healthwatch Kingston upon Thames

Enter & View Report

Milverton Nursing Home

October 2024

Contents

1. Introduction

1.1 Details of visit

Service provider	Milverton Nursing Home
Service address	99 Ditton Road, Surbiton KT6 6RJ
Registered Manager	Cindy Fok
Date and time of enter and view visit	8 October 11.30am-3.30pm
Status of enter and view visit	Announced
HWK authorised representatives	Jill Prawer (HWK staff team) Julie Pilot (HWK volunteer) Richard Allen (HWK volunteer) Graham Goldspring (HWK volunteer)
HWK visit lead	Jill Prawer, Projects Officer, Enter & View
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Service Provider	Surbiton Care Homes Ltd

1.2 Acknowledgements

This visit was undertaken by authorised representatives at Healthwatch Kingston. We would like to thank Milverton Nursing Home (Milverton) residents, relatives/friends, and staff members for their contribution toward the enter and view programme.

1.3 Disclaimer

Please note that this report relates to findings on the specific date and time set out above. The enter and view report is not a representative portrayal of the experiences of all service users and staff. It is only an account of what was observed and contributed through interviews during the time of Healthwatch Kingston representatives' visit.

2. Executive Summary

Healthwatch Kingston (HWK) champions better standards of care in socially funded health and social care services. As part of our remit we recruit authorised representatives, volunteers from the local community who are trained to undertake enter and view visits with the aim of identifying good practice and areas that could be improved in socially funded health and social care services.

This report presents the findings of the HWK authorised representatives' visit to Milverton. Milverton is situated in the Royal Borough of Kingston upon Thames (RBK) and is a privately owned, single provider nursing home run by Surbiton Care Homes Ltd.

Milverton has 29 beds arranged over three floors with a large lounge and a conservatory on the ground floor. When we visited there were 28 residents at the home. The service supports older people, some with physical care needs, 13 of whom have some level of dementia.

HWK has not previously visited Milverton. The last Care Quality Commission (CQC) inspection was undertaken in January 2023 which rated the home 'requires improvement' in the areas 'Safe' and 'Well Led' (CQC report).

The enter and view visit to Milverton was conducted as part of HWK's series of announced enter and view visits to local care and nursing homes taking place between April 2024 and March 2025.

These visits are focused on three specific areas: living environment; residents' mealtime experiences; and activities provided. More details of which can be found in appendix 1 (see page 32).

Entrance to Milverton Nursing Home

3. Recommendations

Overview: Milverton is a nursing home in Surbiton with capacity for 29 residents for which personal and nursing care is provided. On our visit there were 28 residents living there. The home was opened in 1997 and was created from two Edwardian houses which were knocked together. Since then, a conservatory was attached at the back (in 2017/18) and a garden office built for the manager.

The residents' rooms were available on all the three floors of the home. Two rooms were on the second (top) floor, both ensuite, and accessible to the residents by lift. The second floor had nine rooms, eight of which were ensuite, and was again accessible by lift for the residents. The two lifts were in separate places meaning that access to second floor required leaving one life and entering the next.

The ground floor had 18 rooms for residents. All of these were ensuite except for three which used communal shower facilities.

Overall, HWK authorised representatives concluded that Milverton was a clean and well-run home with a cared-for garden. Our visit was on Tuesday 8th October between 11.30am and 3.30pm and during this visit we were able to observe a morning activity and the lunchtime meal.

Living environment: the visiting team found the home to be very well cared-for and well run and undergoing continual improvements both in the environment and in staff procedures. The communal areas were very clean, the atmosphere was very calm and the staff team members we spoke to demonstrated enthusiasm and motivation in their roles. The residents we spoke to also seemed happy to be at the home. The relatives visiting residents at the time of our visit were pleased with the care 'their' resident was given and mentioned that the management were very approachable and responsive to feedback.

Shown from left to right, the wide front door and hallway, and the back of the garden with the manager's office on the left.

Mealtime experiences: Our visit was from 11.30am to 3.30pm so we were able to observe the lunchtime meal. The food was brought from the kitchen to the lounge area and served from there. There were six carers involved in the lunchtime. Food was provided in a timely manner and the residents were encouraged to eat by themselves where this was possible and were kindly and considerate, and supported to eat where appropriate. The food seemed to be enjoyed by the residents.

Meaningful activities for residents: Milverton run daily activities for residents, with an activities coordinator who works 15 hours over three days. The activities coordinator collaborates with the administrator who is responsible for booking the many external activities and entertainers who came to the home. During our

visit we observed a baking activity in the conservatory, the product of which was later offered to all residents.

By listening to people and recording their experiences and observations, HWK has formulated some recommendations designed to help the management of Milverton to improve residents' experience.

