healthwatch Kingston upon Thames

# Enter & View Report

## Sherwood Grange Care Home

September 2024

# Contents

# 1. Introduction

## 1.1 Details of visit

| | |
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| Service Provider | Sherwood Grange Care Home |
| Service Address | 1A Robin Hood Lane, London SW15 3PU |
| Registered Manager | Kristina Jacunskiene |
| Dates and Times of three Enter and View Visits | Wednesday 11th September 11.30am-3.30pm<br>Tuesday 17th September 7am-11am and 3.30pm – 7pm |
| Status of Enter and View Visit | Announced |
| HWK Authorised Representatives | Jill Prawer (HWK Staff Team)<br>Liz Meerabeau (HWK Volunteer)<br>Julie Pilot (HWK Volunteer)<br>Kezia Coleman (HWK Staff Team)<br>Candy Dunne (HWK Staff Team)<br>Helena Wright (HWK Staff Team)<br>Stephen Bitti (HWK Staff Team) |
| HWK Visit Lead | Jill Prawer, Projects Officer, Enter & View |
| HWK Visit Support Lead | Liz Meerabeau (HWK Volunteer) and Candy Dunne (HWK Staff Team) |
| HWK Contact Details | Address - Suite 3, 2nd Floor, Siddeley House, 50, Canbury Park Road, Kingston upon Thames KT2 6LX<br>Phone - 0203 326 1255<br>Email – info@healthwatchkingston.org.uk |
| Service Provider | Care UK |

### 1.2 Acknowledgements

This visit was undertaken by Authorised Representatives of Healthwatch Kingston. We would like to thank Sherwood Grange Care Home residents, relatives/friends, and staff members for their contribution toward this Enter and View report and recommendations.

### 1.3 Disclaimer

Please note that this report relates to findings on the specific dates and times 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' visits.

# 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 Sherwood Grange Care Home (Sherwood Grange). Sherwood Grange is situated in the Royal Borough of Kingston upon Thames (RBK) and is one of the homes run by Care UK.

Sherwood Grange has 59 beds arranged over three floors with a lounge and a dining room on each floor. When we visited there were 54 residents at the home. The service supports older people, some with physical care needs, 38 of whom have some level of dementia.

HWK has not previously visited Sherwood Grange. The last full Care Quality Commission (CQC) inspection was undertaken in March 2024 (published in July 2024) which rated the home 'good' in all five areas (CQC report).

The visit to Sherwood Grange 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 35).


Entrance to Sherwood Grange and showing the minibus belonging to the home.

# 3. Recommendations

**Overview:** Overall, HWK Authorised Representatives concluded that Sherwood Grange was a well-designed home with caring staff that offered a range of activities. The garden is very small but was well-utilised and we observed it being used by a number of residents on our visits on 17th September 2024. We visited three times, covering all mealtimes. We observed lunchtime when we visited on 11th September, and the breakfast and evening meals on our two separate visits on 17th September. We were also able to observe some activities during our visits.

The three floors of the home had residents with different abilities. Those on the ground floor had cognitive ability, while those on the top floor were a mix of those with cognitive ability and some with the dementia. The middle floor residents had more advanced dementia. We were informed that the residents may be moved

to different floors as their health deteriorated. During our visits, the residents appeared to be looked after well, and the general atmosphere was calm and harmonious. Among the main things that worked well for the visiting team were:

**Living environment:** the home was purpose-built 12 years ago and is designed and decorated and furnished with many dementia-friendly features. The corridors are wide, the toilet seats on the 'dementia floors' had contrasting seats and the handrails had raised studs at the ends to signify the rail was ending. The home was clean and fresh-smelling and despite the layout with long corridors, had a homely feel. Although the garden was small, it was nicely designed and decorated with art that residents had made. The lounge areas were easy to access and the dining rooms had plenty of space for people to bring mobility aids to the table. The rooms were light, and each room had an ensuite. In the downstairs area there was a 'café' for residents to help themselves to tea and coffee, juices, and pastries. The coffee could either be instant or taken from a commercial coffee machine serving cappuccino etc. There was also a designated 'cinema' where films are shown, and lectures sometimes held.

Shown from left to right, the café serving area and seating area. The receptionist seated by the main entrance controlling the door and the interior of the cinema (with the curtains open).

**Mealtime experiences:** Our morning visit on Tuesday 17th September was between 7am and 11am so we were able to observe breakfast. During our 11.30am to 3.30pm visit on Wednesday 11th September, we observed lunchtime. Then our afternoon visit, Tuesday 17th September, from 3.30pm to 7pm, allowed us to observe the evening meal. The Authorised Representatives divided between the three dining rooms (one on each floor).

In all areas the residents were encouraged to eat by themselves, in a kind and considerate way, where this was possible and supported to eat where appropriate. The food seemed to be enjoyed by the residents.

