healthwatch Havering

Enter & View

Dothan House

458 Upper Brentwood Road,

Gidea Park, Romford RM2 6JB

(Second visit)

3 December 2018

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

Once the team have carried out a visit (statutory or otherwise), the team 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 Dothan House. 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:	**19**
Current number accommodated:	**13**
Number of care staff employed:	**20**
Number of management staff employed:	**1**
Number of support/admin/maintenance/activities staff employed:	**2**
Number of visitors per week:	**4-6**
Number of care/nursing staff spoken to during the visit:	**3**
Number of management/admin/reception staff spoken to during the visit:	**2**
Number of residents spoken to during the visit:	**None were able to engage with the team**

The Manager

Two members of the team held detailed discussions with the Manager. Although the Manager had been an interim post holder at the time of the CQC report in May, she had subsequently, in November, been appointed to the substantive post. She had worked at the home for some years, in a variety of roles. She had been registered as Manager

in September. She was undertaking training, and an external consultant has been brought in by management to work with her.

The Manager gave a lot of her time to the team, for which they were grateful. She had had a very big learning curve from the CQC visits in February and October. It was noted that she had given a lot of her time to updating policies and procedures and to writing a training matrix. The team wish to commend her for making a significant effort to turning round this home.

Staffing

The Manager told the team that the shift patterns were:

7am-2pm:	Senior care assistant and 2 junior care staff, and a Domestic
2pm-9pm:	3 care staff
8pm-8am:	2 night staff

In total, there are 25 staff at the home. The Manager was employed full time and was happy to be called out at any time.

In addition, there were a full time office administrator, and part time Handyman and cook/chef.

Every effort was made to cover absences with in-house staff. Problems mainly arose for night duty. Two agencies were used for cover staff if necessary.

The Manager made unannounced night visits, the last having taken place shortly before the visit. Communal areas had CCTV coverage which was checked daily by the Manager.

The team were shown records of staff training. Staff were able to undertake training in work time, but if they were unable to do this, they would be paid. Manual handling training was to be undertaken the week following the visit. Training covered:

1. Dementia training: two sessions had been provided by the Council. Staff also undertake e-learning for dementia.

2. Palliative Care: NELFT attended monthly to undertake palliative care/end of life training.
3. Infection control: provided by Skills UK.
4. Fire training: provided by Care Skills UK. All residents had a personal evacuation plan.
5. COSHH: seniors and team leaders had undertaken this training.
6. Equality and diversity training were due to be held in February.
7. All staff had had training on dignity and person-centred care.
8. New staff had an induction over 2 days. All new staff would be DBS checked.
9. Reporting abuse: the team were informed that all staff had had safeguarding training, and that transparency had been explained to them.

Supervision

Staff meetings took place monthly and were fully recorded.

Handover took place every day at 2pm.

The Manager had updated all policies and procedures. The documents were kept in the office and staff were aware of them.

Care of residents

The home had capacity for 19 residents but, at the time of the visit, there were 13, all of whom were living with dementia, some early onset.

Care plans were reviewed every 4-6 weeks. Respite and short stay patients were assessed by the Manager, using the Havering assessment advice. Short-term and respite residents were given an interim care plan. The Manager went through the interim care plan with the staff at the 2pm handover. All records were kept in the administration office.

Residents meetings were held monthly.

Facilities for residents who had communication difficulties included pictorial menus, pictorials on the doors and easy read picture books.

If residents were able to write they were encouraged to do so.

Twelve of the thirteen residents were subject to Deprivation of Liberty Safeguards (DoLS).
The majority of residents were Anglican, for whom a monthly Church service was held. Catholic residents were able to see the priest.

Visitors

Some relatives visited every day, although some residents had no visitors. Visitors were encouraged to give feedback to the Manager and Administrator both in writing and orally on a one to one basis.

Ancillary staff

The handyman recorded in writing what work was needed. Staff were able to report to him any problems requiring attention.

The team were told that fire prevention had been a key concern of the CQC following their inspection in February 2018. As a consequence of which the handyman had ensured (with the London Fire Brigade) that all equipment checks had been undertaken. All doors had been fitted with intumescent strips. All radiators/ pipes had covers. Window restrictions had been checked for safety and door closure mechanisms had been installed, and a key pad had been fitted to the door leading to the car park.

The CQC had raised the issue of the premises not being cleaned thoroughly. At the time of the February visit, carers had done the cleaning, but there was now a domestic in post.

The domestic's role was to ensure that the building was cleaned throughout, including regular deep cleans. The Manager monitored morning and afternoon whether all COSHH items had been put away.

Activities

There was no activity co-ordinator; activities were arranged by the Manager. The following is provided:

Chair exercise (daily)

"Bunny" therapy: a rabbit is kept in the garden

Foot spa

Arts and Crafts

Music Therapy

Mental aerobics

Visit to Queens Theatre

Visit to donkey sanctuary Bedfords Park

Birthdays, Christmas and St Patrick's day are celebrated

Care of residents

Infection Control

Staff (including the chef and handyman) had been trained by Care Skills UK. Audits had been undertaken and procedural and practice changes had been made.

