healthwatch Luton

Enter and View Programme 2023

A review of Care Homes, Nursing Homes and Day Care centres with Luton Borough Council – Thematic Review

Contents

Statutory functions of Enter and View

What is Enter and View?

Healthwatch have a legal power to visit health and social care services and see them in action. This power to Enter and View services offers a way for Healthwatch to meet some of their statutory functions and allows them to identify what is working well with services and where they could be improved. Although Enter and View sometimes gets referred to as an 'inspection', it should not be described as such.

Healthwatch statutory functions

• The legislative framework for Healthwatch is split between what Healthwatch must do (duties) and what they may do (powers). Healthwatch have a power under the Local Government and Public Involvement in Health Act 20071 and Part 4 of the Local Authorities Regulations 20132 to carry out Enter and View visits

• Healthwatch should consider how Enter and View activity links to the statutory functions in section 221 of the Local Government and Public Involvement in Health Act 20073 . The purpose of an Enter and View visit is to collect evidence of what works well and what could be improved to make people's experiences better. Healthwatch can use this evidence to make recommendations and inform changes both for individual services as well as system-wide. During the visit, Healthwatch should focus on:

• Observing how people experience the service through watching and listening

• Speaking to people using the service, their carers and relatives to find out more about their experiences and views

• Observing the nature and quality of services

• Reporting their findings to providers, regulators, the local authority, and NHS commissioners and quality assurers, the public, Healthwatch England and any other relevant partners based on what was found during the visit 1 Section 225 of the Local Government and Public Involvement in Health Act 2007 2 Part 4 of The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 3 Section 221 of the Local Government and Public Involvement in Health Act 2007

20220323_Enter and View guidance final.pdf (healthwatch.co.uk)

Thematic Review

Summary

Healthwatch Luton would like to thank all of the homes, residential and day settings which allowed us to enter and view their provisions between September – December 2023. Without their cooperation, insight and staff, resident and family views, we would not being able to capture this overall thematic review of the care provisions available in Luton.

We were able to review 12 care settings in this 3 month period – some residential homes, day centres, LD settings, mental health settings, and nursing homes. We had hoped to visit 13 homes but were unable to visit the final home due to internal changes in Healthwatch Luton, and in one home we had to leave and raise a safeguarding concern – which has been taken forward to a section 42 enquiry.

Bar this one home where we raised a safeguarding – the quality of all the settings was good, many of whom had done a prior Enter and View programme in 2016. The quality of the staffing, communications, activities and facilities had much improved from the prior visits nearly 7 years prior.

Methodology

Healthwatch Luton have the statutory power to enter and view health and social care services; but we adapted our programme to work with the Adult Social Care Team's Quality Team in Luton – to ensure we could capture areas of interest to them, as well as our standardised outline of questions, including updates from COVID, technology and transfers from hospitals.

Healthwatch Luton and the ASC Quality Team hoped to run this programme in 2022, but due to COVID and Flu outbreaks, and internal Healthwatch staffing, we moved it to Sept-Dec 2023.

Our methodology includes speaking on a 121 interview basis with staff, residents and relatives where possible, to capture an overview of the home. On many occasions, the staffing views correlated with the residents and relatives views, and where they didn't – issues were raised weekly with the ASC Quality Team. Healthwatch Luton provided weekly 'summary' reports, and agreed instead of publishing individual reports on each home, we would complete and review a full thematic overview report – outlining general quality, and sharing best practice where possible.

Overall we spoke to:

- 52 staff members
- 7 relatives
- 45 residents

Thematic Findings

Out of the 12 settings we visited, we have thematically analysed all the responses from all the residents, staff and relatives and have thematically processed their answers to our interview style questions into overall topics.

This report will be shared with local system leaders, the Adult Social Care Quality Team, the CQC and Healthwatch England, to outline our findings, and escalate supporting our recommendations.

We have outlined some innovative shared learning we hope the Quality Team can share among the homes during their on going Quality Visits.

- Management and Leadership
- Care settings that were well led with secure and engaged senior staff displayed an exceptional staff morale. Trust in the management seems imperative to provide a home with confident and happy staff; which transpired to how the residents received care – and how the staff were received by the residents
- Management worked best in care settings where there was a strong leadership and trusted deputy – care settings which displayed a long standing deputy manager rated the best 'engagement' from staff, and staff satisfaction
- Management involvement in operations, and knowledge of the running's of the care settings led to the general engagement of relatives, and residents. Where managers prioritised feedback; involvement and choice, equated to the home being receptive to change and development with co produced ideas with family members and residents
- Where management were more dictatorial and less involved with their staff, led to homes feeling more functionary, and less homely. Some managers could benefit from cross-home peer support / development to learn from other peers in different home settings; although this is unlikely due to the private economical profiteering, and there for, competitive nature of some homes.