**Meaningful activities for residents:** Sherwood Grange runs daily activities, including Tai chi sessions on three days, which we were told were popular. On the ground floor, some of the residents meet at 11am to sing until 11.30am (on the day of our visit there were seven residents singing together). We were told this a session was organised by the residents. The home uses their minibus for regular trips to local venues such as garden centres, Marble Hill Park, and Kew Gardens. The home employs two activities coordinators who both work full-time and cover weekends on alternate weeks.

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

## 3.1 Living environment recommendations 1-11

| HWK living environment recommendations | Sherwood Grange Care Home response |
|---|---|
| 1. Ensure all storage cupboard and fire doors are kept closed and locked when not in use. | Will be monitored as part of daily walkabouts. Managers and maintenance personnel to conduct daily checks. Staff reminded of the importance in daily meetings. |

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| 2. Keep hand sanitisers in place to enable hand hygiene and limit the spread of infectious disease, including any resurgence of Covid. | To be checked as part of daily monitoring by managers and housekeeping colleagues. |
| 3. Ensure all clocks and calendars in the building are kept up to date. | Managers and maintenance personnel to monitor as part of daily walkabouts. |
| 4. Level the paving slabs in the garden so they do not create potential trip hazards. | Risk assessments have been completed and waiting for contractor visit. Follow-up with contractor for a visit date. |
| 5. Monitor the artificial grass during hot or wet weather as it can heat up and can become slippery. | Risk assessment in place and regular checks are performed by maintenance staff. Maintenance person to continue with daily checks |
| 6. Replace missing handles on the chest of drawers in the first-floor kitchen area. | - |
| 7. All staff should wear identity badges at all times when working. Agency staff should be given identification badges denoting their role when working in the home. | Reminder given to all staff and agency workers about badge visibility. Remind the agency provider to ensure that agency staff are given an identity badge. If they do not have a badge, reception will provide one. |
| 8. Assess staffing levels allocated to each floor, with particular attention to the first floor where the resident to staff ratio seemed challenging, as staff were observed struggling to consistently maintain the level of support needed for the higher number of residents. | We complete dependency tool weekly where staff are reviewed. (A dependency tool identifies the individual needs of the resident and assessed these into the necessary staff time and skills required to meet them.) However, we found that there is a lack of structure and skills mix. Review the roster to ensure the right skill mix, and the new management should provide guidance to the team regarding |

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| | structure. Continue using dependency tools and adjust staffing as needed. |
| 9. Explore training / coaching for management staff to improve their listening skills, acknowledge what team members are saying, and, encourage team working to create feasible solutions. | Organise coaching sessions for management. |
| 10. Re-assess management cover overnight and at weekends and take a decision as to whether it is adequate. | Currently, we have two team leaders on night shifts and a day senior team leader who works alternate weekends. The deputy manager covers one weekend per month. We also have 24-hour management on call for out-of-hours support. Continue to review and recruit for addition team leaders for night shifts |
| 11. Review the website and ensure that information is relevant to Sherwood Grange. | This recommendation has been communicated to our marketing dept. |

## 3.2 Mealtime experience recommendations 1-12

During our visit on Wednesday 11th September, we were able to observe the lunchtime meal. During our two visits on Tuesday 17th September, we were able to observe breakfast and the evening meal. Based on the Enter and View visit to Sherwood Grange, Healthwatch Kingston has the following recommendations:

| **HWK mealtime experiences recommendations** | **Sherwood Grange Care Home response** |
|---|---|
| 1. Re-think the positioning /size of the menus containing more than one day's information currently printed and framed on the wall. | Menu frame removed from the wall and large print menus placed on tables. |

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| 2. To ensure nutritional needs, provide a variety of salads for visual interest and taste, and ensure an alternative is offered, if the main salad element (e.g. avocado) is left by residents. | Salad options being reviewed by the new chef for visual appeal and variety. |
| 3. Ensure no knives are left out and visible in any area. | Staff instructed to remove knives immediately after use. |
| 4. Ensure carers are trained to respond to emotional distress appropriately and with empathy. | All colleagues to attend informed dementia training. Management to monitor. |
| 5. Ensure there are sufficient staff on the first floor to allow carers to bring residents to the dining room in good time without leaving caring staff with a high number of residents, or residents alone in the room. | Continue to review staffing levels and schedule adjustments. |
| 6. Ensure that food arrives and is served within 15 minutes of the start of the mealtime. | Discussed with kitchen team, now monitoring by management. |
| 7. Ensure that residents eating in their rooms are not left to wait for their meals after those in the dining room have eaten theirs. | Discuss preferences with individual residents and allocate a carer for room service. |
| 8. Have the resident who likes salt assessed by the GP and assess their needs during meals to monitor their behaviour closely. | We have informed the GP of this, who stated that they were aware, and since the resident has capacity, there is nothing more they can do. We also spoke to the next of kin (NOK), who mentioned that their relative has |