3.1 Living environment recommendations 1-7

HWK living environment recommendations	Milverton Nursing Home response
1. Enlarge the poster of the activities schedule so that it is easily seen on the noticeboard and display it around the home for residents to access it.	We have created a notice board in the communal area leading to the conservatory where we are displaying the activities schedule poster and all the activities that have taken place recently. Completed
2. Ensure that all residents are given the opportunity to sit in the conservatory.	Residents are assessed on admission and discussed with family or with resident (who has capacity) as to where they are best place in the communal area/conservatory for their safety and wellbeing at the time for them to settle in. There are residents that like to be in a space that is less busy and quieter and after assessed can enjoy the conservatory on a daily basis. Many residents like to be seated in the same place and area daily creating that routine. Residents that are able to sit in the conservatory without consistent reassurance and all needs are met will be sat in the conservatory. The conservatory is able to sit between 6-8

	residents daily. This allows for daily activities and family visits. Residents are asked to join the weekly activities in the conservatory where they enjoy and can either head back to the lounge or stay and have their lunch at the table. Completed.
3. Change the toilet seats to a different colour in line with dementia guidelines (See P12 – 6. Using the bathroom)	Majority of the residents are assisted to the toilet and do not attend the toilet on their own which doesn't require the different colour toilet seat. There is also bathroom just for the residents to use downstairs which has all the necessary aids. Those that do attend the toilet on their own are able to identify the bathroom and toilet. There is always on-going assessment regarding the capabilities and when further assistance is required. The communal toilets are used by the staff and visitors only. Completed.
4. Consider using an 'identity box' outside of the residents' rooms, particularly those with dementia.	Residents and families are encouraged to bring items that the residents are familiar with to make their room feel like home. Many residents put up lovely pictures and ornaments making them feel comfortable and reassured by the surrounding of their belongings. We have taken on this suggestion and will be placing a photo of the resident on the front of their bedroom door so that

	residents who are assisted to bed will recognise that this is their room.
5. Consider changing the carpet on the first floor to a more dementia-friendly surfaces similar to that in Kingston Hospital which has been refurbished to suit patients living with dementia and uses a simulated wood effect in parallel blocks which is shown to induce a more calming effect and reduction in anxiety and disorientation.	We will have a look at what you have suggested and visit Kingston hospital dementia- friendly surface
6. Ensure the door to the garden which says 'keep locked' is locked at all times.	The previous door required replacing and reason for the 'keep locked' sign was so that it didn't swing open. This door has now been replaced and closed at all times due to door mechanism attached. New door has been installed and is has the right mechanism to keep it shut at all times. Completed.
7. Securely attach the toilet seat in the ground floor communal bathroom and freshen up the paintwork on the door.	This was actioned and completed. This was raised before review but only completed thereafter.

3.2 Mealtime experience recommendations 1-8

During our visit we were able to observe the lunchtime meal. Based on the enter and view visit to Milverton, HWK has the following recommendations:

HWK mealtime experiences recommendations	Milverton Nursing Home response
1. Move the residents around the lounge and into the conservatory, to avoid them sitting in the same place all day.	Majority of the residents require hoisting and that in itself isn't always pleasant for the resident. We try not to move them too much during the day due to this and the pressure that hoisting can cause. Even when we have an activity we place residents in a wheelchair and there is a limited of hours one can be sat in the chair and we need to take into the account the positions and pressure while being in the wheelchairs. There are residents that enjoy the TV and prefer to sit in lounge this also hinders the change of seating on a daily basis for the residents. Residents are encouraged to take part in the activities in the conservatory allowing for a different scenery. The activities coordinator liaises with the caring team daily as to which residents are encouraged and placed in the conservatory for those activities. The residents are always asked on the day if they are happy to go and attend the activity in the conservatory. Completed.

2. Give all residents the option to eat at a dining table if they wish to.	Yes, a rota will be created for residents that would be keen to eat at the table in the conservatory on a Thursday. Reason for rota is so that residents get used to this routine and feels more secure to know that on a 'Thursday' they would be having their lunch at the table.
3. On the visual menu, use white text on the blue background to ensure easier reading.	To be actioned at the next change of menu which will be spring – March 2025.
4. Redesign the weekly menu to make it visually more interesting for residents.	To be actioned at the next change of menu which will be spring – March 2025
5. Ensure that residents and relatives, where appropriate, are consulted regarding menu planning.	This is reviewed during the 'resident of the day' (started 1st of December 2024) allowing for continuous communication with the residents and families regarding the overall care each month and to discuss food options. This will then, in turn give us a better understanding as to expectation the residents might have relating to the menu and also changes to their food intake which would be assessed by the SALT team.
6. Ensure that the menu reflects the actual food available, e.g. the menu said that fruit was fresh but tinned fruit was served.	Fresh fruit is provided when it is in season as the fruit would not be soft enough for the residents. Canned peaches are used regularly due to the texture and the flavour. It has been noted and that we change the wording not to mislead. Revised the menu wording. Completed.

7. Provide greater choice to residents for the evening meal.	This is reviewed during the 'resident of the day' and the communication with the families. Completed.
8. Ensure that meals and drinks are always heated sufficiently when provided to the residents.	Noted. To be communicated with the clinical team.

3.3 Meaningful activities for residents 1-4

During our visit we were able to observe the activities before and after lunch. Based on the enter and view visit to Milverton, HWK has the following recommendations:

HWK meaningful activities for residents' recommendations	**Milverton Nursing Home response**
1. Create a gardening activity where residents can grow things from seed.	This is an ongoing action plan as there is space in the garden for this. As there has been a change in activities coordinator since summer, last year this is going to be actioned in the Spring. Discuss further planning with gardener to get the ground ready for planting.
2. Ensure that food made by residents is covered.	Noted. Netting has been purchased. Completed.
3. Ensure residents, especially those with infrequent visitors, utislise the garden more.	Discussion is on-going on getting trips out for the residents. Further review of this plan to be discussed after the new year.
4. Re-instigate trips out of the home (lapsed since Covid) and ensure	When the weather is good, the activities are held on the decking and residents

that all residents get the opportunity to leave the home if they can.	are taken out to feed the fish. Continuous encouragement for residents to come and enjoy the conservatory during activities and afternoons

4. What is Enter & View?

HWK works to ensure local people's voices count when it comes to shaping and improving local health and social care services across the RBK.