Cleaning cloths were identified for area of use. Buckets and mops were provided in different colours for different areas. Personal protective equipment was used, including aprons and gloves. Bags were used for soiled linen.

Bedrails were cleaned everyday by the domestic. Chairs were deep cleaned every night by night staff.

Residents fluid charts are completed by the night staff.

Falls

Staff monitor high risk residents, ensuring that there are no trip hazards. If a resident has multiple falls, they are referred to the falls clinic.

The team noted that the carpet in the bar area was due to be replaced.

Medication

The controlled drug cabinet was locked within a cupboard. Residents were assessed whether they needed their medication concealed or crushed, for which authorisation would be sought from the GP. At the time of the visit, no resident was self-medicating, and none was on Warfarin.

Medical and professional support cover

Three GPs from a nearby medical centre provided cover for the Home.

They undertook an audit once a year and visited the home if a resident required attention. MAR charts were reviewed 4-6 weekly.

If need be, residents would be referred for attention by a physiotherapist, optician or dentist.

A chiropodist visited monthly.

Residents were monitored for nutrition, body mapped for tissue viability and weighed monthly. Fluid charts are maintained for those that require them. Referrals would be made to the community dietitian if concerns were raised.

At the time of the visit, the dietary requirements of two residents were met by puréed food, five took food at syrup consistency, and two were fed forkmash. Those residents would be referred to the GP then SALT if need be.

Personal hygiene

Residents chose when they wanted a shower. Weekly charts were maintained. The water was checked for the right temperature by thermometer. The handyman checked every week.

At the time of the visit, no residents had pressure sores. Two air mattresses were available and staff had recently been trained on the prevention of pressure sores.

Hospital Discharge

There had been issues of late where wrong discharge letters had been sent to the home: one resident was discharged in the early morning 5-6 am.

The Home preferred relatives to accompany residents to hospital, if possible, otherwise a staff member would go with them but this was not possible at night.

The team were told that, on the whole, the process of discharge to and from hospital was not too good.

Seeing the residents

The second team of members toured the home's accommodation. When the team entered the lounge, there were three staff, one of whom came over and introduced herself as the Senior Care Assistant. She was happy to talk with the team and show them around.

All 13 residents then living at the home were in the lounge; their chairs were arranged in straight lines against the walls. The lounge had a wooden floor and painted walls, both of which appeared in need of some attention (subsequently to the visit, the manager advised that a new floor was fitted in March 2019, and walls had been painted). A TV was on but nobody appeared to be watching it; some Irish folk music was played continually while the team were in the home, having been requested by one of the residents. Five of the residents were asleep and others did not appear to be engaged in any particular activity: the team were told that all residents had some form of dementia. Jugs of water and glasses were available on a small table in the lounge but no resident was seen to leave their chair at any time during the visit, which lasted several hours. Although the team were told that snacks

and bowls of fruit were readily available, none was visible; on enquiring about this, the team were told the home was out of fruit at that time. Individually wrapped cakes or biscuits were not available because some residents would open a whole packet of biscuits and simply discard what they did not want at that time.

There was a free-standing cabinet in the lounge together with a wall mounted cabinet, both locked, which the team were told were for medicines. Although the senior care assistant told the team that she was the only member of staff who had medication training, the manager has subsequently confirmed that, in fact, five staff have had medication training. The senior care assistant told the team she stayed with residents while they took their medication until sure it had been taken, and the medication round took between 20-45minutes to complete. The manager has since told Healthwatch that all senior staff should know what to do in the event of a medication discrepancy but, at the time of the visit, the senior care assistant who was spoken to was unable to explain what would happen If anyone did not want to take medication, or had difficulty in doing so, taking tablets, but explained that this did not generally happen. She did not wear a tabard. Staff did not have uniforms but wore their own clothing.

At the time of the chat, the senior care assistant was not wearing a name badge although later on she had one, albeit that it seemed to describe her role inaccurately.

The handover procedure between shifts took 15-20 minutes. Only important information was put in writing.

Residents were observed for infection, and any residents who fell ill were isolated in their rooms and staff attending them would wear gloves. All disposable products would be put in red plastic bags. Also, they would clean door handles.

Pressure sores would be dressed by the district nurse. However, residents were turned every 2 hours to avoid pressure sores developing and were checked regularly.

The team attempted to talk to some residents, without success, although they were told that some residents happily converse with staff.

There were two visitors at the time of the visit; they told the team that they had no complaints and that they were happy with the home.

No activities were being carried on but there was information that a party had been arranged for the following Friday; the team were told that staff sometimes sought to entertain the residents but few were able to respond. The home did not have an activity co-ordinator but staff encouraged residents who so wished to participate in planned activities, such as hand massaging. An activity poster was visible on the wall but it was very small and was positioned behind an armchair, and so could not be read without leaning over the person sitting there. Residents were not allowed out of the home by themselves as there was concern that they would not find their way back. They could go out with relatives or friends; the team were told staff would take residents out to the local pub when they wanted. There had been one outing to Southend in the past year.

