healthwatch Cumbria

Enter & View Summary Report

Care Homes 2013-2014

Peoplefirst

Content

Introduction:

Healthwatch is the independent consumer champion for health and social care services in England.

Healthwatch Cumbria has the statutory right, through the Health & Social Care Act 2012, to carry out *Enter & View* visits to any publically funded health and social care settings to gather the views and experiences of customers, patients, families and staff for the purpose of service improvement. Service providers have a duty to respond to our reports and recommendations in the public domain.

Healthwatch Cumbria carried out a planned programme of *Enter & View* visits in Care Homes in West Cumbria from December 2013 to March 2014. All settings visited were provided with individual reports with the findings from each visit and advised that they had up to 20 days to make a formal response. It was clear from these individual reports that there were common themes and trends across all the care homes visited that these could provide opportunities for shared learning. This report provides a summary of findings from all setting visits, highlighting examples of good practice, issues of concern and makes recommendations for improvements based on national and local best practice.

This summary report will be shared with the general public, all settings visited by Healthwatch Cumbria, the Care Quality Commission (CQC), Cumbria Clinical Commissioning Group (CCG) and all Social Care Service providers in Cumbria.

Methodology:

Healthwatch Cumbria receives intelligence about a wide variety of health and social care services from various sources. This intelligence is used to plan activity and to inform options for *Enter & View* visits.

All care home services provided in Cumbria received a letter from Healthwatch Cumbria, through Cumbria County Council in December 2013, explaining the purpose and methodology of Healthwatch Cumbria *Enter & View* visits. The letter informed the setting managers that a programme of

visits was being developed and that these visits would be made, without further announcement, between December 2013 and March 2014.

Following the letter, Healthwatch Cumbria undertook an information gathering process in preparation for the visits, consulting with stakeholders including CQC, Cumbria County Council and Cumbria Safeguarding Board.

The *Enter & View* visits took place between December 2013 and March 2014 and were carried out by an *Enter & View* Lead (EVL) and a number of *Enter & View* Authorised Representatives (EVARs). A variety of methods were utilised at each setting to gain an understanding of the service provided including:

- Discussions with setting management, staff, and visiting professional
- Requests for documentation, such as meal menus, staff rotas and resident activity plans
- Conversations with residents and their families and friends

Guidance was sought on any sensitivities with particular residents' needs that needed to be taken into consideration on the day of the visit.

The EVARs observed residents and staff throughout the settings. Observations were recorded on:

- The general environment;
- Condition and presentation of the home;
- The nature of the care and support received by residents;
- The nature of staff interactions with residents.

Resident, visitor and staff comments were recorded anonymously to protect the identities of contributors.

Letters explaining the role of Healthwatch Cumbria and the purpose of the *Enter & View* visit were left for families and visitors, which included Healthwatch Cumbria contact details should families wish to raise any concerns or forward compliments about the setting.

The visits focused on five service areas and the reports provided summary information for each. These areas were chosen as they are fundamental to overarching well-being of the residents and as broadly indicative of quality of care given and received.

- Environmental (fabric and facilities) Observations
- Service Provision and Management
- Nutrition (Meals and Diet)
- Exercise, Activities and Mobility
- Personal Support and Choice

At the end of each section Improvement "Observations and Considerations", "Positive Observations and Considerations" and quotes from staff, residents and visitors, were provided.

A number of common themes, issues and examples of best practice have emerged.

Environmental Observations:

Internal environments varied with some settings being modern buildings with contemporary styles of decoration and others that had décor more in keeping with older properties. Observations have been grouped into three main headings, general décor and upkeep, internal and external layout and facilities.

Internal and external layout and facilities

The layout of main lounges was similar in most settings with seating placed around the perimeter of the room. However in some cases a less formal seating arrangement was provided, with seats grouped together, around a television or stereo. In some cases good use was made of additional spaces throughout the home for smaller groups or individual chairs. Dining rooms were usually well lit and airy rooms providing opportunities for group seating or 2-4 seating arrangements. In some settings the dining areas were used as extra social areas for residents.

In most settings residents were encouraged to use their own home furnishings and personal effects in bedrooms. This helped residents to settle-in and provided some familiarity in their personal spaces. Bedding and other soft furnishings had to be clearly labelled to ensure that items were returned to the right person after laundering.

Outside recreation areas varied in access and use. In some settings outside areas well utilised by staff and residents, with provision for gardening activities, including greenhouses and flower beds. Several settings maintained seating areas and sun-houses for resident use. The outdoor environment is an alternative facility, available all year and can be a place for exercise and interest. Good pathways around the grounds for residents to walk along were not always provided and there were settings where the outside areas were only used for staff and visitor parking rather than being available for resident use.

General décor and upkeep

In nearly all cases the settings were clean and well maintained but there were areas for improvement. A common challenge is the need to ensure a programme of regular maintenance and decoration can be delivered.

