Enter & View

Beech Court Care Centre

298 – 304 South Street, Romford, RM1 2AJ

(Second visit)

5 June 2019

Healthwatch Havering is the operating name of
Havering Healthwatch C.I.C.
A community interest company limited by guarantee
Registered in England and Wales
No. 08416383

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 Community Interest 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.

Key facts

The following table sets out some key facts about Beech Court. It is derived from information given to the Healthwatch team during the visit, and reflects the position at the time of the visit:

Number of residents/patients that can be accommodated:	52
Current number accommodated:	49
Number of care staff employed:	54
Number of management staff employed:	3
Number of support/admin/maintenance/activities staff employed:	14
Number of visitors per week:	208
Number of care/nursing staff spoken to during the visit:	10
Number of management/admin/reception staff spoken to during the visit:	3
Number of residents spoken to during the visit:	7

The Premises

The team were met by the Manager, who advised that she had been in post for 17 years. She provided management for the home with the assistance of a deputy and a clinical lead. The home had 53 beds, provided over three floors. Most rooms were for residents requiring nursing care, with a mixture of frail elderly, frail nursing and some who were living with dementia.

The home did not have hearing loops as all residents who needed them used hearing aids, with NHS staff attending to carry out tests as required. Opticians also visited the home on a regular basis.

In the light of recent advice from Fire Brigade about homes not always being fully safe, the manager was asked about fire evacuation plans and the team were advised that there was a comprehensive fire evacuation plan on each floor, with duplicates available in the front hall.

There were locked medicine trollies on each floor, all suitably stored in locked rooms and one dedicated, controlled drugs cupboard, situated on the top floor, also in a locked facility. It was confirmed that all MAR sheets were up to date. Two residents were subject to covert medication, both being approved by the GP and pharmacist. No residents were self-medicating, and there were currently none requiring warfarin or other alternative drugs. The GP attended on a weekly basis or when requested. He reviewed medication on a 6-monthly basis and a pharmacist also carried out a review on an annual basis.

Care services

Generally, the home did not offer respite care unless there were rooms available for the short-term. All new residents were assessed, either in their homes or in hospital, prior to admission. Any respite residents would have the same records as permanent residents.

Residents' religious needs were catered for with the regular visits of priests from both the Church of England and the Catholic Church; and occasionally services were held.

The manager confirmed that the home did not have a defibrillator. In the event of a heart 'event', an ambulance would be called (999).

A number of residents were subject to Deprivation of Liberty Safeguards (DoLS) and the manager was pleased to be able to advise that only 3 remained to be confirmed by the local authority - an improvement on the last year.

The team were shown a blank care plan which was very comprehensive, including residents' photos, medical history, professional visits, personal choices, activities, food and drink preferences, and tissue viability. Medical input was provided by the Lynwood practice in Collier Row.

Care plans were reviewed and updated every six months, or more frequently where needed - sometimes as often as weekly - with comments from families as appropriate. Do Not Resuscitate (DNRs) Orders were discussed with the GP and resident and were kept on personal files. Abbreviations were not permitted in care plans.

The organisation's head office carried out audits with the assistance of an outside company. The audits, which were described as being similar to a CQC visit, took place over a 2-day period, and covered all aspects of the service. The reports were very comprehensive, and any issues identified were dealt with immediately.

All staff were trained in control of infection procedures, which included the use of protective clothing (aprons and gloves) and isolating residents in their rooms to help prevent any potential spread of infection. Laundry was handled separately.

Residents who experienced falls were risk assessed, incidents would be reported as appropriate and any necessary actions taken - e.g. GP or ambulance called, as appropriate.

The 111-service was used as a first point of assistance, with 999 only being contacted in the event of residents being ill and having no DNR in place. The team were told that this had happened recently, twice in April and three times in May.

The last night inspection had been carried out at the end of April, with no problems being identified.

Professional services from an optician, a dentist and chiropodist were available regularly and as requested. Physiotherapy would usually only be available through the GP unless a resident were able to pay privately.

New residents were weighed on a weekly basis for the first two months and then on a monthly basis unless more frequent weighing was needed. If there were concerns about dentures, residents would be referred to the dentist. Other problems may entail referral to a nutritionist, usually via the GP.

A few residents required feeding and might also need pureed food. Those residents were reviewed every 6 months. Fluid charts were also used for residents whose input appeared to be low and for those with urinary infections.

Showers were available at the request of residents - most used this facility weekly, but some were reluctant to shower in the winter. All taps were thermostatically controlled, and thermometers were also used.

Some residents who were confined to bed were turned on a two-hourly basis, which is monitored. The services of the Tissue Viability Nurse would be called upon as and when necessary.

The Joint Assessment and Discharge team carried out proper assessment for the CCG within 4 - 5 weeks and this takes about an hour.

There had occasionally been problems with hospital discharges - one resident had returned home at 11.30am but had to be returned to hospital by 3pm. Sometimes transfer notes were not complete, medication was missing, incorrect notes were sent and residents discharged back to the home with bed sores. The team were told that, from the home’s point of view, the Red Bag scheme was poorly

managed. The team were also told that, when information was requested about discharged residents, difficulty might be experienced in obtaining it, with data protection cited as a reason for failing to provide it.