1. Staffing

- There was quite a discrepancy in staffing – for both commitment, involvement, engagement and enjoyment.
- Staff recorded various meeting opportunities, both with peers, and with management – and where regular meetings took place (other than handovers), outlined better integration, team spirit and cohesive working
- The most engaged and happy staff were those who had regular 121 support with peers, leaders and management. Some staff found online apps and WhatsApp groups useful in communication, as well as team bonding.

- Most staffing recorded as being offered training when needed; and many had access to further training. However, few had personalised training offers; such as role development, management opportunities, or medication / clinical development – which tended to lead to staff leaving to get this elsewhere.
- Lots of staff found their role almost 'vocational' – and this was felt when speaking to some staff; and displayed in the homes supportive and homely culture. Others felt it was more 'just a job' – and where these staff were employed, there was felt within the home a disconnect between staff and residents.
- Some staff employed had English as a second language; and where this was apparent, residents displayed having a disconnect with understanding and feeling supported. Some staff would benefit from dialect and comprehensive English speaking training.

2. Links to Health Care Professionals inside and out of the home

- Most care settings outlined having links with a GP, a Dentist (although many care settings left residents to keep their own dentist and for families to initiate dental care) and links to services such as District Nurses. Some care settings offered more health care professional interventions to residents, as part of their home package – including physio, chiropractor, optometry. Some had hairdressers onsite.
- With the Primary Care Network, some care settings have no 'choice' in their allocated GP. Where this was apparent, there was poor relationship management between primary care within the home to residents. Some homes felt they should have more consultation regarding PCN choice with homes – as some were geographically unsuitable, with one home having staff travel each day to collect prescriptions; and one home having to use the general public telephone line to contact their GP.
- Where homes had a good relationship with their GP; access to their GP on a direct line, or multi disciplinary meetings weekly, resulted in the residents receiving good quality and effective primary care support.
- Some residents requested more mix of health care professional support attendance; but felt this wasn't available. This led to some homes having a better service delivery in other care, such as chiropractor or dental care than others.

3. Facilities and Décor

- Most of the care settings felt updated, in good condition and generally homely and comfortable. Those in need of care were recorded as being aware they needed facility development, and either had in planning or hoped to plan in soon
- Some settings were very accessible; both wheelchair and supportive effects providing residents and families with accessible means to most of the homes. Some however, would need more suitable accessibility, both for residents and for family members.

- Homes which allowed personalisation and decoration felt more 'homely' and provided a more personalised approach to resident care. Some homes allowed door knockers and door fascia's and fronts to be personalised with things relative to the resident, and these homes received more positive feedback from residents and family members.

4. Activities

- Activities and activity priorities were widely varied across the settings. Some provided outstanding activities, and residents and families felt the activities kept them engaged and were enjoyable. Some needed to be reviewed
- Where activity coordinators were in place and prioritised as a role, in general – meant that activities were varied, engaging and provided in various formats. This led to a positive experience by the residents. Some anomalies were recorded where at least 2 or more Coordinators were in place in some homes, and the residents recorded not being involved in the activities, or knowing what activities took place. This should be reviewed.
- Having activity lists and schedules is important for family and residents to know what activities are taking place; but should not be a 'tick box' without providing the actual activities to hand. Some homes provided many schedules, but few residents or family members knew when or what activities would happen when.
- Understanding the audience, the activities are being provided for is paramount; some exceptional examples of linking to local schools to provide young children to come and do activities with the residents; or Pet Therapy as an example was shown to be massively positively received by residents and family members, particularly for elderly, infirm, dementia or learning-disabled residents.

5. Resident Engagement

- Many homes attempted to engage their residents in planning or developments of the home, in various forms of gathering feedback. Most homes found resident feedback difficult to collect; and again, understanding the audience of the homes would contribute to this. Dementia residents or those infirm and unable, would find it difficult to complete surveys, questionnaires or meetings, and yet this seemed the option of choice of most homes
- Exceptional care was taken over particular homes to build relationships with family or carers to understand individual resident needs, as well as using sensory boards or other media and picture charts with 121 work to capture resident views.
- Therapies or person- centred care programmes apparent in homes provided the most individualised care and activities, leading to better resident engagement.