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| | always used a lot of salt at home and does not want her to stop just because they now live in a care home.<br><br>Continue to monitor and encourage the resident to use less salt. |
| 9. Take care not to block fire extinguishers with walkers outside dining rooms during mealtimes. | Remind colleagues of the importance of keeping fire exits and fire equipment clear. |
| 10. Create a barrier on tray table to ensure residents are unable to push their food off the table. | Evaluate the need for additional table barriers. |
| 11. Ensure that the resident who gets agitated has an assessment to assess if 1:1 care is needed, especially during mealtimes. | Initiate an assessment to determine care needs during meals. |
| 12. Ensure food is temperature checked before being served to residents. | Remind colleagues of the importance of taking food temperatures before serving. This is to be monitored by the team leaders. |

## 3.3 Meaningful activities for residents 1-11

During our visit on Wednesday 11th September, we were able to observe the activities before and after lunch. Based on the Enter and View visit to Sherwood Grange House, Healthwatch Kingston has the following recommendations:

| HWK meaningful activities for residents' recommendations | Sherwood Grange Care Home response |
|---|---|
| 1. For themed days that are relevant to some residents, create activities that others might also be able to enjoy. | Activity coordinators to plan inclusive activities during themed days.<br><br>Complete the PALS assessments for all residents on the Care UK Relish app to identify their ability to participate in activities |
| 2. Devise activities for the residents based in the lounge of the first and second floors so they do not have to leave their lounge to attend. | Complete the PALS assessments for all residents on the Care UK Relish app to identify their ability to participate in activities |
| 3. Southwest London Integrated Care Board have a pilot programme where the 'interactive sensory projector' is being shared across Kingston care homes by rotation. Check if Sherwood Grange is due a slot. | Contact SWL ICB to inquire about the pilot programme slot. |
| 4. Provide spoons for the residents to eat the fruit when cocktails are drunk by the residents. | Activity coordinators to provide utensils for fruit consumption. |
| 5. Create and display a more visually attractive schedule of activities to allow residents to identify what is | Design and display an appealing activity schedule. |

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| happening and to encourage their participation. | |
| 6. Display the activities schedule on the first and second floors. | Activity planners will be displayed on all suites. |
| 7. Improve the communication between the residents and the activity coordinators about what activities and outings are available. | Discuss outings in the residents' monthly meetings to advertise the outings, including the day and time, in all suites. |
| 8. Assess why residents from the first and second floors do not like to take part in trips and activities. | Discuss activities with residents and their representatives as part of the Resident of the Day program.<br><br>Complete the Flower of Needs for all residents on the first and second floors |
| 9. Talk to residents and relatives (where appropriate) about what activities they would like to do, to create a more varied schedule and a system to ensure that all residents from all floors can participate in all activities including excursions. | Continue to discuss activities with residents and their relatives and review the activities planner based on their feedback. |
| 10. Provide more exercise and seated exercise / mindfulness / yoga classes for residents with a whole range of abilities in the lounge area on each of the floors. | Add more exercise activities across lounges on all floors. |
| 11. Create more activities to include residents who are bedbound or who chose to stay in their room. | Expand activity options for residents confined to their rooms. |

# 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 Royal Borough of Kingston.

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 Royal Borough of Kingston upon Thames (RBK) and Kingston Care Governance Board (KCGB).

## 4.2 Reason for visit

During this pilot Healthwatch Kingston are keen to learn what 'good' looks like and what works well, as well as identifying where improvements might be made. Sherwood Grange had a rating of 'Good' at its last full CQC report in 2024.

## 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
- Sherwood Grange 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 Sherwood Grange was an announced visit, meaning that the setting was aware that we would be conducting the three Enter and View visits on two days, across two weeks. The management team at Sherwood Grange 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.'

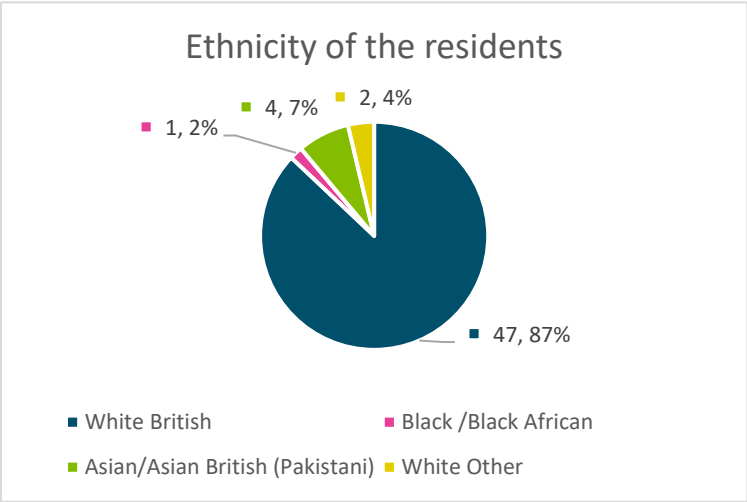
The Kingston JSNA also inform us that Alzheimer's Disease and other dementias were the third highest cause of ill health for people over 70 in the borough. The JSNA also mentions Dementia as being the top 5 causes of death in Kingston for people aged 70 years and older