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 2007 and Part 4 of the Local Authorities Regulations 2013 to carry out enter and view visits.

Healthwatch should consider how enter and view activity links to the statutory functions in section 225 of Local Government and Public Involvement in Health Act 2007.

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. For more information on enter and views please visit the HWK website.

4.1 Purpose of visit

This visit was undertaken as one of 18 visits to be undertaken across 13 care homes in Kingston as agreed with RBK and Kingston Care Governance Board (KCGB).

4.2 Reason for visit

During this pilot HWK are keen to learn what 'good' looks like and what works well, as well as identifying where improvements might be made. Milverton had a rating of 'Needs improvement' at its last CQC report which assessed the areas of 'Safe' and 'Well Led' in January 2023.

4.3 Methodology

The HWK staff team conducted an information review prior to the visit, this included:

- Discussion with the Kingston CGB to identify suitable care settings
- CQC reports and meeting with area managers
- RBK Quality Assurance guidance
- Milverton Nursing Home website page

The research was then presented to the HWK Board to support decision making. Other factors that influenced our decision included size of building, its location, and the number of residents.

For the visit, HWK followed Healthwatch England Enter and View Guidance.

Our enter and view of Milverton was an announced visit, meaning that the setting was aware that we would be conducting enter and view visits. The management team at Milverton welcomed the opportunity to engage with HWK.

The visiting team was issued with an observations and question framework that supported engagement with residents, visitors, and the care workforce.

5. Results of visit

5.1 Local context

The 2021 Census gives the current population of Kingston at 168,063, with 25,000 people aged over 65 years old. The Kingston Joint Strategic Needs Assessment (JSNA) states:

> 'With 766, Kingston has the second highest number of care home beds per 100,000 population (second to Croydon, which has 779) in London in May 2023. Kingston has 1,286 care home beds across 39 care homes. In May 2023, there were 45 registered domiciliary care providers operating in Kingston providing care in people's homes.'

Dementia and Depression

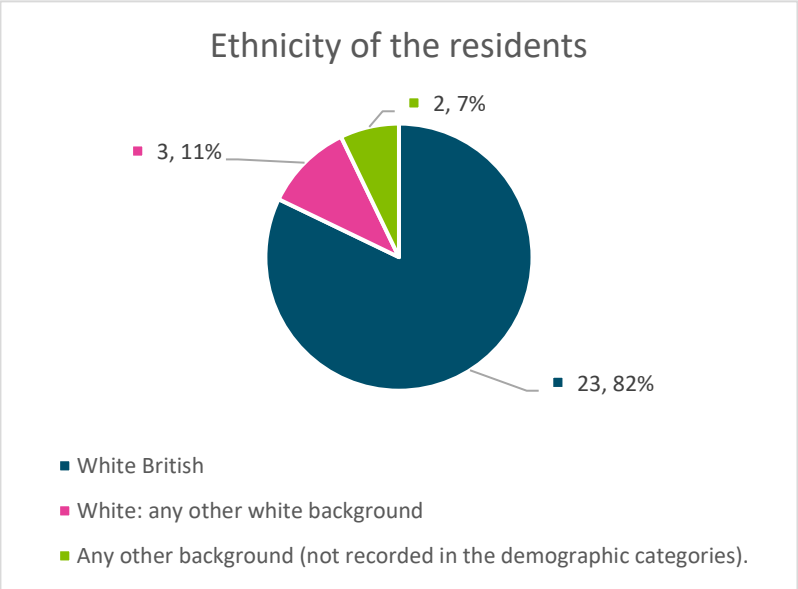
HWK notes: The 'Kingston Refreshed Heath and Care Plan – 2022-24' estimates that there are 1,700 people in Kingston living with Dementia, of which 61% (1,037) are diagnosed. The plan also informs us of the following:

> 'One in five older people, and two in five living in care homes, have depression, although it is not always recognised and treated.'

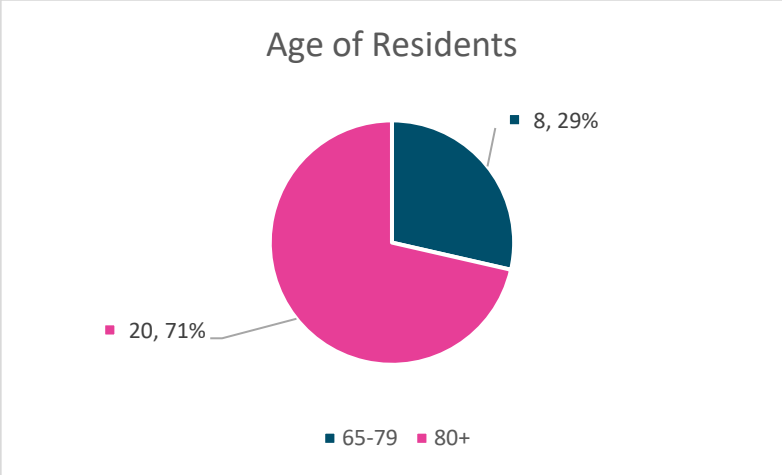
The Kingston JSNA also inform us that Alzheimer's Disease and other dementias were the third highest cause of ill health for people over 70 in the borough. The JSNA also mentions Dementia as being the top 5 causes of death in Kingston for people aged 70 years and older

