Derbyshire County Council Residential Care Homes Review

Derbyshire County Council - Improvement and Scrutiny Committee – People

Final Report of the Review Working Group

22 August 2017

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Acknowledgements –

The Chair and Members of the working group would like to thank the Members and officers of Derbyshire County Council who have contributed to this report:

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1. Introduction

Councillor Judith Twigg, Chairman of the Improvement and Scrutiny – People Committee and Chair of the Working Group, introduces this report;

"This review came from a desire to visit all Derbyshire County Council residential care homes. Members of the working group wanted to meet with staff, residents and their family members to see the level of care being provided to the residents, how members of staff were being supported and how overall standards were being achieved.

The visits by Members were designed not to replicate other 'inspections', for example the Care Quality Commission (CQC), but more to get a 'feel' for each residential care home in the context of the authority's estate being a mix of older built homes and more recent developments with additional elements, for example Extra Care.

This report presents our findings of how the authority is providing care to residents in our care homes. Members of the Improvement and Scrutiny Committee have worked with Cabinet Members, officers, partners, Care Home Staff, residents and their relatives to bring this report to a conclusion and I would like to thank all those involved for their assistance and contributions."

Councillor Judith Twigg

Chairman, Improvement and Scrutiny Committee - People

2. Key observations and recommendations

The review of the authority's residential care homes focused primarily on scheduled visits. The visits were scheduled over a four week period in July and August 2017. All 22 residential care homes were visited, with each visit lasting between one and two hours. Each visit involved Members of the working group, the supporting Scrutiny Officer and Care Home staff, usually the Care Home Manager (or deputy) with input from Senior Care Workers. Appendix One lists the schedule of visits.

Observations were of each visit, based on discussions with staff, residents and their family members (where possible). In addition, data and information was supplied to Members to help prepare for each visit (see detailed information in chapter 5), together with the latest CQC rating and the relevant Derbyshire Healthwatch 'Enter and View' report.

Based on this, below is a set of key observations and recommendations.

Key Observation 1: ***Derbyshire County Council staff display excellent levels of care and compliance and good practice should be shared to ensure standards are the same throughout all care homes.***

Members of the working group observed and discussed various areas of how care standards and compliance are maintained. Members noted, overall, the excellent work which is undertaken to ensure the various duties relating to care homes are met. This included the following; provision of person-centered care, deprivation of liberty safeguards, regular activities, access for relatives, and residents and relatives having a voice through meetings with care home staff. Personal care services, for example washing, cleaning, podiatry, hairdressing etc…are at the heart of the home care staff's work. There was also evidence of good levels of understanding and compliance in regard to turning, hydration and nutritional charts and tissue viability. Very few pressure issues were observed during the visits. However, there seems to be differing frequencies of visits from other healthcare professionals. This is covered in more detail under key observations 5 and 6.

During the scheduled visits, Members of the working group observed some excellent initiatives designed to maintain high standards of care to residents

(and also their relatives). However, upon visiting all 22 of the authority's care homes, it was apparent these initiatives are not consistently employed. It is recognised that as each home should be managed for the needs of their own residents, however Members felt that these initiatives should be shared. Some of these ideas are described below, with a fuller list in Appendix Two.

- Locating the Care Home Manager's desk was in the reception area (as appose to a separate office) – this ensured the Manager was at the 'centre' of everything and could be easily accessed.

- Encouraging residents not to stay in own bedrooms and be in communal areas, but must be balanced against personal needs and their Care Plan. Where in rooms, doors open (if not against wishes of resident) and checked regularly (every hour).

- Air conditioning in medicine rooms ensures the integrity of medicine and care home staff using the room are comfortable.

- Regular (for example quarterly) meetings with relatives as well as residents meetings to ensure their voice is being heard with regard to such things as activities, amenities and care provision.

- Care worker dispensing medicines with a bib saying "do not disturb" – many medication errors are due to being disturbed.

