maintenance worker, there was a Housekeeper who supervised domestic staff, catering staff and a part-time gardener.

An activities co-ordinator worked weekdays, organising activities such as bingo, reminiscence therapy and films. A volunteer had been recruited to support the co-ordinator. Residents were notified daily of the activities on offer. Special events, such as Royal weddings and the World Cup, were celebrated and new residents were welcomed on arrival.

Staff are permitted to travel to and from work in their uniforms, which they launder.

The team noted staff wearing nail varnish/false nails; the manager has subsequently commented that their doing so is contrary to the home's policies.

Students from the nearby Frances Bardsley Academy and Havering College undertook work experience at the home.

Care services

At the time of the visit, there were 26 residents, whose ages ranged from 68 years to 99 years. The home is usually fully occupied. The home accommodates people living with dementia, and staff receive training on the caring for them. The majority of staff have undertaken Advanced Dementia training.

Residents requiring short stay or respite care are accommodated if there are beds available and subject to an assessment of their needs.

All residents seen by the team were properly dressed and well-groomed, and the interaction observed by the team was respectful and appropriate. Residents in the sitting room appeared to be happy; the TV was switched on but no-one appeared to be watching it.

At the time of the visit, seven residents were subject to Deprivation of Liberties Safeguards (DoLS).

Palliative care is provided at the home, working closely with the Palliative Care Nurse at Queen's Hospital. Assessments of potential residents are undertaken at the hospital, emailed through to the Manager, who then decides if the home can accept the resident.

Nurses are all trained in first aid, as are the care staff. There is no defibrillator on site. The majority of residents have Do Not Resuscitate (DNR) notices in place, based on prior informed consent by the residents and taking their views into account. The home is not far from Queen's Hospital. If a resident is unwell, nurses carry out an assessment and decide whether to call NHS111 or 999.

Following a spate of residents contracting urinary tract infections, infection control audits were carried out monthly and strict fluid intake and output measurements were maintained, greatly reducing the incidence of infection.

New residents and those re-admitted from hospital were body-mapped to ensure tissue viability issues were identified. Turning charts were available on iPads and any issues identified would be referred to the

Tissue Viability Nurse. It was noted that a third of the residents required turning, mostly 2 hourly during the day and 4 hourly at night.

Falls were monitored monthly and the reasons for them assessed.

At the time of the visit, no residents were self-medicating or being treated with warfarin but three residents were receiving medication covertly (as agreed between the home, the pharmacist and the GP). Drugs were checked prior to rounds and spot checked by both the Manager and the MD.

GP services were provided by a nearby practice, with calls taking place as necessary after surgery times. Annual health checks and inoculations were arranged through the practice. Dental, optician, chiropody and physiotherapy visits were arranged as necessary. A hairdresser visited regularly.

The Manager told the team that hospital discharge tended to be “hit and miss”. Residents were sent to hospital with a photo and care home details/requirements, but despite that residents had been discharged back to the home without discharge summary or medications in place.

In an effort to improve discharge arrangements, the home was participating in a trial of the Red Bag scheme, whereby residents who were admitted to hospital would take with them a bag containing personal effects and medication; the bag remains with them throughout their stay in hospital and returns with them when they are discharged back to the home, and includes any medication prescribed by the hospital. Staff confirmed that they were aware of the scheme, had received training in managing it and thought that it was a good idea. Two bags had been allocated to home for this purpose; staff felt that this was likely to be sufficient for a home of its size (26 beds) but that larger homes were likely to require more bags.

Residents choose whether they have baths, showers or wash bowl; the team were told that the majority prefer showers. The water is adjusted to the right temperature. Legionella testing is undertaken twice yearly.

Religious services were provided in the home by a local church monthly and some residents were able to go to church with their families. Special dietary needs for religious reasons were catered for by the home.

Most residents were visited regularly and family meetings were held twice-yearly, usually well attended. Families' views were regularly surveyed by an outside company. A newsletter was published three times a year.

The team were told that account was taken of views expressed by residents in surveys: as a result of recent surveys, for example, boiled eggs had been added to the menu, and touch-free soap dispensers have been acquired.

Staff views

The team spoke to a number of staff, all of whom confirmed that uniforms and badges were provided for them and that they felt that they were given sufficient support to carry out their duties.

Most of those spoken to had received training, including dementia, Deprivation of Liberty, and safeguarding in addition to the statutory requirements. Although none of the staff who were spoken to had undergone End of Life training, the manager has confirmed that such training had been available for staff shortly before the visit took place and there was a poster on the corridor noticeboard about this. Updates to training and appraisals were due in the near future.

It was confirmed that there is a handover period of half an hour between shifts when the incoming shift can be advised of any issues experienced by the outgoing shift.

Staff confirmed that there was a 'do not disturb' tabard for those distributing residents' medication but told the team it was not always in use.

Around half of the residents required assistance in feeding so every effort was made to get as many resident up as possible and into the dining room to facilitate this, but some were content, and had opted, to remain in their rooms. Additional assistance was given by the activities and domestic staff. Outside of mealtimes, drinks and snacks were available to residents and drinks were offered on a regular basis. The team were advised that, during the then recent hot weather, particularly with residents who were reluctant to take fluids, jellies, ice cream and ice lollies were offered.

It was confirmed that residents are able to go out, accompanied, if appropriate.

Residents' views

The team visited a resident in his room on the second floor. He advised the he had been pressing his call bell for some time without success. The team tried the connection to confirm that it was operating properly but there was still no response and therefore pressed the red button on the end of the cord (for emergencies); even so, there was a wait of more than 5 minutes before someone attended from the first floor (apparently, the carer on the second floor was involved with assisting another resident). This seemed to be an unacceptably long wait, given that this bell was likely to have been activated by a member of staff rather than a resident.

The team were unable to identify any staff who were unhappy with any situations that they had experienced.

The residents to whom the team spoke appeared to be very happy overall with their care and felt safe in the home. They said that the food was good, there was plenty of choice and they were offered plenty of drinks.

They confirmed that activities included bingo, painting, hobby craft, drama and visits by a pet dog who came in on a regular basis.

There was a call bell system and the team were advised that, in general, staff responded very quickly. There seemed to be some confusion about the role of named carer as the team were advised that there were 'several'. It was confirmed that a hairdresser attended weekly.

The residents to whom the team spoke said that they and their relatives were involved with decision making.

Recommendations

- That, notwithstanding the possibility of additional land being acquired, urgent consideration be given to improving the laundry and the infection control issues highlighted in this report be addressed.

  Note: in responding to this report, the home has commented that the limited space available within the home makes altering the laundry facility impracticable without the acquisition of additional land

- That consideration be given to providing a lock to the medication room door.
- That a more varied colour scheme be considered when re-decoration takes place.
- That the home continue to work with Queen's Hospital to secure improvements in discharge arrangements, especially through use of the Red Bag scheme.

Healthwatch Havering thanks all service users, staff and other contributors who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit on 17 July 2018 and is representative only of those residents, staff and other contributors who participated. It does not seek to be representative of all residents and/or staff.

Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**

email **enquiries@healthwatchhavering.co.uk**

Find us on Twitter at @HWHavering

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