5.2 Milverton demographic information

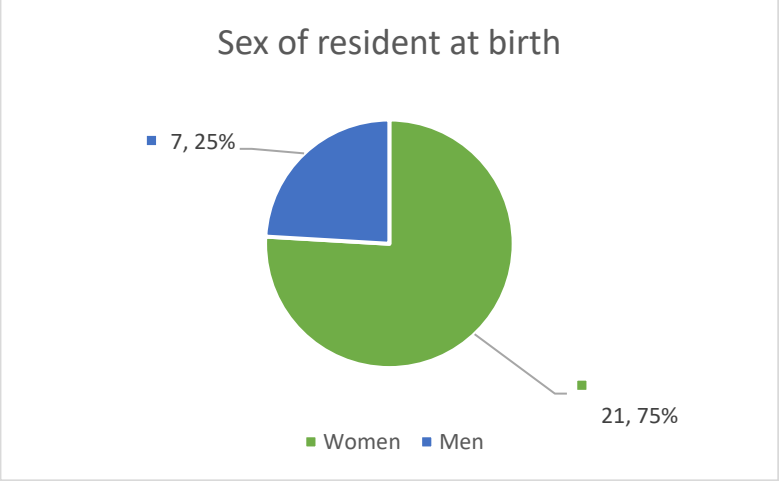
At the time of our visit the home had 28 residents, of whom 10 were funded by RBK. Milverton has no RBK block contract beds.



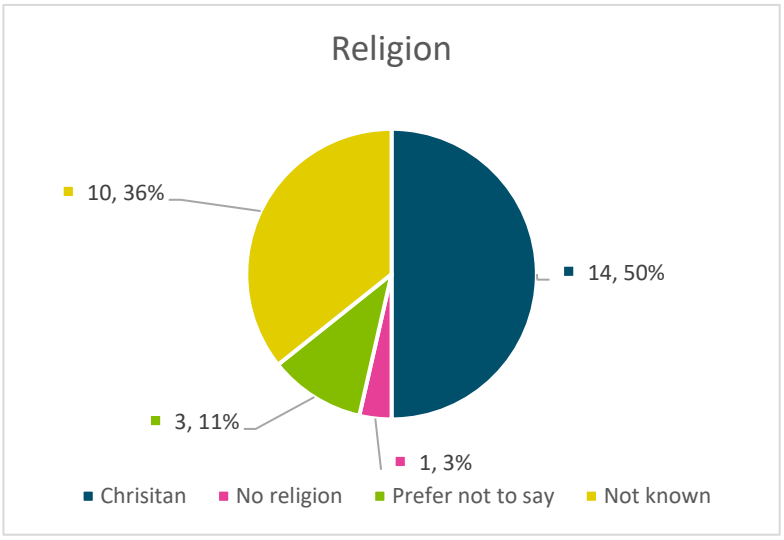
23 (82%) of the residents were White British, three (11%) were White: any other White background and two (7%) were from any other background (not recorded in the demographic categories).



Eight residents (29%) were between 65-79 years (71%) were 80 years and above.



There were 21 (75%) women and 7 (25%) men currently resident.



There were 14 (50%) Christian residents, one (3%) who professed no religion, three (11%) preferred not to say, and ten (36%) were not known.

18 (64%) of the residents were heterosexual / straight, while for ten (26%) of the residents this information was unknown. All of the residents understood and spoke English. One of the residents had a medical dietary requirement and one was a vegetarian/vegan.

The residents can be living with a number of different health issues: 11 (39%) of the residents had a physical or mobility impairment, and 13 (46%) had some degree of dementia (some residents had both).

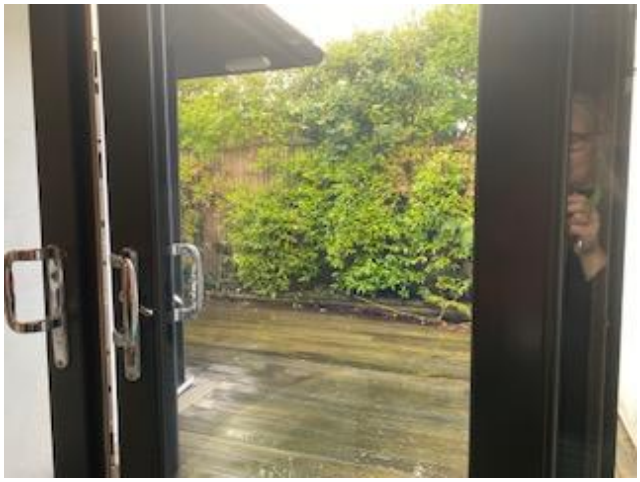
The home had 45 staff and on average one agency staff member per week.

5.3 Living environment

The HWK visiting team used an observation and question framework to prompt insights about the residents' living environment at Milverton.

The home had a large hallway, with the office of the administrator and the housekeeper (which they shared) and access to the nurses' station. Leading through from the hallway was a corridor to a large lounge. A conservatory had been built at the back of the lounge leading into the garden and out to the manager's office. The lounge was light and had access to the garden on three sides, with a television in the middle of the room allowing residents who did not want to watch television to be undisturbed by it. The communal areas were spacious, allowing easy access for residents to move around – many were in wheelchairs and very large supportive chairs for residents with little movement capability.