The team were then shown the kitchen where there was only one member of staff, the cook, who said he worked alone, preparing the food, cooking, dishing up, washing up, cleaning, etc. In the kitchen, there was evidence that the floor between units and near the bin required attention and the extractor fan did not appear to have a filter. There was a dishwasher in place and working. The kitchen units appeared to be in need of cleaning, as was the trolley (which was also chipped), but both were in active use at the time. The team did not see a hygiene rating or hygiene report. Residents' special dietary needs were catered for.

Three meals a day were supplied: breakfast, lunch and dinner, and there were two menus to choose from. At lunch time, small portable tables were put in front of each resident while they were sitting in their chairs in the lounge. The team were told they usually ate in the dining room but the heater was not working at the moment. Because

there were only three staff on duty in the day (and two at night) it took time to feed those who needed help, so meals were staggered.

The team were then shown 3 bedrooms, one of which was not being used by a resident. The first was very basic with bed, wardrobe and en suite toilet and washbasin. The team could not see much of the room as a large hoist was kept in the en-suite. However, the team did notice that pipes and floor were dirty. Paintwork was chipped and the whole room appeared quite depressing even though there were personal photos on display. There was no pull cord to be seen but there was a push button, albeit out of reach of the bed. The team were told there was a pressure mat instead which was kept under the bed: when anyone walked or stood on the mat a bell would sound. However, as the resident in this room needed a hoist to get out of bed, a pressure mat would not particularly if help were needed. The second bedroom was much the same as the first, including a hoist and having no alarm pull cord.

The third, vacant, room was like the others; all three appeared in need of cleaning.

The vacant room also did not have a pull cord and the buzzer was out of reach of the bed. The team were told that, as one resident had put a cord around her neck some time ago, the home preferred not to use them.

The team then visited the laundry, which had to be unlocked to admit them. The washing machine was working and there was one dryer. There was a laundry basket for each resident. There were no laundry staff for the team to talk to.

The team went into a general toilet on the ground floor where the floor was dirty, especially around the base of the toilet bowl. The sink had two taps, both with cold water and a build-up of limescale was apparent.

There were no bathrooms in the home, but there was one shower room with a toilet. The shower head was attached to a side wall with a long

hose to reach over the toilet seat, on which residents sat to be washed and showered. The shower compartment had a very large bin in it. There were other containers on the floor with wipes, etc. and posters on the wall (which prompted the team to wonder how they stayed on the wall in a wet room).

The senior care assistant told the team the staff received a lot of training, mainly in home, including dementia awareness, Deprivation of Liberty Safeguards (DOLS), safeguarding, moving and handling and palliative care, for which they were paid. They also received training in fire safety, equality and diversity (but did not seems to know what COSHH was).

The team were told that the fire extinguishers were due to be inspected shortly.

One fire door had a security bolt at the top which only staff could manage but the home has subsequently confirmed that the fire escape arrangements had been approved by the Fire Service. An emergency lighting system was in place.

An evacuation plan was displayed on the wall in the upstairs lounge and the manager subsequently confirmed that evacuation plan folders were placed by every fire exit.

Window restrictors were working on the windows that the team checked

All heaters had guards and appeared clean.

The residents seemed well dressed, clean and tidy. The team were told that a hairdresser came once a week

Some staff were wearing rings, earrings and nail polish. They appeared to be caring.

There were general information notices in reception and photos of residents along corridors, along with various paintings.

Conclusion

In general, the team felt that the home needed attention and redecoration. Most walls were painted; there was wallpaper only in the upstairs lounge (which was also used for prayer services). The manager has subsequently explained that redecoration is undertaken on a rollig basis and some areas would be in need of attention.

The manager is to be commended for her successful efforts to bring the home out of special measures but there was clearly some way to go yet. The team were pleased to note that, subsequently to their visit, the CQC had published their report of the October inspection, which improved the home's rating to Requires Improvement and lifted its placement in Special Measures.

Recommendations

That:

1 As a matter of urgency the shower room should be upgraded

2 Staff should be trained in treating residents with respect and dignity

3 Staff should be reviewed to ensure that their understanding of what they have learned in training is reinforced and applied

4 If the bar area is to be used by residents, the ruffled-up carpet should be replaced, as it is a trip hazard

5 Audio books for the residents could be obtained from the library

Subsequently to the visit, and as a result of the feedback given to the Manager, she advised that:

(a) a shower chair had been ordered and would be installed on delivery

(b) the kitchen area had been deep-cleaned and steamed

(c) the handyman had been instructed to attend to the toilet

(d) staff training would be given additional support

(e) further deep cleans would be undertaken

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 3 December 2018 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. the team 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 the team on **01708 303 300**

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

Find the team on Twitter at @HWHavering

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