- Corridor walls, gardens and other communal spaces having themes, pictures, paintings, art and sensory equipment (eg boards) and plants (eg lavender plants for smell) and memory boxes on doors.

- Making use of volunteers either as individuals or in groups to perform specific tasks within the care home. Examples include gardening, recreational activities or tea/coffee making which frees the care staff to be assisting their residents.

An appropriate method of communication should be agreed to ensure good practice is routinely shared between residential care homes. Service Managers have an important role in delivering adult care services in their respective areas. This role could be used to collect and disseminate particular initiatives found to be successful in other care homes.

Recommendation 1. Service Managers to share the best practice ideas as listed in Appendix Two with Care Homes and to consider how best to share good practice on an ongoing basis, for example through Unit Manager Leadership meetings.

Key Observation 2: ***The outdoor areas of residential care homes are important for residents, but some are in need of better and more regular maintenance by Property Services.***

It was apparent that residents, their relatives and staff place a high degree of importance on the outdoor areas in their residential care homes. Through the visits, Members found gardens, seating areas and open land which is vital for the wellbeing and contentment. This included raised beds where residents and volunteers could grow vegetables, herbs and flowers. There was also various garden seating (gazebo's, benches) which allowed for communal activities and interaction outdoors. Additionally, there were many examples of artwork and sensory items in outdoor areas which can play an important role in maintaining mental and physical wellbeing of residents.

Members found there was a lot of reliance on the good will of staff, residents and volunteers to maintain gardens. There were numerous examples of staff volunteering themselves to tend to gardening. This can be seen as very positive as such activities can bring people together and Members found there was a lot of pride in their efforts.

However, Members found maintenance to be a big issue, particularly with regard to grass and hedge cutting, moss and weed removal and uneven surfaces. Many homes raised concerns and issues over the contracted work of the authority's Property Services on ground maintenance. This included:

- moss and weeds being allowed to grow
- uneven paths (some on several levels)
- grass not being collected
- Overgrown plants restricting access and views for residents, their relatives and staff.

Members had concerns that this could result in trip hazards and a general disincentive for residents to use and appreciate outdoor areas.

Recommendation 2. The Strategic Director of Adult Care discusses the issues raised over ground maintenance with Property Services, voicing particular concerns of both members, care home staff and relatives as to the quality of grass cutting, collection of garden waste and general maintenance of aesthetic aspects and considers how best to ensure these issues are resolved going forward.

Key Observation 3: ***Not all the authority's residential care homes are totally secure in terms of outdoor areas.***

As part of the scheduled visits, Members observed the overall security aspects of the residential care homes. Members noted that many of the homes are not 'secure units' in the sense that they are mainly residential homes and as such, resident who have capacity can leave the premises if they wish. However, there were some examples where both Members and care home staff raised concerns over overall security. This was primarily down to the external border of the home (ie fence of hedge) having holes or unlocked gates. Nevertheless, in one specific instance, there was a regular practice of giving regular visitors the code to enter the building.

Members noted some isolated incidents which were in part caused by these issues, for example members of the public walking across the residential care home because of a hole in a hedge and walking dogs across the grounds. Although there is no one answer to resolving these issues, Members have noted these individual concerns and will take them up with the relevant officers and Cabinet Members.

Recommendation 3. The Strategic Director of Adult Care raises the lack of security for residents when using outdoor areas of the residential care homes and encourages the installation of adequate fencing for outdoor areas used by residents.

Recommendation 4. The Strategic Director of Adult Care encourages the adoption of standard security practices amongst all the local authority owned residential homes and shall consider the viability of upgrading more older 'code' door systems to fobs for entry and exit by staff members.

Key Observation 4*: **Many of the authority's residential care homes have issues with storage due to increasing amounts of equipment for residents.***

During the scheduled visits, Members observed that most of the residential care homes have increasing issues over storage. Members noted that this was, in part due to some homes designed in 1970s where there was less equipment, such as hoists and profile beds. With the increased usage and need for equipment, Members noted incidences where homes have had to use spare bedrooms and other rooms to accommodate this equipment. Also, some homes have taken off cupboard doors to allow for wheelchairs to be stored. Additionally, some have bought storage units to be located outside.