In the hallway by the front door were notice boards showing the activities schedule and pictures from activities that had taken place (see 3.1 recommendation 1). There was a staff board along the corridor which seemed to be up to date. Stairs led to the first floor but these were not used by residents who were mostly too frail to climb stairs. We were told that the conservatory wasn't visible from the lounge, so it is mainly used by the able-bodied residents, especially if the home is short-staffed for the day (see 3.1 recommendation 2).



Images show (from left to right) the notice board in the hallway showing the activities schedule and photos from recent activities. The staff board which seemed to be fully populated, the views from the garden from both sides of the lounge, the conservatory seen from the garden, and the fishpond full of Koi which came jumping to the surface as we passed in expectation of being fed.

The second floor had two bedrooms with one resident who was bedbound, and one who chose not to go downstairs and participate in communal activities. This resident said they found it 'upsetting' to be with the other residents who' seemed very frail'.

The first floor had nine rooms leading off three corridors which were quite narrow – a legacy of the conversion of a residential house. We were told that of the nine residents on this floor, eight had dementia. One resident used communal facilities on this floor (see 3.1 recommendation 3). Unlike other care and nursing homes we have visited, Milverton residents did not have a box outside their room which they could decorate with items that reminded them, and the health care professionals, of their lives before coming into the home (see 3.1. recommendation 4). We noted that the home had made good use of internal windows and glass doors to make areas as bright as they could be. The home had good fire escape signage and the signs on the doors denoting communal toilets were adequate. We noted that on the first floor the ground was carpeted (see 3.1 recommendation 5).

The lifts used by residents to access their rooms were small with capacity for one wheelchair and one healthcare professional, or four individuals. We were told that the staff used the stairs and not the lift, but that residents would not use

them as they were steep and unsuitable. The lifts used by residents to access their rooms were small with capacity for one wheelchair and one healthcare professional, or four individuals.

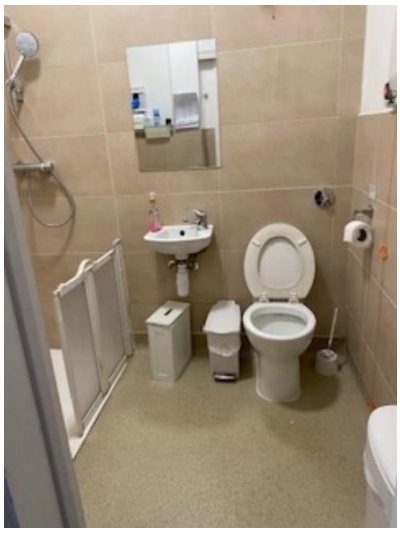
The home used a call system which allowed all staff to see if residents needed attention. The system shows when the bell was rung and if the resident was attended to. There were three of these in the home, the one on the first floor, one in the reception area above the refreshment station, and one in the lounge area visible from the nurses' station (an office separated from the lounge with glass doors).





Images above show (left to right) show one of the corridors on the first floor, one of the other corridors with a glass door to allow light (with the stairs down to reception on the left) a sign for one of the communal toilets, the lift on the first floor (through the grey surround with the manager in the distance), and the steep stairs not suitable for residents to use with the carpeted floor, and the call system used by the home.

The ground floor was where all the communal space for the home was situated. We were told that there were two residents who were bedbound, and two residents who stayed in their room through choice. Six of the residents had rooms directly opposite the kitchen and laundry room for the home (to which they had no access). The corridor was narrower at this point. At the end of this corridor was a door which had a sign which said 'keep locked'. We tried and were able to open the door (see 3.1 recommendation 6). There was a communal bathroom along this corridor with a sliding door. On one occasion when passing it, the door had been left open. The toilet seat was not fixed securely to the toilet and moved from side to side. The door of this bathroom was scuffed and in need of some renovation (see 3.1 recommendation 7).



Images show (left to right), the toilet with moving seat, and the scuffed door in need of freshening up.

The home was generally in good state of repair and very clean. There was a full-time gardener and a full-time staff member who did maintenance. We saw lights being fixed outside of one of the residents' rooms during our visit.

The gardener had been working at the home for 18 years and had created a beautifully landscaped garden with areas of interest for residents and lots of flowers. Everywhere in the garden was accessible by gentle slopes.

While we were visiting the community dentist was also visiting the home. We were told that they visited on a six-monthly basis unless called in to review a particular resident with an emergency.

We were told that the owner of the home had a very clear philosophy for the home which was encapsulated with the slogan 'Care with Dignity' and that the owner's overall wish for the home was that it was a friendly, family, home and that residents were able to live in a good environment, were well-looked after and were well-respected by staff.

We found that this ethos was demonstrated during our visit. The home and garden were being continually repaired and upgraded and had two employees focused on the garden and maintenance. The manager demonstrated they were keen to improve systems in the home and told us that they had implemented good IT systems which allowed for clear communication and handover amongst staff.

At least four members of staff had been at the home for a number of years. One carer told us they had worked at the home as agency staff and offered a contract with because their skills were recognised and they worked well with the residents (this was corroborated separately by another staff member). This carer reported they had worked in seven or eight different care homes and that Milverton was 'pretty decent'.