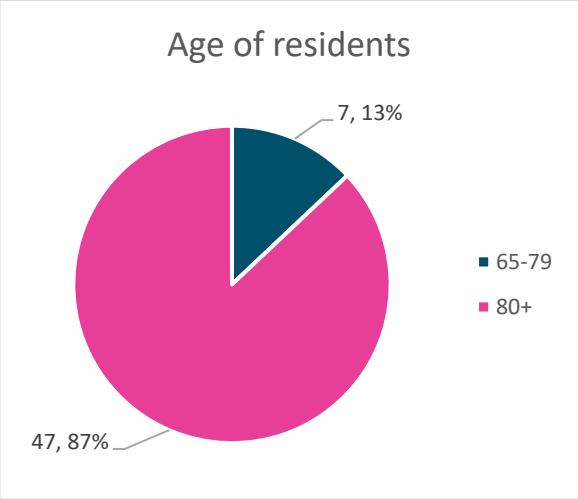
## 5.2 Sherwood Grange demographic information

At the time of our visit the home had 54 residents, 19 (35%) of whom were funded by RBK. Sherwood Grange has no RBK block contract beds.

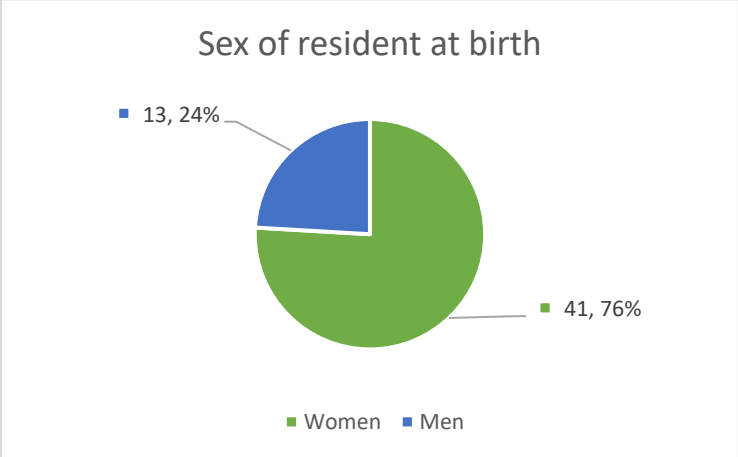
47 (87%) of the residents were White British, four (7%) were Asian/ Asian British (Pakistani), one (2%) was Black/Black African and two (4%) were White: any other

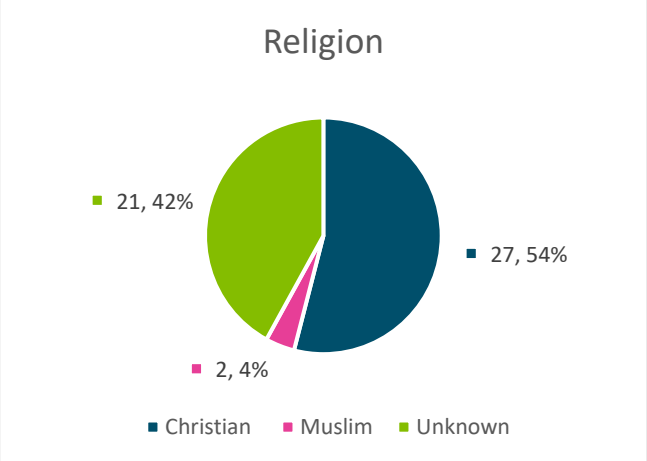
white background. Seven residents (13%) were between 65-79 years and 47 (87%) were 80 years and above.




There were 41 (76%) women and 13 (24%) men resident. 21 (42%) of residents were Christian, 2 (4%) were Muslim and for 27 (54%) their religion was unknown.




All (100%) were heterosexual / straight. All except two (4%) spoke English, one spoke an African language and one spoke an Eastern European language, but both communicate by gesticulation, and there was at least one member of staff who could speak their languages. During our visit we observed a staff member talking to one of these residents.

3 (5%) of the residents have religious dietary requirements, 14 (26%) have medical dietary requirements, and one (2%) is a vegetarian. 36 (77%) of residents had no recorded dietary requirements.

At the time of our visit, a number of residents were living with a range of health impairments / disabilities, including: 23 (43%) of the residents with a physical or mobility impairment, and 38 (70%) with some degree of dementia.

The home has 73 staff and, on average, 7.6% agency staff per week.

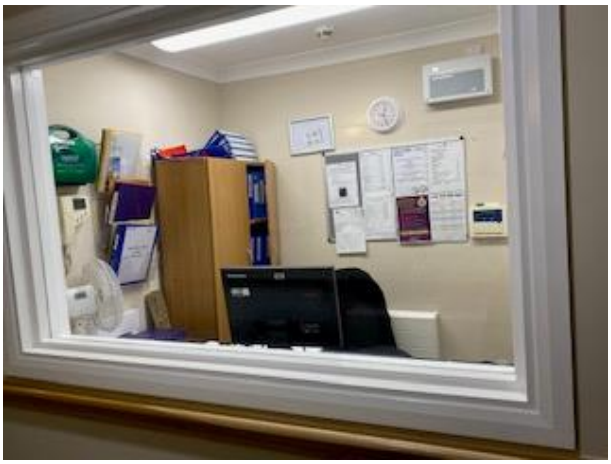
## 5.3 Living environment

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

The entrance to the home is spacious with a reception area that houses a receptionist stationed at a desk who controls access to the home. Accessible from reception is the café area where residents and visitors can help themselves to tea, coffee, juice and fresh fruit and pastries. In addition, this area has a cinema and a hairdressing and manicure salon. Also in this part of the home are the manager's and other offices, and a training room for staff.