6. Technology

- Technology use across the settings was widely varied, with some homes using to collate all resident / patient data – and being able to monitor and track medicine and care needs in a central data system. Others were still using paper records, and those in this area found this time consuming and prohibiting to recording themes and trends in patient care
- Most care settings provided some forms of technology to residents and families to communicate with each other; but some did not; leading to some residents unable to communicate outside of the home without management / staff supervision.
- One care setting did not have access to private space to phone and speak to family members, and this was recorded as being for the safety of the residents, but also diminishes dignity and respect for the resident and family members to have confidential conversations.
- Use of technology in most homes was limited to televisions, with few offering other media such as phones, tablets or interactive games. Even in one supported living the TV was the only option for technology.
- Few homes offered books / games / or resources other than TV for engagement; but where resources were available, the residents recorded being more positively engaged
- Where more technological resources were provided, more training and integration was offered to residents to use the technology. This would be paramount in order for residents to be able to use the technology in a suitable way

7. Cultural Appropriateness

- Many care settings had leaflets or flyers in the foyer / notice boards on outlining if people wanted information translated to ask; however, this was in English – and therefore, potentially not translated into relevant languages.
- One home had a Chinese resident, and had translated all their flyers / leaflets and communications into Chinese – so the resident could see these all round the home. Despite the resident not being very interactive or able to communicate well, due to her age, the home felt it was important she could see recognisable language in her native tongue to feel more at home.
- Staff were from many cultural backgrounds, which is positive, however some staff had strong dialects or accents which residents found difficult to understand.
- Some care settings provided culturally appropriate and available food for different residents, and where this was available, it was regarded very highly.

8. Communications

- Communications were recorded quite high on most resident feedback we gathered, both positive and negative. Where positive, it was mainly noted with individual staff who provided exceptional care to individuals, speaking clearly and using other methods to communicate.
- Some residents recorded the lack of communication led to lack of comprehension sometimes of what was happening to them, or around them. One day setting outlined how when they trained staff in inductions, they trained them to experience having things 'being done to them' – so they could learn how to orally communicate with residents / setting users to understand what was happening.
- Communications to staff mainly was recorded as positive, although homes which had more 'all staff' meetings more regularly were generally more positive in feedback overall
- Communications with families was varied – with many care settings opting to provide many mediums in which families could be involved. Where family members were communicated with more regularly, and more on a 121 basis – the more engaged with the homes they were. Care settings which struggled to engage family members, aside from those who did not have family or carers, were lacking variety in their attempts. If families did not attend family meetings – they could offer other mediums, such as monthly / weekly 'catch ups' or reports as some homes offer.

9. Training

- Many care settings reported offering lots of training to staff – and many staff reported as feeling they could access training, and more training if needed on demand.
- Some of the training seemed standardised across homes but it was noted that there were limited training options for further development of staff outside of their caring role. Training provided by some homes included 'active listening skills' or 'peer reviewing' skills, supporting team development or communication routes with residents.

OTHER THEMES

- Food and dining overall were recorded as being fairly agreeable with residents; some care settings did some innovative ideas of linking resident cultures with the food of the day / week which was recorded as fairly positive.
- Transfers from hospitals, from most of the care settings was recorded as positive, particularly when the home team collected residents from hospital. However, where issues were recorded, - this was mainly reviewed as outlining issues with the hospital discharge team – and lacking

communication, completed discharge plans and support packages or missing medicine.

Thematic Recommendations

- For integrated care for residents, it would be advised to ensure that all homes have an **access phone line to primary care** – aside from the patients of that surgery. Homes which had this reported a better relationship between primary care GP access, and resident support.
- For choice and relationship management, the PCNS have been assigned to the care homes – and sometimes this geographically does not work. There would be a **recommendation to support PCN and Care Home provision and integration – and choice**. Some home staff had to travel in a car for over 10 minutes a week to collect and sort prescriptions. A delivery prescription service could be supported.
- In a few care settings, when HWL arrived, there were no management on site -and seemingly no manager in charge to support our visit. On both occasions, managers were called and came within an hour – but it would be **recommended for the care settings to have an obvious and linear line of management** – to support the staff left in the homes, as much as dealing with visitors such as HWL. We would recommend when management have training, to not have the Home Manager and Deputy in the same training, equally – if the Home Manager is visiting other sites, to ensure staff are aware of an escalation pathway. On both visits, we asked for the next in line and were told there was no one available.
- It would be **recommended for care settings to provide more engaging communication to the families and carers**. In some care setting, there were forums and meetings, and individuals could meet the management and care teams. In some homes it was observed the only communications families got about residents was when they visited. In more progressive homes, there were opening afternoons to invite all the families and carers into the home to meet each other and discuss elements of the home. In some observations, families and carers received weekly bulletins and newsletters outlining upcoming activities and past events. Families and carers stated more communication about the home would be encouraged.
- All the care settings displayed **activities for the residents** – however, few were actively being used, or many taken part in. Some good activities provided on a 121 basis seemed more engaging – but for home activities, the better homes displayed all resident activities ensuring even if they could not participate, they could observe activities. Some homes had outside activities and events and where possible it **would be recommended to provide more engaging activities relevant to the individual resident. (See sharing best practice – Innovative ideas).**