We spoke to a visiting relative who told us that relatives ran a coffee morning for relatives but that staff didn't attend these. They said that the home did run the occasional relatives' meetings but these were not well attended and tended to be information-giving sessions. The relative told us they were more than happy to give any feedback about the care of the resident they were visiting, directly to the manager who had always implemented their feedback.

We spoke to six residents during our visit, two relatives and seven staff members. We have captured some comments about the environment below.

"My room is comfortable and the staff do their best." (Resident)

"It's pretty good here – residents are enjoying being here. There are no restrictions for residents." (Staff Member)

"My relative is well cared for here. I pop in and out a lot and they are always well-dressed like this." (Relative)

"The support from management is good. The manager is amazing with help and very supportive of my role." (Staff Member)

"It's light and airy and clean and the staff are lovely." (Relative)

"There is a really good team of staff. Everybody is happy to help each other out." (Staff Member)

Since (my relative) has been here it's taken such a stress off me." (Relative)

"Everyone is friendly and it's a homely environment. Sometimes it's busy – the days differ." (Staff Member)

"I love it here. I live in a 'Milverton Bubble'. I can't wait to come to work." (Staff Member)

"Any feedback I have I'm happy to give to the manager directly." (Relative)

"Some of the residents can be quite rude, racist, but you can turn the conversation around." (Staff Member)

"The food is nice." (Resident)

"We were emailed last night to say that you (Healthwatch Kingston) were visiting today in case we wanted to speak to you.... We weren't told what to say!" (Relative)

"I'm happy here." (Resident)

5.4 Mealtime experiences

The HWK visiting team used an observation and question framework to prompt insights about the residents' mealtimes experiences.

The home does not have a dining room. In the lounge area there was no dining table and around 14 residents were present and sat in their armchairs with tray tables (see 3.3 recommendation 1). We were told that four residents eat in their rooms and that this can change if a resident is feeling unwell and chose or needed to stay in bed. We were told that those residents on pureed food were provided with their meals first. One resident in the lounge told us that they would like to be able to sit at a table to eat their lunch (see 3.2 recommendation 2).

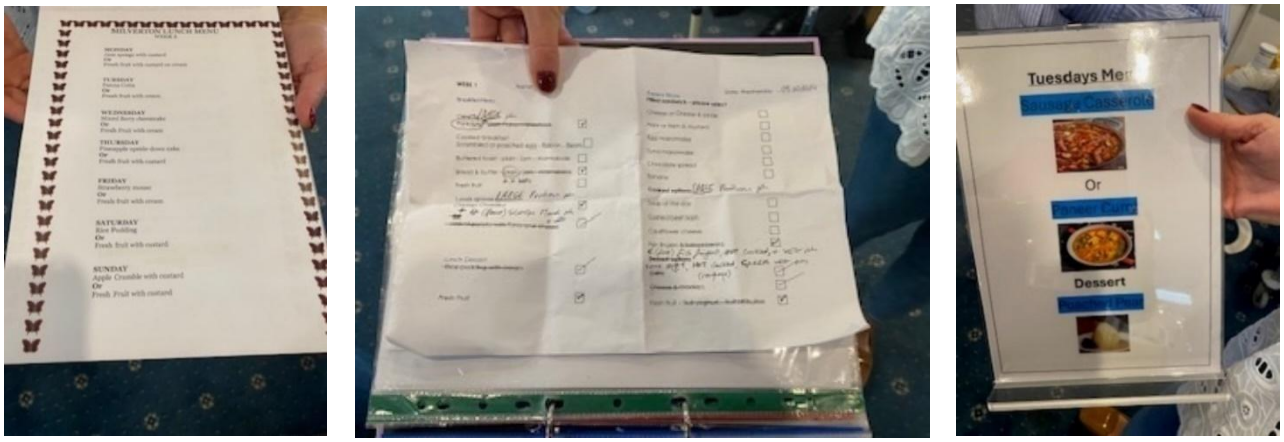
Six carers were present during the mealtime and we were told that if there were any issues, the activities worker and administrator would join as backup (to encourage residents to eat). Other staff - the clinical lead, the nurse, and the manager, were also available if needed. The visiting team were told that each carer is allocated a group of residents. If residents in this group need help to eat the carer will help them. If another carer has helped all the residents in their group, they will go and help another carer if it is required. One staff member told us that staffing was not an issue at mealtimes but that there was never enough time for the carers to spend 'quality' time with the residents as much of their time was engaged in caring activities. This was not given as a criticism of the care of the home, rather the problem of the care sector as a whole.

We observed three residents sitting at the table in the conservatory, and five others in armchairs with tray tables. One resident had a relative visiting who was engaged in feeding them. Another resident had a relative visiting and was able

to feed themselves. We were told that visitors are encouraged to come at mealtimes and the chef will provide food for them if they would like to eat.

We were shown the menus and the choices sheet made by residents which was given to those residents who ate in their rooms on the day before, and the menu that had photos illustrating the food which was shown to residents in the communal area on the day (see 3.2 recommendations 3 and 4). The weekly menu was displayed in the home in the communal areas and given weekly to the residents who stayed in their rooms. We were told that the menu was run on a two-weekly basis and changed every quarter so that there were different options during spring, summer, autumn, and winter.