During our three visits we did not see anyone from the first or second floors use this ground floor area.

Images from left to right, the café serving counter and the seating area. On our visits earlier in the day, there was a bowl of fruit and pastries available on the counters.



Through doors accessible with a code, there is a long corridor with a large lounge leading to the back garden, the dining room leading to the small outdoor area with two garden seats and rooms for 15 residents. There was also an office with a large window where the team leader for the floor was stationed (see image left.

We learned that staff were generally assigned to the same floor and only move to a different floor to cover holiday, or sickness absence of colleagues.

The ground floor has two carers and a team leader for the 15 residents (13 while we were visiting). We were told that as a resident's care need increases, they were introduced to the second floor to help them get used to the space before they were moved there. This floor has 22 residents with mixed levels of dementia and has three residents who need assistance and is staffed by three carers and a team leader. The first floor has 22 residents with dementia, five of whom need assistance with eating, and has 3 carers and a team leader.

The home was clean, nicely decorated in neutral colours with pictures on the wall, and 'installations' of clothing items signifying coming in from the outside, like hats and shoes. We were told that these were to add interest and provide tactile stimulation. The signage was clear, fire evacuation procedures were well documented. The fire doors were kept closed and there were evacuation chairs at the top of staircases. We noticed that the signs for the toilets differed across the three floors, with dementia friendly signage being used on the first and second floors, but not on the ground floor.




Images (from left to right) show one of the 'tactile installations', fire evacuation procedure, evacuation chair, sign for the toilet on the ground floor, and for the first floor.

There were doors along the corridors which were unmarked, and we were told that this was on purpose in order to make the place feel homely. The manager suggested that we wouldn't want a label on our wardrobes at home! On one of our visits, we observed two cupboard doors that should have been locked, were left open and an unlocked fire door. Both cupboards had soft items inside like towels, and personal care items, and nothing hazardous, however items strewn on the floor could cause a trip hazard (see 3.1 recommendation 1).

Along the corridors on all floors, there was a system that alerted staff to any calls for help and showed when staff were attending the resident.



Images left to right show the contents of one of the cupboards which had been left open and unlocked, an unlocked fire door, and the alert system used by staff.

The first and second floors were laid out in a similar format as the ground floor. The second floor had a library room with books and comfortable armchairs, but residents on first floor had no extra areas to explore, having only the lounge and dining room as communal areas.

The home had sanitising dispensers inside of every entrance, and outside dining rooms which were filled and working. The manager told us that Care UK were wanting to remove these as in their view 'Covid' was no longer a threat (see 3.1 recommendation 2).

There were good-sized clocks with clear faces around the building showing dates and times. Unfortunately, two of these clocks were showing the wrong date and / or time. One of our visits was on Tuesday 17th September but the clock showed the day before. We also saw a clock that had stopped in the dining room on the second floor. Our visit was between 3.30pm and 7pm on that day and the clock read 12.20pm (see 3.1 recommendation 3).



Images (from left to right) show one of the hand sanitising dispensers and the two clocks detailed above.

For a nursing home with 54 residents there was very little outside space, however, the space that was available (built on top of a basement extension) was well used with the option for up to 15 residents to sit outside, raised beds for residents to enjoy gardening and decorated with ceramic items made by the residents. We noticed that there was a dip in the garden which could cause a trip hazard and were told that the garden was to be refurbished in the near future (see 3.1 recommendation 4). The 'lawn' was made of artificial grass, necessary as the garden is on top of the basement (see 3.1. recommendation 5).

Images, left, to right, show views of the garden with the artificial lawn, and the cracked paving stones where the dip in the garden could cause a trip hazard.

While the fixtures and fittings all seemed to be in good repair, we did note a chest of drawers in the kitchen area of the first floor that was missing some handles (see 3.1 recommendation 6).

Image left shows the chest of drawers missing some handles.

The toilets and bathrooms in the home were all spacious, clean and odour free, some with decorative touches to add to the feeling that this was a 'home' for the residents. We noticed that the toilets had a different colour seat and lid, in line with good practice for dementia care.

Images from left to right. show examples of the bathrooms and toilets, with the central image showing a 'homely' decorative addition.

We were told that agency staff were used to cover staff illness and leave if regular staff were unable to fill the gaps. We observed one agency staff member in the lounge on the first floor who was wearing their own clothes and had no form of identification that designated their role. We were unsure whether they were a staff member or a relative until we asked. This was not the first time they

had worked at the home. Another agency staff member told us that they frequently worked at the home but had yet to receive any form of identification with their name or their role. We also saw a number of the staff members working to prepare the dining rooms for lunch who were not wearing identity badges. During the mealtime the badges were being worn. (see 3.1 recommendation 7).

