healthwatch Havering

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Enter & View

Romford Care Centre

(Fourth visit)

107 Neave Crescent,
Harold Hill
Romford RM3 8HW

20 September 2018

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
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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.

Key facts

The following table sets out some key facts about the Romford Care Centre. 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:	114
Current number accommodated:	91
Number of care staff employed:	110
Number of management staff employed:	4
Number of support/admin/maintenance/activities staff employed:	9
Number of visitors per week:	186
Number of care/nursing staff spoken to during the visit:	9
Number of management/admin/reception staff spoken to during the visit:	4
Number of residents spoken to during the visit:	2

The team were surprised and disappointed to find that, on arriving at the home, they were not expected, despite due notice having previously been given of the visit and a poster provided for display within the home so that residents and their relatives were aware that the visit would be taking place. It appeared that a new manager had just taken up her post and that her predecessor, with whom Healthwatch had been liaising about the visit, had failed to tell her about it. Nonetheless, the manager welcomed the team and assisted them with the visit.

The Manager told the team that she had come from a care home in Brixton, where she had been the manager for 10 years, prior to which she had worked for 4 years with another company. She was a registered nurse and the process of registering her as manager with the CQC was in hand. She planned to remain at the home although she was commuting at present out to Havering. She was aware that the demography of Havering was very different to that of Brixton but was adjusting to the differences.

The Premises

The home has capacity for 114 residents but, at the time of the visit, there were 91. It is divided into 5 units and there are about 110 staff. There is an Administrative Officer and a Receptionist who steps in when the manager is absent. All residents on short stay or respite care are assessed before admission and the Manager says records are kept. Most residents are living with dementia but systems are in place to overcome communication issues with them.

The building was welcoming, with flower beds in the car par.

The entrance hall was very welcoming, with pleasant music being played. There was a fountain in the reception area. The entire home was clean, colourful, with good furniture in all rooms, both private and public.

All toilets and bathrooms were clean, and well equipped, with hand sterilizer available.

There was a notice at the entrance advising of relatives' meetings, with a relatives' forum taking place every month. The team noted that, on the day of the visit, a barbecue for the residents was scheduled.

There was also a memo advising that the new winter menu was being introduced on 1 October. There appeared to be good choices available.

Care

Some residents were subject to Deprivation of Liberty Safeguards (DoLS) and the manager told the team that she was checking whether any DoLS authorisations were outstanding from Havering Council.

The manager also told the team that she planned to put electronic systems in place for care and other plans relating to individual residents. Care plans and MAR charts were reviewed monthly, unless circumstances changed, and fluid charts were in place. The Manager was also planning to have relatives' and staff meetings in the near future and said that notices to this effect would be displayed in the foyer; she then hoped to establish a cycle of three-monthly meetings.

Concerns over infection, medication, health and safety and general care would be dealt with and handover information was held for 24 hours. Staff would undergo mandatory training for infection control and either a unit or the home would be closed if necessary if a widespread incident of infection arose. All falls were logged and the manager would be notified as they occurred and would investigate. Three residents were receiving one-to-one support, two exhibited challenging behaviour and one was prone to falls.

Head injuries would result in a 999 call; otherwise medical incidents were referred thorough NHS111. The allocated GPs attended the home regularly, usually on Thursdays. At the time of the visit, the manager had yet to establish night time inspections but told the team that she planned to do so.

Drugs were stored in double walled cabinets which were kept locked. Controlled drugs were in use, and a protocol was in place with the families to use crushed or concealed drugs where necessary. No resident was self-medicating. Information was not available about the

use of Warfarin. There was access to physiotherapists, opticians, a dentist and chiropodists.

Residents were weighed monthly. Loss of weight would trigger an action plan involving the GP and/or dietitian. Staff picked up on missed meals.

A board in the kitchen notified staff about those residents needing pureed food or assistance with eating.

The frequency of baths or showers was arranged in consultation with families. The maintenance man checked water temperatures regularly.

Charts are kept relating to residents who require turning and the Tissue Viability Nurse would become involved if necessary.

The home preferred not to accept residents discharged from hospital after 4pm. The team were told that the release of medication on discharge from hospital could still be a problem.