The ARs asked if residents were involved in planning the menus. One staff member told us that the staff are asked as they know the residents' likes and dislikes (see 3.2 recommendation 5). The menus indicated that fresh fruit with either ice cream or custard was available for pudding at the lunchtime. However, the pudding we observed looked more like tinned fruit with custard (see 3.2 recommendation 6).



Images above show, from left to right, the weekly menu, the choices sheet filled in by residents who eat in their rooms, and the visual menu with photographs of the meals of the day.

We were told that five residents ate pureed food (because of a risk of choking) but that two of them could feed themselves but needed to be observed due to this risk. Those who needed support to eat were attended by carers who were kind and considerate and took time to allow the resident to eat at their own pace. The pureed food was the same as on the menu but made into puree. We

were told that many of the residents with dementia did not have capacity to make a choice about their food so were given food. We were told that care was taken to ensure the resident's likes and dislikes regarding meat or vegetable dishes were considered. During the mealtime there seemed to be a good rapport between the staff and residents.

One resident we spoke to told us that the evening menu was always the same and they would like more variety (see 3.2 recommendation 7).

The food was brought from the kitchen a short way along the corridor to the serving counter in the dining room. From there it was served onto plates and then distributed to the residents. We were told that the kitchen had recently been refurbished, a process that had taken two weeks. During that period, the home had 'borrowed' the kitchen of a local primary school which was two minutes from the home. Everything had gone very smoothly. A number of staff commented how well-organised the process had been and how well the kitchen staff had managed.

The plates in the home that the residents ate off of were blue. The manager of the home told us that they had identified research that showed that eating off a coloured plate aided independence in eating as it allowed residents who were visually impaired to identify 'white' food more easily such as potatoes, sandwiches, and rice, on a plate. The manager showed us a write-up of a project she had undertaken in the home to trial the use of blue plates, which had resulted in an increase in the residents eating independently and had therefore implemented the change.

All of the residents and staff we spoke to told us the food was satisfactory or good, although two residents said they felt that their food could be warmer, and our ARs observed a resident asking for their tea to be hotter and a new cup being provided (see 3.2 recommendation 8).

Our ARs spoke with the relative of a resident who had come to the home in April after a stroke. The resident had since been making a partial recovery and the

relative was pleased with the quality and dedication of the care shown to the resident and was very positive about the food and the help in eating by staff in the earlier stages of the resident's recovery.

The ARs were served lunch and between them tried both main meals – sausage casserole and paneer curry. They reported their experience of the food was that it was a good temperature, well cooked, and tasty.

Mealtimes were, breakfast from 6.30am, 12.30pm lunch and 5pm supper. We were told that the kitchen was open 24-hours a day and that residents could be provided with snacks, hot chocolate, yogurt, tea, and coffee at any time of the day or night. We were told that as well as offering meals to visitors, there was a drinks station available for staff and visitors to help themselves.

Image below show, left to right, the area in the lounge where the food is brought through to for serving with the blue plates visible, the paneer curry that one of our ARs was eating (the food was subsequently eaten), and the drinks station for staff and relatives to make themselves drinks, with biscuits available.

We observed a member of staff wearing white at the medication trolley and giving out medication. They were using a pestle and mortar and going through the notes on the trolley as they dispensed. The medication was dispensed in small cups.

During our visit, we spoke to six residents, two relatives and seven staff members. We have captured some comments about the mealtime experience below.

"All I ever get is the same thing – I'd like some more choice in the evenings." (Resident)

"It's pretty decent food." (Staff Member)

"There are six or seven who eat by themselves." (Staff Member)

"The food is good; the kitchen is close so it comes off a warm plate and is served straight away." (Staff Member)

"Food is good." (Resident)

"I help those who aren't at risk of choking, if we are running short." (Staff Member)

"We try to keep timings (of meals) specific – breakfast, lunch, dinner." (Staff Member)

"Food is very good here – my (relative) enjoys it." (Relative)

"If someone needs help, we all join in, particularly if we're short staffed." (Staff Member)

"The food is lovely, roast chicken. Banoffee pie is back on Thursdays – it's lovely!" (Staff Member)

"The food is nice." (Resident)

"Today's chef is one of the best for feeding you – he makes nice and tasty food. He's a kind soul who tries to prepare well and is proud of what he's doing." (Staff Member)

"Perhaps residents could have more vegetables, salads and fruit - I'm comparing with my own diet here…." (Staff Member)

5.5 Meaningful activities

The HWK visiting team used an observation and question framework to prompt insights about residents' experiences of the activities at Milverton.

Milverton employs an activities co-ordinator who works 15 hours over three days each week, Monday to Wednesday 9.30am-2.30pm who has been in post since June 2024. They work in collaboration with the administrator of the home who is responsible for booking external professionals to provide activities on other days. These include entertainers, musicians including an accordion player, a guitarist, and a local choir. One person comes in to explore memories with the residents. The home organises talks on various subjects – we were told the D-Day talk was popular.

We were told that volunteers came to the home and chatted to residents, and that wildlife and animals were very popular. There are visits from farm animals organised, and some animals and the small ponies can be taken into the residents' rooms. A staff member sometimes brings in their dog, which is very popular, there is someone who comes in to do Tai Chi, and a craft lady called 'Busy Lizzy'.