Meetings with residents and relatives took place quarterly and were undertaken individually as this had been found to be easier for the residents.

Staff

The manager confirmed that there was always a registered nurse on duty on each floor. Shift patterns were 8.00-2.00 and 8.00-8.00 - night and day. There were 54 members of staff with 1 nurse on each floor, 4 carers on the ground and first floors and 2 carers on the second floor. Many of the carers held NVQ 3 & 4 qualifications. Meetings with staff were held on a monthly basis.

In addition to nursing staff, there were 5 kitchen staff, 6 domestic staff for laundry and housekeeping, 1 activities co-ordinator, 1 administrator and 1 maintenance assistant.

The activities co-ordinator worked Monday to Friday, 8am-5pm but attended at the weekend for special occasions and carers provided activities over the weekend at other times. Activities provided included one-to-one chats for residents confined to bed, bingo, quizzes, arts and crafts, and music. Most residents were too dependent to be able to go out. All special occasions were celebrated.

Staff were provided with all mandatory training on a face-to-face basis and were paid for this. They were also encouraged to consider and undertake self-development. Palliative care (and training) are provided with input from St Francis Hospice.

The maintenance man had worked at the home for several years and enjoyed the work. He was responsible for general maintenance,

painting and decorating, PAT testing, water temperatures, gardening and mending furniture. The water tanks were inspected for Legionella by an outside company.

The nurses and care assistants were all long-term employees and happy in their work. They felt supported by senior staff and said they worked as a team and felt part of a family. The nurse in charge of the dementia patients stood out for her dedication to dementia sufferers. She said she had always wanted to work in this field and understood her patients. All staff said they undertook regular training, some on-line and some in-house.

The home had its own whistle-blowing policy which included encouraging staff to contact the local authority, police etc. and this was included in training.

The team was able to look round all three floors of the home and spoke freely to many members of staff, residents and relatives.

Residents

The team spoke to several residents who said they were very happy at the home, felt they were well looked after and would not want to go anywhere else. Relatives confirmed that they were confident that staff were looking after their loved ones well.

Residents who were confined to bed said they were turned regularly, and someone always came when they rang for assistance. The buzzers were attached to the side of the beds within easy reach. A relative, whose partner had special medical needs, said she knew that the staff kept an eye on him, and she was confident that if he needed assistance at night the staff would be there immediately. One resident told the team that, when her bed broke, it had been mended promptly; she had come from another home (since closed) where she had been very unhappy and had been verbally abused.

Residents and relatives in one of the lounges were happy to talk and spoke of their satisfaction. One resident had only been accommodated two days but already was adamant that she wanted to remain there.

The team observed staff reacting with residents in a caring, respectful way.

General

The residents' rooms and their facilities were all spotlessly clean. Each door had a knocker for use when closed, with the name and photo of the resident next to the door frame.

Drugs were dispensed by a dedicated qualified nurse on each floor.

Each floor had its own sub-kitchen from where the food from the main kitchen was served through a hatch into the dining room. The tables were laid out with cloths, placings and menus.

There was a sensory room with coloured lights and a piano.

The lounges looked comfortable. One opened onto a garden with paving, seating and flower beds. There was a small memorial plot to patients who had died. The manager told the team that one gentleman, whose wife had died, continued to visit the home and sit in the garden.

The team looked at the bathrooms on every floor and noted that, although clean, the wash basin taps were worn and in need of replacement; the Manager confirmed that attention to the taps was one of the items on the refurbishment plan, and that one of the bathrooms was currently being renovated by the maintenance man.

The main kitchen was spotlessly clean, the fridges and freezers were well organised, and items were suitably labelled. The storeroom was clean and tidy with no items on the floor. The extractor fans were clean.

The laundry was also well-organised, with clean and dirty entrances, and a storage area (where the residents' clothes were put on numbered coat hangers and into numbered baskets, responding to the residents' room numbers). The washing machines were all working and measured dosing devices were in use.

It was very warm on the dementia floor although it was not a particularly warm day. The nurse in charge said fans could be brought in if it got too warm. She said that sometimes, when the windows were open, a resident would go around closing them!

The team were very impressed with this care home. The atmosphere was pleasant and everyone, staff and residents, appeared to be one happy family.

The team noticed, and discussed with the manager, the fact that a bathroom on the third floor was being used to store a large number of incontinence pads. The manager advised that deliveries by the local authority were made only every three months, that only 3 pads per 24-hour period were allocated to a resident, and that all pads were one size. The team considered this to be unsatisfactory and advised that the matter would be pursued with the local authority to see if improvements could be made.

Recommendations

The team did not find it necessary to make any recommendations as a result of this visit but will pursue with the local authority improvements in the supply of incontinence pads.

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 5 June 2019 and is representative only of those service users, staff and other contributors who participated. It does not seek to be representative of all service users 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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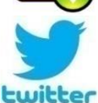

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