Enter & View

Havering Court

Havering Road, Havering-atte-Bower

Romford, RM1 4YW

Second visit

6 February 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 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 Havering 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:	**51**
Current number accommodated:	**48**
Number of care staff employed:	**36**
Number of management staff employed:	**3**
Number of support/admin/maintenance/activities staff employed:	**8**
Number of visitors per week:	**15**
Number of care/nursing staff spoken to during the visit:	**6**
Number of management/admin/reception staff spoken to during the visit:	**2**
Number of relatives spoken to during the visit:	**2**
Number of residents spoken to during the visit:	**None (their respective conditions precluded conversation)**

The premises

The Manager met the team on their arrival. She had been in post since September 2017 and was registered with the CQC. When she was not available Managerial responsibility lay with her Deputy; there was also a nurse Manager.

In view of the recent CQC rating of Requires Improvement, the team asked whether she felt supported by the parent organisation. She responded that she felt fully supported: the Regional Support Manager was always available by telephone and visited the home weekly (her next visit had been due the day following the visit: but, in the event, the Regional Support Manager arrived during the visit).

The kitchen was staffed by a chef and a number of assistants who were aware of the dietary requirements of the residents. Store cupboards and fridges/freezers were clean and well organised. Menus were displayed in the dining rooms. The kitchen had been awarded a '5 star' rating by the Environmental Health Officer.

The laundry was well equipped, and the staff appeared to be aware of control of infection procedures. The team were told that machines were sanitised following red bag (infected linen) washes. Clothing was marked discreetly.

The garden areas were clean and tidy and only one small area was inaccessible to wheelchairs (contrary to a complaint that the slopes were not wheelchair-friendly). There were pleasant seating areas, a dedicated smoking area and a covered area on the edge of the wood where residents could sit in inclement weather.

The team were disappointed to learn that the £1million pound refurbishment that they learned of during the previous visit had not so far materialised as keeping up the fabric of the home may be critical to good care.

Fire risk assessments were carried out on a regular basis. The maintenance staff had a comprehensive list of weekly checks, including fire alarms, and checking loft spaces. The BUPA property team carried out 6-monthly checks. The local Fire Brigade attended occasionally. There was an evacuation procedure and an emergency plan available in the event of fire.

All rooms in the home were equipped with TVs and all residents seen appeared to be happy. The team noted that there appeared to be no named carers.

In general, the team found the home to be clean and tidy with no unpleasant smells. All toilet and bathrooms were clean and there was no evidence of scale build-up. The decor appeared rather bland, with all walls painted in magnolia, although there were colourful pictures all around. Generally, the home was light and airy. Boards were displayed with group photos and details of activities; there were several notices giving information, and a group of residents were actively engaged with co-ordinators. Hand sanitisers were seen. In the main reception area, the results of an internal survey showing residents' satisfaction were rather negative, so it was commendable that this information was on public display.

The dining rooms were bright, light and attractive with views over the grounds. There was a water dispenser in the main restaurant and visitors were able to prepare drinks in the attached pantry.

Care services

The home could accommodate up to 51 residents, all of whom would be brain-damaged in some way; at the time of the visit, there were 48. In response to a question about residents who might be the subject of Deprivation of Liberty Safeguards (DoLS), the team were advised that, although brain-damaged, most residents had mental capacity. Some residents exhibited signs of developing dementia, but they would be monitored to ensure that appropriate action for their care could be taken when needed. Assessments for all potential residents, including those admitted for respite care, were carried out in the same way and the same records were kept. Long term residents' care plans were usually more complex. At the time of the visit, 17 residents had PEG feeds and 3 had tracheostomies, conditions presenting particular difficulties as they were often linked with communication problems.

Additionally, there were several residents with in-dwelling catheters. Staff had learned from the residents themselves how they prefer to, and are able to, communicate; as they got to know the individual residents, the staff learned from their interactions what they meant. Some residents used written means of communication; one used email to communicate with staff. The Manager remarked that most carers were expert in understanding residents' wishes.

