healthwatch Havering

Enter & View

Moreland House Care Home

(Second visit)

5 Manor Avenue, Hornchurch, RM11 2EB

17 May 2023

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
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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 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?

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 <u>your</u> voice, 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.

<u>Your</u> 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.

Visiting after the Covid pandemic

During the period of the Covid pandemic, the Enter & View programme was inevitably suspended. Now that the pandemic is largely over, we have been able to resume the programme but with safeguards to ensure the safety of the users and staff of the facilities we visit and of our members who are conducting the visit.

For that reason, visits will generally be carried out by a small team, who will wear personal protective equipment (PPE) appropriate to the facility they are visiting and take sensible precautions such as the use of hand sanitiser.

We have also changed our approach to conversations with the management, staff and users of the facility. Previously, this would have been done face-to-face on the day of the visit but, after Covid, that is no longer practicable. So we will hold such conversations, where possible in advance of the visit, using an online video meeting.

The visit that is the subject of this report was carried out in accordance with this new approach.

Pre-Visit interview with Zoe Goddard – Manager of Moreland House Care Home

Before the visit, members of Healthwatch met the home's manager in a video conference meeting to discuss the home and to set the scene for the visit.

The manager advised that she had been in post for nearly one and a half years, having been a registered nurse for 20 years; her deputy was also a qualified nurse. She told the team that the home was currently full, with 50 residents.

All but one of the rooms had ensuite facilities comprising toilet and showers (one room did not have a shower). In addition, there were two bathrooms, one on the top and the other on the middle floor, for those residents who preferred to bathe rather than take a shower. There were also toilets on every floor for visitors to use.

There were currently 65 full time care staff (many of whom had been employed for more than 6 years), and more were being recruited, and housekeeping, laundry, domestic and kitchen staff. The day shift comprised around 21 staff, with 10 usually on the ground floor and 5 on each of the two upper floors; one-to-one care was available for those residents requiring it. At night, there would be 10-12 care staff, more if one-to-one care was in place.

When necessary, agency staff would be called in to provide cover from an agency that has been used for many years,

usually with the same people being used. There were currently no staff vacancies.

Staff meetings took place regularly, with staff receiving supervision and annual appraisals, and for those authorised to administer medications, a competence check.

Different dietary needs were catered for, with advice being taken as necessary from hospital or other healthcare professionals, and those requiring particular ethnic foods provided for. The manager emphasised that, although light refreshments were available for them, staff were not provided with food.

Residents' weight and fluid intake was monitored regularly in accordance with advice from the dietician or GP. Food supplements and protein milkshakes were available for those needing them.

Residents with particular needs such as incontinence, podiatry/chiropody and diabetes were given appropriate support. Dental care was generally arranged by residents' families: there had never been a visit to the home by a dentist. Wheelchair maintenance was arranged as necessary. Residents requiring hearing assistance would be taken to the appropriate service. Although some families made their own arrangements, an optician attended the home to see residents with sight problems.

A GP was assigned to the home, who visited the home every Tuesday and Wednesday, seeing all residents, not just those who were unwell, and attending (or arranging other cover) as necessary at other times.

Although as a nursing home staff were expected to manage wounds, District Nurses attended when necessary. The home arranged diabetic insulin injections.

Some residents had mental health needs, which were dealt with and supported by the Community Mental Health Team and other support was arranged when needed although there were occasional difficulties at weekends when staff were not on call.

For those residents who have to be hospitalised, the home has made clear that they cannot accept residents returning after 5pm but, despite that, there have been occasions when residents have been returned in the early hours of the morning, when there would be insufficient staff available to settle them in. This is not a regular problem but has occurred sufficiently often to be remarkable.

All staff received induction and mandatory in-service training and undergo a period of shadowing before being accepted into the full team. Where necessary, staff from other homes or from overseas are given acclimatisation training to the ways of the home and, indeed, living in the United Kingdom. The home had an in-house trainer.

The home provided respite care (if spaces were available) but not day care. Respite care occasionally led to a resident being admitted into full time care.

When necessary, the home offered palliative and end-of-life care. For those residents requiring a care plan, the home was moving from a paper-based system to one computer-based. Residents and their families were consulted about care plans which were reviewed monthly or as changes of circumstance occurred.

Contact with families was maintained by telephone or email and, of course, when they visited. In addition, relatives' meetings were held every few months and an open-door policy was in place so that any issues could be discussed.

Activities were arranged for weekdays.

The home had a complaints policy in place.

Some residents had their own landline or mobile phones, and a communal telephone was available. One resident currently had, and used, his own computer and for those wanting it, a wi-fi connection was available.

The home had managed to procure and maintain sufficient supplies of PPE and other sanitisation products during and since the Covid disruption. One or two residents had declined the Covid immunisations but the majority had been "jabbed". Staff and residents continued to be tested regularly for Covid and

visitors were asked to wear masks to maintain residents' protection against infection.

The home was regularly visited by local authority and District Nursing staff, including safeguarding and muti-disciplinary teams. All safeguarding issues were reported. Quality Assurance Systems were in place to cover issues including safe medication administration, health and safety, fire alarms, wound audit, antibiotics and infections such as UTIs and chest infections. These were all checked each week.

The visit

The home's manager was aware that our team would be visiting during the week beginning 15 May 2023 but was not told in advance precisely on which day. In the event, the team carried out the visit on 17 May.

On arrival, the team noted that the outside of the premises to the front was taken up by parking but was clean and tidy. There was a notice on the door requesting that all visitors wear masks and that these were available on the inside where a receptionist was based; it was noted that all staff (including the manager and her deputy) were wearing masks. It is believed that this has helped reduce the incidence of other infections such as colds and flu.