We talked to staff during our visit and found that all showed a deep commitment to the residents in the home and in providing good care. We heard, however, that staff morale was low. We heard there were often not enough staff to cover caring duties, which meant that staff were often working without breaks, leaving work extremely tired and then finding that they were too tired to do a 12-hour shift the next day. This meant at times, they called in sick and this left staff feeling bad for the rest of the team who then needed to cover for their absence, This added to the use of agency staff, who did not know the residents as well, and meant that the care they offered was less personal (in that they were not familiar with the likes and dislikes of a particular resident). We were told by staff throughout the home that the first floor needed more support to be able to provide good quality care consistently. We were told that there were up to five residents who needed 1:1 care, but were not identified as such, so did not figure in calculations in the staff to resident ratio (see 3.1 recommendation 8).

We were told that team leaders often had so much paperwork to complete that they were unable to provide the 'extra pair of hands' that the floor required. Staff told us that when raising the issue of feeling the need for more staff or support, senior management often replied with comments which dismissed the concerns of the staff and focused on their own workload.  One of our Authorised Representatives also witnessed a similar interaction (see 3.1 recommendation 9).

We also heard that there was no management cover overnight, and one team leader worked alternate weekends so that there was no management cover on the weekend they did not work. The staff member who told us this felt that it caused more work for the day staff as they came on shift (see 3.1 recommendation 10).

When reviewing the Sherwood Grange website, we noticed that many of the images related to other care homes run by Care UK. The visiting team felt that this could be misleading (see 3.1 recommendation 11).

We spoke to 12 members of staff during our visit and four residents. We have captured some comments from the staff about the Sherwood Grange environment below:

"Rooms are clean and spacious. On the ground floor, most have [mental health] capacity and it's like a family. The dementia floor (first floor) is quite conducive to residents." (Staff member)

"We care about the residents who are well taken-care of – the staff have a passion for the job, they're not here for the money." (Staff member)

"This is a lovely place to work, residents are well looked-after. Carers come with their heart." (Staff member)

"We don't often have our breaks." (Staff member)

"Our concerns are dismissed, and we do not feel listened to by the management." (Staff member)

"We always need more staff and support, especially the kitchen and the carers." (Staff member)

## 5.4 Mealtime experiences

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

The home has three dining rooms, one on each floor, all with a kitchenette and areas to serve the food. During our visits the dining rooms were nicely laid out for the meals with napkins and flowers on the tables.

Menus were printed and displayed on tables and in each dining room, there was a framed printed version of the menus. On the second floor this was difficult to

read and we felt that to be useful to the residents the type should be much bigger and the time period made much shorter (see 3.2 recommendation 1).

The dining areas were clean and we observed the cleaning cart in the second-floor dining room after the lunchtime meal, cleaning the floor and preparing for the evening session.



Images show, from left to right, the menu that needs redesigning, the first-floor dining room and the second-floor dining room with cleaning cart.

We were told that on the ground-floor most residents came to the dining room to eat, and that those who stayed in their rooms did so through preference, or because they were feeling unwell on the day. During the evening meal two residents stayed in their rooms with one carer taking food to them and ensuring their needs were met.

During the evening meal on the ground-floor, we observed the residents make their own way into the dining room and choose their seats. There were two tables of four residents, one resident was accompanied by a relative, and two residents sat alone at tables of two. One resident seemed unhappy and fractious throughout the meal, but they were given attention and calmed by the carers gently and patiently.

Two carers served the meal for all the residents in an efficient and friendly way and the room had a calm and unhurried atmosphere. We were told that mealtimes have two carers and the floor manager on duty. Two residents were on a pureed diet who were able to eat by themselves but needed observation due to the potential risk of choking.

The food was brough to the dining room at 5.10pm (mealtime started at 5pm) and comprised French onion soup or tomato soup, followed by macaroni cheese with a fried egg on top.

One resident was served a salad by request, which was lettuce, tomato, and sliced avocado. The resident left the avocado on the side of their plate. No one asked if there was a problem or if something else could be brought. The Authorised Representative felt that the salad did not look enticing and seem limited in its scope (see 3.2 recommendation 2).

Images shows the soup and macaroni cheese and fried egg to go on top being served in the first-floor dining room.

During our lunchtime visit we observed the kitchenette on the ground-floor (after the meal had been cleared up), we observed a bread knife left out on the bottom shelf of food trolley (see 3.3 recommendation 3).

Residents on the ground floor seemed happy with the food they were served at all the meals we observed. However, in a recent residents' meeting (held monthly), they had put in a request for more simple food like 'bangers and mash'. The new chef told us the kitchen was happy to provide food the residents requested.

Images, left to right, show the ground floor dining room with menus on the tables. The dining room has access to a garden area at the front of the house where there are two benches to sit out on. The other image shows the knife left out on the food trolley in the kitchen area of this dining room.