Residents' religious needs were supported as far as possible. A local church attended monthly to provide a service and some family members chose to pray/read with their relatives.

Referring to a CQC comment about insufficient care for residents' property, the team enquired what facilities were available. They were advised that each resident had at least one lockable drawer in their room. Additionally, there was a system and safe for storing valuables at residents' request, although not all residents chose to use this facility.

The marking of clothing was regarded as being the responsibility of relatives but, where this had not happened, a simple marker pen would be used.

Palliative care was available and was provided in conjunction with St Francis Hospice. Care plans were developed in conjunction with residents and relatives to ensure that all aspects were covered.

Care plans, MAR sheets and risk assessments were reviewed regularly through a "Resident of the Day" scheme. At least one resident from each of the two units would be selected and all aspects of their care reviewed and adapted/amended as appropriate. This ensured that all residents were reviewed on at least a monthly basis, usually more frequently. In addition, reviews would be initiated when significant changes were noted by staff. The GP allocated to the home attended on a weekly basis. A local pharmacy provided all medication but appeared not to have been involved in carrying out medication audits, which were led by the clinical and unit manager.

The home did not have a defibrillator, but all care/nursing staff undertook a one-day first aid course, with some undertaking the full 3-day course.

Procedures for infection control were in line with best practice in terms of protective equipment etc but it was not always possible to isolate individuals with infections etc because of the nature of the residents. A recent outbreak of severe infection had been reported to infection control and all residents had been treated as a precaution.

Yearly surveys were undertaken, together with meetings with residents, to assist monitoring quality issues, the most recent of which had taken place in January and had included all aspects of care.

Because of the nature of the residents' conditions - most were wheelchair bound or otherwise immobile - the incidence of falls was minimal. In the event of a fall occurring, a full assessment would be carried out.

In general, the 111 service would be utilised in preference to 999, unless there were obvious reasons for using 999.

The most recent night time inspection by management had been in January.

All medical records were kept by the GP who attended every Wednesday. Additionally, there was a professional log kept for all permanent residents. Following comments by the CQC, medicines were checked daily and weekly in accordance with the action plan that was developed following the CQC visit. Similarly, MAR sheets were checked on a regular basis. However, the Manager told the team that CQC suggestions about timed medication were not practicable as some patients might ask to take their medications later (most of them had mental capacity to make such requests); and it would be impossible to administer medication at a set time for every resident. Additionally, it was BUPA practice that medication that had to be administered via a PEG could only be administered by nurses rather than carers. Drugs were stored in accordance with best practice. Only one resident was

approved to self-medicate; her medication was kept in her room in locked storage. One resident was the subject of covert medication, which has been approved by the GP, family and the pharmacist. Following the CQC report, all residents on PEG feeds had been supplied with individual pill crushers - also included in the action plan. Just one resident took warfarin and he attended the anticoagulant clinic accompanied by his wife.

Special occasions were always celebrated - cakes for birthdays etc. Entertainments were frequent and all residents were encouraged to participate. The team were advised that BUPA was particularly keen on activities and that staff attended organisational conferences about this.

A considerable number of residents received nutrition via PEG feed and those residents, as well as all others, were weighed on a monthly basis (unless there were concerns about weight gain/loss when a more frequent regime would be implemented). Fluid charts were completed as and when necessary, particularly where there were concerns about hydration.

Residents could have showers/baths as they wished, with preference for showering; individual preferences were noted in personal records. All taps/showers were temperature controlled and checked on weekly by maintenance staff.

At the time of the visit, no residents had impaired skin and the physiotherapist reviewed positioning to ensure the risk of pressure areas developing was kept to a minimum. The Manager was aware that they must contact the Tissue Viability Nurse for advice as soon as possible if problems occurred.

The home had had only minimal dealings with Joint Assessment and Discharge Team as most residents were long stay. Residents who were admitted to hospital would be re-assessed prior to returning to the home.