- **Limited technology** applications were available in many care settings; some only had the telephone which was manned by the Manager for residents to use to speak to family or people outside the setting. In some cases, this was appropriate depending on the resident mental and health needs, but in times it was noted to be lacking. **It would be recommended to support the homes in making available more technological devices for residents**; supported either by staff or training. Some good care settings had an array of mediums available, including mobile phones, tablets and devices to aid speaking and writing communications.

- Some care settings ran with a '**personal care' approach** – meaning each resident had individualised care depending on their needs. Some residents had specific aids and support to ensure they felt comfortable. Some settings did not discuss or outline this approach as much as others. For better care, all the staff, residents and families were aware of this approach and spoke of it. **It would be recommended where good practice such as this approach is taken, to be shared across care home managers**- to ensure residents are treated and feel like they are individuals. One care setting had a sign saying 'they don't live where we work, we work where they live' and this resonated with all the staff's approaches to the residents.

- **Training** seems to be available for many staff and most staff felt they could access more training if needed. All homes seemed to have a standard list of health and safety and care training programmes, but it would be recommended to attempt further training for staff on 'active listening' or 'supporting older people to communicate'. Many of the care settings were having to manage and support people who had dementia or learning disabilities, and communication was raised by many staff as being 'tricky'. Many options were available such as feedback loops, but acknowledging the difficulty in communication with dementia patients should be highlighted more – with particular specific training allocated to staff to support this: A person-centred communication approach to working with older people who have dementia | British Journal of Healthcare Assistants (magonlinelibrary.com)

- Few care settings asked to see Healthwatch Luton's **identity badges**; for safety reasons and safeguarding; along with dignity and respect, we would recommend all care settings develop a more stringent check on those entering their homes / settings. Only one home in particular asked to see our badges, and refused entry until all authorised representatives had them on. This would be recommended due to some of the footfall in and out of the homes; and some homes didn't require us to sign in or out during our visits.

LEARNINGS – Sharing Best Practice and Innovative Ideas

- Some care settings dedicated time in providing Dementia clocks with days of week and times; this was massively positively received by residents
- Some care settings provided personalised décor – including door knockers on doors for entry for dementia residents
- Some care settings provided pictures in the home with staff and residents, large enough to be seen, and with names
- One home linked their activities to local school encouraging young people to interact with residents, and also with community groups – which was very positively received
- One home offered Pet Therapy as an activity – and this was heralded by families and residents, and staff
- Use of technology for staff by one home recorded high levels of engagement – such as the use of apps / Facebook / WhatsApp
- Care settings that had long term staff, or lack of lots of agency staff seemed to have the best feedback; having a good relationship with the agency also provided good staff for the residents.
- One setting provided such innovative and functional care to individuals, it was commented on by authorised representatives to provide a shared package that could be offered and 'sold' to other homes to learn from
- One care setting had created an individualised 'Bar' area within the newly decorated home for residents to enjoy during the evening which was innovative and outlined the response to feedback from the residents.

Next Steps

Healthwatch Luton met with the ASC Quality Team in Luton in January 2024 and outlined our thematic findings.

We will also print our report in April 2024 and share our findings with the CQC, ICB, Healthwatch England, the Local Authority and the ASC Management team.

We would hope the next steps would be for the Quality Team to review our recommendations, and support a potential ongoing review of the settings; to ensure quality continues to improve for people in Luton.

Appendix:

List of Homes Enter and Viewed

1. Widecombe Nursing Home
2. Alicia Nursing Home
3. Moorlands Gardens
4. St Marys Nursing Home
5. St Anne's Residential Home
6. Mulberry Court Residential
7. Mulberry House Residential
8. Georgiana
9. 240/242 Ravenhill Way
10. Heywood House Day Centre
11. Castletroy Residential
12. Capwell Grange

Healthwatch Luton
Marsh Farm Futures House
Luton LU3 3QB

www.healthwatchluton.co.uk
t: 01582 817060
e: info@healthwatchluton.co.uk