The company Medequip do provide delivery and collection services for some of this equipment. Members noted there was varying levels of satisfaction by care home staff on their service provision. Some homes stated the company responds quickly (ie within 5 days) to requests, however others highlighted issues such as taking a long time to collect equipment – this in part causes storage issues for the care home.

Recommendation 5. The Strategic Director of Adult Care discusses with Property Services the need found in the majority of the Council's residential care homes for additional storage space either by internal or external means.

Recommendation 6. The Strategic Director of Adult Care reviews the performance of Medequip and considers ways of providing a consistent service level to all residential care homes.

Key Observation 5*: **There are different levels of support provided to residential care homes from District Nurses and other health professionals.***

As part of the scheduled visits to residential care homes, Members discussed with care home staff the support provided by health professionals. The medical care undertaken by professionals such as District Nurses, Community Matrons, Advanced Nurse Practitioners and GP's ensure that the resident's

medical needs are being met. Care staff spoke very highly of the level of service, for example District Nurses sharing their direct mobile phone number with care home staff so they could be contacted in the event of an urgent matter.

Members noted that there are different levels of support provided to care homes, most usually through frequency of visits. For example, some care homes are visited by Advanced Health Practitioners and District Nurses at set intervals, for example twice a week, and consisted of 'ward rounds'. Other homes had the support of these healthcare professionals as and when required. Sometimes this was every day, for example if a resident needed insulin.

Members observed that support by healthcare professionals to residents in care homes is driven by the local need and circumstances, and that developing good relationships are important to ensure continuity of service. Members also noted that care home staff are developing their skills in monitoring such issues as pressure sores and tissue viability to ensure the safety and wellbeing of residents.

Key Observation 6*: **Some residents arrive at the authority's residential care homes with pressure sores from hospital and that tissue viability and safeguarding issues should be managed promptly***

Members noted that in some incidences, residents have arrived at care homes with pressure sore issues following discharge from hospital. These issues can be very dangerous to the health of the resident and must be managed promptly and expertly. There were a small number of other pressure sore issues, which appear to have developed whilst a resident was in long term care. These were observed during the scheduled visits by Members, through discussions with care home staff. Care for these was being administered by healthcare professionals and care home staff.

There was evidence observed that in the vast majority of cases care homes were complying with standards in terms of provision of pressure cushions, profile beds, regular turning and monitoring of turning charts. Members also observed that some care homes provided residents with one pressure

cushion, where upon it was transferred to wherever they were sitting. Others had multiple pressure cushions, for example one for a wheelchair and one for their chair.

Through discussions with care home staff, Members also asked about safeguarding issues. Members have noted these individual concerns and will take them up with the relevant officers and Cabinet Members. Members also noted that issues such as these meet two of the CQC's Fundamental Standards;

- safety: you must not provide unsafe care or treatment, or put people who use your service at avoidable risk of harm
- safeguarding from abuse, improper treatment, or neglect.

Recommendation 7. Research is carried out to investigate the extent to which there are pressure sore issues after being discharged from hospital into residential care homes and for reablement.

Recommendation 8. The Strategic Director of Adult Care will ensure research is carried out to ascertain whether all residential care homes are properly equipped with the correct apparatus such as fall mats and alarms as to reduce the frequency of safeguarding issues including falls and pressure sores.

Key Observation 7*: **The authority is well placed to learn from recent new care home builds and to use them for any future care home development.***

During the scheduled visits, Members observed the excellent facilities of the newer built care home premises, which incorporate services such as Extra Care and Day Centres, spa rooms, treatment rooms and ensuite bedrooms.

Members also acknowledge that some of the newer built facilities, although not all, brought challenges to the relationship between staff and residents. This is especially true of senior staff who are provided with a much greater burden of looking after a bigger variety of care services and a much larger premises.