Local historical scenes were often displayed to add interest and stimulate conversations with residents.

In several settings hand sanitizer gel dispensers were empty. This is an unfortunate indicator of good practice not always being followed through on a 24/7 basis.

CONCLUSION: The importance of a well maintained and welcoming environment cannot be understated and is a key factor influencing the initial and more lasting impressions of each home visited. The vast majority of settings observed had reasonably well equipped and well set out internal and external environments that appeared beneficial to residents' health and wellbeing.

Service Provision & Management Observations:

Evidence was collected of a number of issues relating to Service Provision & Management which affect the running of the setting and the quality of care that it provides. Observations have been grouped into four areas: Staffing, Additional Services, Complaints, Concerns & Compliments and Communications

Staffing

Staffing levels and ratios varied considerably from setting to setting and it was evident that in some cases there appeared to be low levels of staff compared to the number of residents. There are no specific guidelines for the number of staff required other than a requirement that the service must have adequate staffing to meet the needs of residents and to ensure that individual care plans can be delivered. It was clear from the visits that needs can vary dramatically over the course of the day and that this can result in peaks of demand at specific times or when an individual resident needs prolonged one to one care. It was noted on more than one occasion that staff were under pressure to deal with all of the needs that occurred simultaneously.

Obvious peaks occur during meal times and in some cases residents complained about having to wait for access to toilet facilities or to be moved from one area of the home to another, for example to bedrooms or dining areas.

It was also noted at several settings that staff sickness or unplanned leave could cause additional staffing implications. This was generally addressed through 'doubling-up' of shifts, bank workers and management covering shifts where necessary.

Additional staff are employed in homes and were often present during visits. Domestic staff add to the total care package provided for residents and in most cases appeared to gain satisfaction from their personal interactions with residents. Maintenance staff were employed at all settings to provide daily maintenance tasks and appeared to provide an efficient service. Many were well known to residents and maintained a rapport with staff and residents alike.

Overall, it was apparent that the majority of care staff across the setting were committed and enjoyed their work although at times found it challenging. It appeared that staff genuinely cared about the residents and tried to ensure that quality of care and safety standards were maintained.

At some settings Management utilised a mentoring system to support new staff recruits to learn the ways of providing good quality care. This provided guidance on protecting the respect and dignity of the resident, as well as covering the technical requirements of delivering personal care.

CONCLUSION: Staff at all settings appeared committed and well trained. Particularity where staffing levels/ratios were low frequent pressure times were observed and unplanned absences could put additional strain on the setting and its staff. Flexible working patterns and the availability of extra staff during peak times could help to ease these types of pressures and increase the effectiveness of the care offered to all residents at all times.

Additional Services

All settings had some services externally provided, such as community nurses, chiropodists, hairdressers, and in some settings, alternative therapy practitioners. Some of these services have to be paid for by the residents, which may restrict take up as those without independent financial means may not be able to pay for such services. It was clear from residents that had

the opportunity to use some of the non-clinical external services, such as hairdressers, that there was a positive impact upon wellbeing.

It was evident that record keeping associated with General Practitioner (GP) visits varied, and settings have their own recording systems. GPs visit residents when necessary and are responsible for updating patient records. In some cases staff found keeping resident files fully updated difficult if the attending GP didn't share information. Staff were completely aware of patient confidentiality but felt that providing limited medical information would assist them in meeting the resident's needs after the GP visit. In some settings detailed notes were maintained at the home showing the name of GP, resident visited and the time and date of each visit with a brief overview of the resident's medical condition.

A consistent method of GP engagement within all Care Home Settings would be advantageous as practice differed from one setting to another. By developing such a sector-wide methodology the rights of residents for equality of access, and issues surrounding confidential and quality record keeping could be addressed.

CONCLUSION: The development of a Social Care specific information sharing and recording protocol would be beneficial across all settings in order to manage resident's access to external community health and wellbeing services.

Additional services are welcomed but there can be a disparity of access where the availability of services is dependent on residents' resources.

Complaints, Concerns & Compliments

At all settings visited the complaints/compliments/comments log was requested. However, it was common for there not to be a formal approach to recording and managing complaints and concerns, although this type of feedback was more generally recorded in individual residents' files. It was often reported that no formal complaints were made and that concerns and ideas for improvements tended to be raised more informally through conversations between staff and visitors. Healthwatch Cumbria made a frequent recommendation for homes to consider introducing a formal policy for receiving and recording all feedback whether compliments or complaints

in order to monitor trends, support learning, drive improvements and tackle issues quickly and proactively.

CONCLUSION: All Social Care Settings should have a centrally stored resident/family issues log, as a place to record and track all feedback and associated action in relation to each resident. Residents and their families should be proactively informed of this policy approach and encouraged to report all concerns, complaints and compliments. Regular analysis of common issues raised can be used to drive improvements and inform training needs.