Notices in the foyer included statutory insurance and occupier's liability insurance details. A small waiting area off the foyer was stacked with boxes which were confirmed to be 3 months'

incontinence supplies. This large delivery presented a storage issue for this home, as it does for many others.

Inside the main home there were photos of all members of staff, full details of a 4-weekly activities programme and various pictures which appeared to be of, and relevant to, residents.

The Manager and her deputy welcomed the team and had a brief discussion with them, particularly around the issue of communication with deaf residents. The team were advised that there were currently three deaf residents although it was not possible to confirm whether these residents had been deaf from birth. The team were advised that one resident communicated with staff by writing notes and vice versa. No-one could use British Sign Language and lip reading was not usually possible owing to problems with accented speech. The team were told that, when residents needed ear wax removal, the GP arranged for them to go to a surgery that provided this service. During the discussion, the subject of reporting safeguarding issues was raised and the manager was able to give details of incidents that had occurred over the past few weeks. She advised that the safeguarding team had responded very quickly to reports. Not all issues reported had met the safeguarding threshold but it was better to have this confirmed rather than not having reported potential issues. There appeared to be some delays in the confirmation of Deprivations of Liberty Safeguards for some residents. It was noted that this procedure would be converted to Liberty Protection Safeguards at some time but this had been

put on hold, possibly due to the Covid epidemic. There were occasional issues regarding discharges from hospital mostly because of timescales – the home would not accept discharges over the weekend or after 5.00pm which presented issues for the LAS and the hospital. Additionally, there had been some issues with pressure sores but good relationships with Tissue Viability Nurses contributed to prompt treatment of these.

The Manager advised that she has an open-door policy for staff and visitors and that she carries out a daily walk around the home to ensure she is up to date with all issues and that the residents know her. She advised that although the GP is excellent – visits every week and sees all residents necessary - no weekend service was available, so staff at the home had to call NHS111 for help and advice.

The home is situated on 3 floors and there is a basement where laundry and catering services are provided, together with a training room and staff room. The training room is used for on-line and face-to-face training. In response to a question, the manager confirmed that staff who were not on duty but who undertook training were not paid for their time (the team suggested that the manager should consult the HR or payroll provider about obligations around paying for training time). A secure COSHH store was provided across the garden. The kitchen was clean and tidy and there was evidence of temperature checks. There was a four-week menu system in operation and the cook confirmed that he could prepare Halal food for one

resident and other cultural foods as appropriate. There were no items at floor level in the stores which were clean and well organised. The laundry was large and extremely well appointed with racks housing baskets for each resident. There was a hanging rail for larger garments. When the team visited during the early afternoon there was no backlog of items awaiting to be laundered and there were no unpleasant smells.

The ground floor accommodates 15 residents with all rooms having toilet and shower en-suite facilities. A secure facility for medication was also situated on this floor, close to the manager's office. This had a refrigerator and air conditioning to ensure appropriate temperatures for medication. The team noted that stairs were protected on all floors with coded locks.

All rooms were well decorated, with personal items on display. The residents to whom the team spoke were appropriately dressed and had no complaints about services provided. There was a dining area/kitchenette with facilities for beverage/snacks, and a sitting room with TV and comfortable armchairs that was sufficiently large to accommodate all residents and visitors. The garden was accessed from this area: it was spacious and simple, with well-cut lawns and a supply of outdoor furniture suitable for the residents.

The first floor accommodated 20 residents, most of whom were able to walk, and the team noted good interaction between residents and staff and the activities co-ordinator carrying out

activities. The team spoke to members of staff, all of whom were in uniform, and were pleased to hear their satisfaction with the home. All rooms were clean and tidy and well-decorated. There was a kitchenette for the preparation of snacks and a dining area to accommodate all residents.

The second floor accommodated 15 residents, all of whom had some degree of dementia. They appeared to be well cared for and staff were interacting with them. It was noted that some could be aggressive, and some were being cared for on a one-to-one basis. It was confirmed that carers encouraged these residents to take part in activities etc. There was a kitchenette and dining area here, also.

Once again, all areas were well decorated and clean and tidy. The maintenance assistant was painting the corridor whilst the team were there. However, we noted that there was no contrast between doors and frames on this floor, which is considered to be best practice for this client group; coloured toilet seats were also recommended. The team were pleased to note, however, that handrails were coloured.

Overall, the team felt that the home had a good atmosphere and represented a good example of residential care. It was unfortunate that there were no visitors to speak to at the time the team were there.

Patients' views

Although the team were able to chat informally to a few residents, it was not possible to obtain views formally for inclusion in this report.

Conclusions and recommendations

The team offer the following recommendations for consideration:

1. Develop a colour scheme appropriate to residents with dementia – e.g. coloured frames around doors, on the second floor.
2. Provide coloured toilet seats on the second floor.
3. Introduce some coloured plants in the garden, which appeared to have no special features or coloured plants etc. and perhaps an area where able residents could 'potter'.
4. Replace carpeting in the basement by hard flooring when appropriate to allow better movement of trolleys and to make cleaning easier.

Acknowledgments

We would like to thank everyone at Moreland House for their co-operation before and during the visit.

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.

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.

Healthwatch Havering Friends' Network

Join our Friends' Network for regular updates and other information about health and social care in Havering and North East London. It cost nothing to join and there is no ongoing commitment.

To find out more, visit our website at https://www.healthwatchhavering.co.uk/advice-and-information/2022-06-06/our-friends-network-archive

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