The first-floor dining room is a large room which was clean and nicely laid out. During our observation of the lunchtime on this floor, we saw a number of care staff getting the room ready who were not wearing identification badges, although everyone was wearing one by the time the meal was being served and the manager confirmed to us that they should be worn throughout the day (see 3.1. recommendation 7).

Some of the residents were able to make their own way into the dining room, but many needed support from the carers. This meant that it took a long time for all the residents to be brought into the dining room and that there were periods where there was only one carer in the room with eight residents. During this period one resident shouted at another which made the resident being shouted at upset and tearful. The carer did calm the altercation and encouraged one resident to move to a separate table, but did not appear to acknowledge this residents' distress (see 3.2 recommendation 4). At one point the carer left the room to go and help another resident into the room, leaving all the residents including the two who had had the altercation in the room alone (see 3.2 recommendation 5).

During the lunchtime session on first floor, the food did not arrive until half an hour after the mealtime had begun (see 3.2 recommendation 6). One resident

sitting alone and with a tray table was agitated and kept calling for their food. The carers were very patient with them. We were told that this resident sits aside from the other residents as their behaviour can be erratic.

During the lunchtime meal we observed 16 residents and six staff, two of whom were activities coordinators with the residents. The atmosphere was calm and friendly and staff were talking to the residents in a way that seemed familiar and was enjoyed by the residents. We calculated that there were four residents in their rooms and were unsure when they would be served their food. (see 3.2 recommendation 7).

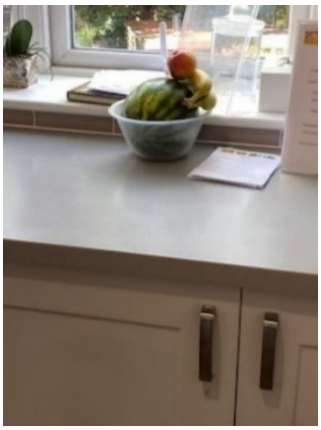
During the lunchtime meal, Authorised Representatives on the first floor observed a resident remove a large container of kitchen salt from a bag by the side of their chair. They poured a handful of salt onto their food before they began to eat it. We informed a carer who went and spoke to the resident but did not remove the salt. A little later in the meal we observed the resident do the same thing again. At that point, the manager came to the dining room and told us that this resident was known for pouring lots of salt from the salt dispenser on the table. We told the manager what we had seen, and she was unaware the resident was bringing their own salt to their meals. We expressed concern for the resident's blood pressure. The manager said that she would organise the GP to visit the resident and do the relevant tests to check their health (see 3.2 recommendation 8).

During the evening meal and again on the first floor, we observed that the walkers and wheelchairs were left outside the dining room while the residents were eating (see image left). These were placed in front of a fire extinguisher making it hard to access (see 3.2 recommendation 9).

Also, during observation of the evening meal in the first-floor dining room, the resident who had been agitated during the lunchtime meal was again agitated and attempted to swipe their food off their tray. It would have fallen onto the floor but for the quick response of one of the carers, who managed to catch it (see 3.2

recommendation 10). Later during this meal, a carer raised their voice in what sounded like anger, in response to this resident's agitation. Although the carer resumed a normal tone immediately the other residents seemed shocked by the outburst (see 3.2 recommendation 11).

During the evening meal and in the dining room on the second floor we observed a carer helping a resident to eat their soup. The carer identified that the soup was too hot and made efforts to cool it down before giving it to the resident (see 3.2 recommendation 12).



On our first visit we observed bowls of fresh fruit in the kitchenettes (see image left), however on our visits the following week, there was no fruit available apart from in the café area downstairs.

We spoke to four members of staff, two residents and two relatives / friends during our visits. We have captured some comments about the environment below.

We spoke to 12 members of staff and four residents during our visit. We share a couple of comments about the mealtime experience below.

"Very delicious food. We have just recruited a very experienced new chef." (Staff member)

"The food here is good." (Resident)

## 5.5 Meaningful activities

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

The home has two full-time activities coordinators who between them cover the week and weekends alternately. One activity coordinator had been employed in this role since January 2024, having previously worked there as a carer. We observed this activity coordinator dancing with a resident and speaking with them in their language, which the resident appeared to be very much enjoying. The resident was celebrating a National Day from their home country and music and dancing from the country were being shown on the television. No other resident was taking part in the celebration in the lounge (see 3.3 recommendation 1).

The second activity coordinator had been in post since June. We were told that when the previous manager had left the home (two years ago), the activity team had left at the same time and that the home had had difficulty replacing them with people with whom the residents were satisfied. We were told that the current team were working well. The second activity coordinator told us that they were very happy in their role and enjoyed devising craft activities for the residents to do by request from the residents. When we visited, they were creating a cardboard 'fence' for the residents to decorate which was part of a larger project to make a model village. It was unclear which residents were benefitting from these crafts which took place in the cinema room. There was an obvious tradition of residents making pictures and ceramic objects and the garden and ground-floor were decorated with the results. This seemed to be an activity enjoyed by residents from the ground-floor only (see 3.3 recommendation 2 and 3).