Communication:

Good communication is essential between staff, residents and all care home visitors. However, the effectiveness of communication approaches and skills varied. In some homes there was greater awareness of the need for a variety of methods to meet residents' individual needs. Some settings used 'easy read', large print, colour and pictures as an aid to communication but this was not prevalent in all settings visited. Effective use and positioning of noticeboards also varied.

CONCLUSION: All Social Care Settings would benefit from considering in detail the effectiveness of their communication approaches. Sharing good practice sector wide could help to compile a Communication Tool Kit which could include recommendations for the use of Spelling Boards, Speech Boxes, colour coordination, newsletters, notice boards and websites.

Nutrition (Meals & Diet) Observations:

In all of the settings visited it was evident that residents and families felt that nutrition and diet were well catered for. Residents were given choices and individual needs were also addressed. Catering staff provided specialised meals including gluten free, soft foods and high protein options where required and there was ample evidence of the provision of drinks and snacks in between main meals.

Residents tended towards traditional meal options rather than trying other options i.e. Italian or Chinese, however catering staff did occasionally try to introduce new recipes.

One setting providing a service for those living with dementia had switched main meal times and were providing a main hot meal in the evening with a lighter option at lunch time in an attempt to increase food intake and to address behaviour problems associated with dementia.

As dementia progresses there can be an adverse effect on calorie intake, as sufferers may not able to self-feed or may refuse food. Good practice noted, and to be encouraged, included the provision of staff with a specific responsibility for monitoring resident's weight and eating patterns. Other good practice included staff with a specific responsibility of ensuring that residents were kept hydrated by providing drinks throughout the day. In other homes there were jugs of water and juice available in all seating areas, so that residents could help themselves.

CONCLUSION: All settings provided meals that appeared to be appreciated by the residents. Good practice would include the provision of staff with responsibility for monitoring appetite and weight management and for ensuring residents are adequately hydrated throughout the day.

Exercise, Activities & Mobility Observations:

The level of activities provided varied enormously across settings. In some settings activity coordinators visited daily to provide mobility and creative activities, local history sessions and other activities. However, in some settings there was no evidence of any activities taking place.

Where activities were provided they were mostly delivered in a professional manner. At some settings there were personal records and weekly plans displayed for residents.

It was evident that meeting the needs of all residents was difficult. In some settings where an activity coordinator was in post they appeared to rotate themes and interests in an attempt to involve and encourage as many residents as possible to participate.

In some settings there were some purely social activities on offer, designed to help to keep residents involved and interested in what is happening around them and in other people.

In general there were very low levels of activity for residents with dementia. These residents have specific needs and can benefit from simple exercise, activity and movement sessions designed to maintain mobility and stimulate wellbeing. In some settings '*Singing for the Brain'* sessions were provided and well attended.

CONCLUSION: Settings should review their activities and ensure that they are providing a variety of activities that can cater for all resident's choices and needs, as far as is achievable.

Support & Choice Observations:

In most of the settings it was clear that dignity and respect of the residents underpinned all activity. From asking residents how they'd like to be addressed to giving residents control over their get up and bed times, residents, where mentally capable, were included in the choice and nature of the care they received.

In many settings end of life planning was discussed on admission either with the resident or with family members.

Many settings had invested in end of life training for staff, which provided them with the necessary skills and knowledge to deal with end of life situations. Palliative care nurses work in many of the settings that are committed to keeping residents in 'their own homes' (within the setting) until end of life.

Comments from a number of family members were received detailing excellent end of life care and that there had been a great deal of support for family members.

CONCLUSION: **Settings should continue to invest in the provision of end of life services for residents and training for staff.**

GENERAL CONCLUSIONS:

Through this programme of Enter & View visits we observed a broad range of facilities and services at social care settings in West Cumbria.

Generally the settings were suitably equipped and set up to provide a quality environment for residents. The majority of services were delivered and managed well.

There are opportunities for improvements in relation to;

- Staffing levels and ratios especially at peak times and to cope with unexpected pressures.
- The systematic recording of and learning from feedback, compliments, and complaints.
- Centralised records being available to support visiting community care services and GPs
- An enhanced approach to regular stimulation, exercise and activity provision
- Regular and effective communication in a variety of formats

Generally staff appeared well trained and cared deeply about the standard of services provided for residents. Overall the nutritional requirements of residents appeared to be met and there was an example of best practice in altering meal times for residents with dementia. There was some disparity between settings for the provision of entertainment and activity for residents. Some settings had a good variety of activities for their residents and showed great initiative in trialling new ideas for their residents.

Resident choice was encouraged at most settings and end of life choices at some settings showed adherence to best practice by including the resident and/or family members in the decision making process at an early opportunity.

We have included a brief bibliography which readers may find of interest with regards to standards and best practice at care homes for the elderly.

Healthwatch Cumbria would like to thank all of the staff, residents and families we met for sharing their views and experiences with the Healthwatch Cumbria enter and view team.

Bibliography

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