It was apparent that some of the newer builds are still developing these facilities and ensuring there is adequate staff to service residents and other users of the facilities. Members had some concerns that some areas of these new builds were still not open, even though the premises had been open for some time. To ensure the best provision of services whilst providing value for money, it is ideal that there is a full establishment of staff and residents as soon as the facility is open where possible.

The authority is well placed to learn from the recent care home developments that have opened. This can be as described above, but also for more specific elements of the design. For example ensuring there is adequate catering facilities under the authority's control instead of using external catering companies. Members observed with concern that there were issues such as having to train new chefs (as they don't have a lot of experience catering for residential homes) and care staff having to over-order food (as they have to order night before) to allow for residents who change their mind.

Recommendation 9. When planning the construction, development and use of new residential care home establishments under the authority, Derbyshire County Council will endeavour to consult and engage both staff and residents throughout the process. The practical needs of the facility and its residents should always be paramount to any appearance or status concerns and desires.

Key Observation 8*: **Some residential care homes are using agency staff to fill vacant posts, with differing levels of success and where it is not working well, this is adding to resourcing issues both in terms of cost and time on existing staff.***

Members observed, through discussions with care home staff, the usage of agency workers and the number of vacancies each homes has. There were differing levels of vacancies and also staff retention. Further information regarding staff retention is in Chapter 5. Members noted the recruitment drives to attract more care workers into the authority.

Some care homes had very little or no vacancies with low or no usage of agency staff. Some care homes spoke of having excellent and well-motivated workforces. Others also stated they had very little problems recruiting staff.

However, others did raise concerns of the difficulty to fill posts due to low number of applicants. Members observed these recruitment issues were partly to do with wage levels - domestic staff and new care workers are on same wage, and other industries are targeting care workers (eg supermarkets such as Aldi, Lidl).

The use of agency workers seemed to have mixed results, through discussions with care home staff. Where it has worked well, this seems to be due to the care home having good working relationships with particular agencies. As a result, some agency staff have come to work full time with the authority. Other care homes have highlighted issues such as having to devote existing care staff resource to train up agency workers and inconsistency in who the agency sends, which can have the possibility of confusing the residents. There was also varying satisfaction levels with the dependency tool which is used by care home staff to ensure there is the required ratio of care workers to residents. However, overall it seems to be working for the care homes.

Recommendation 10. The Strategic Director of Adult Care considers further ways of ensuring there is adequate provision of care home staff, either by considering the use of a pool of relief care home staff who can provide short term placements where required or by making efforts to centralise the more clerical aspects of the recruitment process as to reduce the burden of unit managers.

Members also noted that some care homes did have vacancy issues as a result of the change to the 3 shift rota system which is being implemented by the authority. However, there was also very positive feedback received as a result of the change. Members observed numerous staffing issues over the schedule set of visits, some of which fall outside the remit of this review. Members would be keen to follow up on this though, which may be through a separate piece of scrutiny work. This may include the following:

- The impact of the change to the 3 shift rota system on staffing levels and staff and resident satisfaction
- How night staff can be supported in the new 3 shift rota system
- The impact of the change of activity coordinators into care worker hours
- Care worker staff ratios to residents
- Care staff vacancy levels
- The perception of care work in Derbyshire (and beyond) and how the authority is making it positive

- How to attract care workers and the use of placements in care homes (for example college student placements)
- Care staff wage levels

In the first instance, Members would wish to have a detailed briefing from the Strategic Director of Adult Care on the rationale of the change to the 3 shift rota system and the bulleted areas above.

Recommendation 11 – The Strategic Director of Adult Care arranges a briefing to the Improvement and Scrutiny Committee on the rationale of the 3 shift rota system and the impacts on care home staff and residents.