The activities coordinator told us that on Monday morning they do a 'wake up and shake up' session. This includes chair exercises and uses shakers, balloons, and bubbles. The bubbles are particularly popular with all residents who enjoy popping them. The activities coordinator told us they take photos of these activities which they collate in a folder (which was shown to the visiting team) which is then shown to the residents. They reported that one resident when seeing a photo of themselves enjoying an activity, had said 'thank you for reminding me who I am.' There are also opportunities to sing and dance.

On Tuesday, the activity is baking and on Wednesday it is reflexology massage, and manicures (for which the activities coordinator is qualified). In the afternoons, the activities coordinator told us they go to the residents in their rooms, bringing some element of the morning's activities with them, to ensure the resident is included in the life of the home.

Other activities offered were dominoes, flower arranging and watering the plants (see 3.3 recommendation 1). The ARs were told that on days that the activities coordinator was not working other staff members led activities such as bingo, and the wine and cheese evening on Fridays.

On the day of our visit, we observed a baking activity taking place in the conservatory with five residents and the activity coordinator involved in the session, with others in the room looking on. The product of this activity was then offered after lunchtime to all of the residents and left on the side to be offered for afternoon tea (see 3.3 recommendation 2).

Images show, left to right, the baking made by the residents (the large 'bun' at the back of the counter), and the conservatory where the activity took place, cleared of all residents who had gone into the lounge area.

A number of staff mentioned that the garden was not used as much as it could be (see 3.3 recommendation 3). The visiting team were told that there was a summer barbeque once a year

The manager told the ARs that there was work underway to organise better-weather activities both outdoors and away from the home. The sudden, unexpected death of the previous activities co-ordinator had resulted in the loss of variety of some activities but the home was planning to return to hiring a minibus to take those wanting to go to a garden centre or to see local areas of beauty, like the riverside in Kingston, and Kew Gardens.

The activities coordinator separately mentioned that they were planning to take residents out to local areas, like to a pub garden nearby and to local garden centres (see 3.3 recommendation 4).

The team were told that some of the activities led by the activities' coordinator were crafts and games as well as the cooking we observed. Those residents who were bed-ridden had some opportunity to participate in activities through a games consul that allowed the activities coordinator and other staff to play with the individual resident in their room.

The home was decorated with a number of items made by residents, although these seemed to precede the time of the current activities' coordinator. The current activities coordinator told us they considered themselves to be very creative and said that they were well supported by management in the acquisition of items to help with games. They mentioned the buying of a parachute to create a physical activity with the residents.

Images shown above (from left to right) crafted pictures made by residents of the home, and a decorated area of the conservatory.

During our visit, we spoke to six residents, two relatives, and seven staff members. We have captured some comments about the activities below.

"We get involved in activities when we have time. I do 1:1 stuff like puzzles, chatting to the resident, reading the newspapers to them." (Staff Member)

"One resident has asked for playdough. It's now on order." (Staff Member)

"They try and encourage me to come down and do activities, but I don't want to." (Resident)

6. Next Steps

This report will be shared with Milverton, KBC, CQC, the KCGB and other stakeholders. We will also share this report with Healthwatch England and will publish the report on the HWK website. We will agree with the management of Milverton the next steps to be taken in response to outstanding recommendations, and work with them to ensure any agreed actions are followed through and implemented.

6.1 About Healthwatch Kingston

HWK was set up by the Health and Social Care Act of 2012 to be the independent champion for local NHS and social care.

We seek the views of patients, service users, carers, and the public to help services work better for the people who use them. We play an important role bringing communities and services together. Everything we say and do is informed by what local people tell us.

As well as encouraging those who run local services to act on what matters to people, we also share local views and experiences with Healthwatch England and the Care Quality Commission who make sure that the government put people at the heart of health and care nationally.

6.2 Appendix 1

In the autumn of 2023, Healthwatch Kingston (HWK) entered into conversations with the Royal Borough of Kingston upon Thames (RBK) and Kingston Care Governance Board (CGB) to pilot an announced Enter and View at a local care home. The aim was that HWK's independent legal powers to visit NHS health and social care services and see them in action, could support a wider understanding of care provision and the wellbeing of elderly residents in the borough. This work would also support the 'Age Well' focus in the 'Kingston Refreshed Health and Care Plan 2022-2024' and 'Age Friendly' ambitions set out in the 'RBK Director of Public Health's Annual Report 2023: Ageing Well in Kingston' and 'A Decade On: Report on progress since 2013, the previous Kingston DPH Report focussing on older residents living in the borough: 'Older People: Living Well in Later Life'). This enter and view work will also allow us to support the RBK New vision for Adult Social Care and Health which aims to better understand the needs of residents from all our diverse communities.

The remit of the KCGB is to report on and manage quality and risk across the whole care market in Kingston. This board also helps report on any issues and concerns, manages risks in the marketplace and supports good practice in quality and delivery. KCGB members include RBK Adult Social Care and the Quality Assurance Team, Care Quality Commission (CQC) and HWK.

As there is already oversight of local care provision via members of the KCGB regarding risk management, safeguarding, performance monitoring and quality management, the HWK Board made the decision to focus this Enter and View on three areas (environment, activities, and mealtimes) within the care home setting. The focus on these three areas, will allow residents to share their lived experience of being in a care home, and for the HWK team to observe mealtimes

and the care home activities throughout the day. It will also provide independent insight into local care provision.

It was later agreed that this enter and view would function as a pre-pilot for a series of announced HWK Enter and View visits to local care and nursing homes between April 2024 and March 2025.

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