The activities coordinators had a designated room to work from and activities generally took place in the cinema room or in the lounges.

The residents on the ground-floor were relatively self-sufficient at providing entertainment and had created a singing group every morning at 11am-11.30am

in the lounge. On our first visit there were three people engaged and on the second there were seven. On the first visit we were told that others had been out on a trip. Ground-floor residents only are invited to attend this.

On our second visit, we observed a cocktail party in the garden with five residents enjoying cocktails accompanied by one of the activities coordinators. We observed a resident eat some fruit from their cocktail off a fruit knife, and relatively quickly, the activities coordinator asking for the knife and removing it from the resident (see 3.3 recommendation 4). The ground-floor lounge had a half-finished jigsaw puzzle on a table, comfortable chairs, access to the garden, a piano in the corner and a television.

Our visiting team were given a schedule of weekly planned outings and saw that this was displayed outside of the cinema on the ground floor (see 3.3 recommendation 5). We were also told that this was distributed to residents' rooms, but one resident expressed the view that they did not think all residents were able to know where to find the information. We did not see the activities schedule displayed on any of the other two floors (see 3.3 recommendation 6).

We heard a conversation between two residents, where one told the other that there was a trip, they thought to Marble Hill (which was on the schedule), but they were not sure. The other resident knew nothing about it. They then told the Authorised Representative that communication between the home and the residents could be improved (see 3.3 recommendation 7). It was unclear who was invited to attend the outings but during a later conversation with a carer, we were told that they were available to all residents, but those on the first and second floors "never wanted to go" (see 3.3 recommendation 8).

The residents we spoke to told us that there were far fewer activities at the home than there had been previously, something that they regretted. We were told by the manager that there was a 'wishing tree' in the reception area that was for residents to put their ideas and requests onto the tree. However, there did not seem to be a straightforward way to affix a wish and we did not see many wishes hanging there. We felt that there could be a more active way of finding out the residents wishes and ideas (see 3.3 recommendation 9).

We were also told that all activities on the ground-floor were for all residents of the home but that when it was time to do an activity, the residents on the first and second floors didn't want to move and so stayed in the lounge. We were told that this was because they all wanted to stay together. We identified that the weekly activities schedule outlined two activities held in the first-floor lounge: 'aqua paint' on Monday afternoon and 'music and more' on Friday morning. Activities based in the second-floor lounge were: 'aqua paint' on Monday afternoon, 'Tai chi' on Wednesday afternoon and 'Amanda fitness club' on Thursday morning. We observed the tai chi in the second-floor lounge which was enjoyed but was attended by only three residents. We were told that the usual group consists of around nine (and lower numbers were due to others being on trips or appointments).

The residents performed exercises from their chairs and were highly engaged. The instructor emphasised the importance of foot exercises, especially for residents who sit for extended periods. Although early in the programme, the instructor noted that residents are already showing noticeable improvements in strength and ability. We felt that many of the activities provided on the schedule were passive e.g. 'BBC Proms, Jazz music in the lounges' 'classical music morning', and during our conversation with residents we were told that they thought that 'watching TV and films' should not count as activities' (see 3.3 recommendation 10).

We asked the activity coordinators how activities were provided to residents who stayed in their rooms, either by choice or through necessity. We were told that they provided 'namaste care' which included aromatherapy, hand massage and conversation. They also provided manicures, (small) ball games and tactile stimulation with small physical objects (see 3.3 recommendation 11).


Images shown, from left to right, the cinema and the wishing tree which displayed a number of wishes.

We spoke to 12 members of staff and four residents during our visit. We have captured some comments about the activities provided below:

"I sometimes get involved in the singing sessions (ground floor) and do residents' nails. The job has a lot of paperwork, but the residents' needs have to come first." (Staff member)

"There are lots of outdoor activities - residents go out on the bus with friends and family, we went to the theatre, Tai chi is on offer, we go to Richmond Park" (Staff member)

"I think there's a trip tomorrow, I think to Ham House – we think communication could be better about activities." (Resident)

"We used to do a lot more previously with the old manager and activities staff - we did a day trip to France then! (two years ago)." (Resident)

"Those with dementia need a lot of encouragement to join in activities. We do pamper sessions, ask them what they want to do, try to engage them." (Staff member)

"We had a disco (in the cinema) and will have a Halloween party with make-up and dressing up." (Staff member)

"Not enough activities." (Resident)

# 6. Next Steps

This report will be shared with Sherwood Grange Care Home, 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 Sherwood Grange Care Home 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

Healthwatch Kingston 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 3 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 act 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.

Healthwatch Kingston upon Thames
Suite 3, 2nd Floor, Siddeley House,
50, Canbury Park Road,
Kingston upon Thames
KT2 6LX
www.healthwatch.co.uk
t: 0203 326 1255
e: info@healthwatchkingston.org.uk
@HWKingston
Facebook.com/HWKingston