The team were told that the morning medicine round was expected to commence at 8.15am and be finished by 10am but, on the day of the

visit, it was still under way when the team were looking around and the nurses were very busy; the team were told that the medical conditions of some residents prevented strict adherence to the timetable. Generally, nursing staff administered medications, particularly to those residents with PEG feeds. This also applied to the suction of tracheostomies, which should be done on a regular basis.

All residents appeared to be appropriately dressed, well-groomed and to be happy. Unfortunately, the team were unable to talk to residents because of their medical conditions.

The team were able to speak to two relatives, both of whom appeared to have concerns about hydration. However, the Manager told the team that the residents in question had no problems in taking fluids; the team suggested that fluid charts be kept in order to confirm that residents were receiving appropriate levels of fluids, possibly with the help of relatives when they were visiting.

Group physiotherapy was taking place, which a number of residents appeared to be enjoying.

Staff

In terms of staffing, the Manager reported no difficulty in recruiting carers but, like many organisations, had difficulty in recruiting nurses. The intention was to have a minimum of 3 nurses on duty during the day but to try to provide 4; at nights, this was reduced to 2 essential and 3 preferable. Sickness/absence cover was achieved with overtime as far as possible but there was a small staff bank and agencies were used with the proviso that only agency staff who knew the home would be used, as far as possible. Shift arrangements were 8am-8pm and 8pm-8am although there was some flexibility to accommodate staff, particularly the twilight shift. At the time of the visit, five members of staff were on maternity leave. BUPA, the home's owners, offered a financial package to incentivise prospective employees.

Staff meetings were held every three months but a variety of ad hoc meetings, including a daily 'take 10', took place in between, to ensure that staff were kept aware of issues etc. The Manager confirmed that she had an "open door" policy.

In addition to nursing and care staff, there were ancillary staff, including housekeepers, catering assistants, chefs, laundry and administration staff. There were 3 activity coordinators who, between them, provided 7-day cover. Activities on offer included arts and crafts, external entertainers and visiting pets. Particular attention was paid to residents who were immobile or confined to their rooms, for whom individual visits were arranged.

All new staff undertook a four-day induction and night staff were not permitted to carry out night duties until they had completed four weeks on days. New staff were allocated a "buddy" to support them. All training was paid, usually carried out at the home and included mandatory elements as well as more specific subjects. BUPA had assessors to ensure competency, and annual refreshers were undertaken.

The organisation's whistle-blowing policy involved the use of an external agency - Speak Up - and any issues raised with this organisation were regarded as priorities and would be dealt with in conjunction with the organisation's legal team to ensure problems were resolved as soon as possible.

As with staff meetings, relatives' meetings were held on a quarterly basis and friends and relatives were welcome to take advantage of the Manager's open-door policy.

In addition to nursing care staff, the home employed a full-time physiotherapist and one physiotherapy assistant. There were regular visits by dentist, optician and chiropodist.

Complaints would be dealt with as a matter of urgency - the Manager had an open-door policy and complaints were dealt with as soon as possible and a log of complaints was kept.

The members of staff to whom the team spoke agreed that they felt supported and were happy in their work. One staff member had experienced difficulty obtaining permanent employment at the home but that was now resolved. Staff were all friendly and helpful. All were wearing uniforms and had name badges. There was no evidence of staff wearing jewellery or nail varnish.

Recommendations

1 **That** consideration be given to training senior carers, where it is clinically acceptable to do so, to administer medication to patients who have special feeding needs in order to relieve the pressure on nursing staff and ensure that medication can be given in a timely manner.

In making this recommendation, the team were conscious that BUPA policy required medication to be administered by qualified staff but felt that the difficulties in recruiting nurses meant that an exception to this policy could be justified in current circumstances. It is understood to be standard practice in care homes for carers to receive training on setting up and administering gastronomy feeds.

2 That consideration be given to the provision of a defibrillator

3 That consideration be given to completing fluid charts where relatives are concerned about residents' hydration, with the assistance of those relatives if possible.

4 Given the negative results of the recent satisfaction survey consideration be given to an external, in-depth survey be undertaken to explore the reasons for this and how it can be improved.

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 6 February 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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