A hairdresser attended weekly, for both men and women, including manicure, hair and relaxation. The room set aside for this was well appointed and well equipped. All special occasions would be celebrated, and there was a weekly cinema show.

The team walked around the home and could see that all residents were well-dressed and their clothes were clean; residents appeared to be treated with respect. There was music and television in all rooms and a relaxed atmosphere. There were information boards around the premises notifying of social events, and plenty pictures and posters.

The rooms were bright, fairly clean and tidy although in nearly every room the curtains required some attention. At the time of the visit there did not appear to be any cleaning staff on duty.

The corridors were very colourful and walls were decorated with memorabilia from the past, including an old-fashioned post box, and memories of past professions.

The kitchen was clean and tidy, with the appliances in working order. The menu worked on a 4-week cycle and was illustrated.

The laundry was clean, with residents' clean clothes placed on named hangers - it seemed well organised. However, only domestic appliances were available, which seemed inadequate for 91 residents.

Staff

At least 2 registered nurses were on duty at all times and both the manager and her deputy are nurses. At the time of the visit, there were 2 nursing vacancies. When necessary, agency staff would be used but care was taken to ensure that such staff had worked at the home on previous occasions. Shift arrangements were 8am-8pm and 8pm-8am, with 15 minutes' handover. The day shift included 3 qualified nurses and the night shift 2 nurses and 1 Care Home Assistant Practitioner (CHAP), with 17 carers on duty during the day and 8 or 9 at night. The manager told the team that she intended to establish regular staff meetings.

In addition to the nursing and care staff, there was 1 FT Maintenance Man plus 1 Handyman who is also the gardener, 2 - 5 Laundry Assistants and, on any one day, 1 Chef and 2 Assistants (there were 2 Chefs who worked different days), and 3 Activity Co-ordinators (with a fourth then currently on maternity leave).

Training was undertaken by e-learning and in-house training (for which a training room was available), for which an outside agency was used. Nurses were trained in End of Life (EOL) care and palliative care was provided under the manager's supervision. No defibrillator was available. Staff knew how to respond to monitors and call bells and the maintenance staff knew how to deal with fire equipment.

The manager told the team that staff who wished to whistle-blow were welcome to do so; she observed an open-door policy and was approachable at all times.

The team met a nursing assistant who had been at the home for four years. She was a CHAP. She had had full training but told the team that she found end of life care difficult, especially if there were

pressure from families, although she felt well supported by her employers. Staff from St Francis Hospice came in to train in care of a dying patient. Her general training was updated every six months and she had regular supervision, training on moving and handling patients took place once a year, and she could discuss her progression every six months. Although some training was undertaken in her own time, she was paid for it.

The nursing assistant told the team that one member of staff did the medication rounds, wearing the appropriate tabard and staying with each resident while the medication was taken. Drinks and snacks were available outside meal times.

Two carers told the team that they had had dementia, safeguarding and mental capacity training - their training was updated as needed and they had regular appraisals.

The activity co-ordinator told the team that residents could access daily exercise sessions and other entertainment. The home held coffee mornings and a summer fete. Work was underway to create a sensory garden. Special occasions were always celebrated.

Views of residents' family members

The two family members spoke to the team. They said they had complained about the home to the Ombudsman as their relative had bad bed sores because she was bedbound and they are worried about infection. They found family communications and involvement lacking. In subsequent conversation, the manager told the team that she was aware of these complaints and was working to address them.

Another family member said she was concerned that her relative had not had her daily wash and it was by then mid-afternoon. She also felt there was a slow response to her relative's daily needs and even to her medication. It was said residents are offered drinks every half an hour but there was no evidence of this. Body mapping was done once a week.

Conclusion

It was unfortunate that the new manager had been in post for only a few days at the time of the visit and had not really had opportunity to get to know the staff and residents. She was clearly enthusiastic about her job and keen to make her mark.

It was also unfortunate that the team were escorted by a member of staff, whose presence might have deterred some staff or residents from discussing any concerns freely with the team.

Recommendations

Given the short time that the manager had been in post, the team felt unable to make any formal recommendations as a result of this visit. The home has, however, been listed for a further visit in the first half of 2019, when it will be possible to gauge the progress made in the intervening period.

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 20 September 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. 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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