Key Observation 9*: **Some residential care homes benefit from having access to a Handyperson to provide maintenance and free up time for Care Home staff. However, this resource is not across all of the authority's homes.***

Members observed throughout the visits to residential care homes that there are maintenance jobs, such as decorating, furniture building/repairing, light fittings which can have a big impact on the overall health and wellbeing of the residents. Members noted that some homes, relied on the goodwill of volunteers or whilst in others, work had to be arranged through the Care Home Manager. The former is very positive but may not be a sustainable solution, and the latter can be time consuming (for example having to obtain 3 quotes from contractors) and can be disruptive to residents.

Members observed the use of Handyperson who works across residential care homes in North East Derbyshire and Chesterfield (as well as buildings managed by the authority). The feedback was that it was a very good resource and used a lot. It was observed that there was a plan for this type of resource to be rolled out across Derbyshire, but this doesn't seem to have been done.

Recommendation 12. The Strategic Director of Adult Care discusses with Property Services the viability of having a Handyperson to service all residential care homes in Derbyshire. It would be desirable to have an individual assigned to a set of residential care homes who would be able to take care of minor garden maintenance and specific cosmetic work within the home.

Key Observation 10*: **Many of the authority's residential care homes in Derbyshire are housed in dated facilities and require considerable refurbishment to ensure staff can deliver the most effective means of care in the contemporary environment.***

Members upon speaking to care staff have seen how the demands of the care system has changed in the last few decades. Unfortunately many residents still reside in buildings of a different era. Whilst staff generally do an excellent job in coping with more dated facilities and refurbishments appear to be taking place often, too much excitement amongst the staff, they do not seem to fundamentally change the internal structure of the buildings.

As larger facilities have recently been or are planned to be built, it is conceivable that some of the older facilities continue with lesser numbers of residents. Even in the current environment many older homes that originally housed around 40 residents have seen that number reduce to between 20 and 30. There is a possibility of a more comprehensive refurbishment of these older facilities which could see the creation of larger bedrooms and / or ensuite facilities which would bring said homes in line with some of the County's newer buildings.

Recommendation 13. The Strategic Director of Adult Care will consider a more comprehensive refurbishment programme of the authority's residential care homes in the future considering that newer build facilities are able to accommodate larger number of residents and that many existing facilities are struggling to meet the structural needs for the delivery of residential care in the 21st century.

3. Background to the report

In recent years, there have been developments in the statutory duties on Local Authorities that can impact on provision of services in Adult Care. This includes the responsibility for Public Health, which moved over to Local Authorities in 2012 and changes to the governance of Public Health. The Social Care Act 2014 has also added responsibilities onto Authorities. In addition, there are inspection regimes including the Care Quality Commission (CQC) and Derbyshire Healthwatch, through their Enter and View programme.

The review will aim to understand how best the authority can ensure the consistent delivery of care to residents of its care homes. This will include the extent to which potential and actual care home residents (and their families) are supported and listened to, so their care needs are met. The review will focus the following key lines of enquiry:

- The authority's response to Derbyshire Healthwatch's programme of Enter and View visits to the authority's care homes.
- How standards are maintained to provide the appropriate level of care, for example risk assessments, social workers and care plans.
- How staffing levels are appropriately managed and residents are placed in facilities appropriate to their care needs.
- How residents are being treated with dignity and how a quality of life is maintained.
- The use of appropriate auditing to ensure the measurement of compliance to standards.

The working group were clear that the visits would not replicate inspections by the Care Quality Commission (CQC) or Derbyshire Healthwatch. However, Members noted some of the guidance and research by the CQC.

The CQC report 'Better care in my hands' emphasised the importance of residents' relatives being able to help plan their care and support. The CQC's more recent guidance 'Information on visiting rights in care homes' explains that such involvement is better enabled by family members being able to visit residents in their home, talk to the staff and pass on their feedback.

Care home staff should respect residents' relationships and allow as much privacy for visits as possible. Where this is not facilitated, the provider may be breaching a number of regulations contained within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which may result in the CQC exercising its enforcement powers.

The guidance states the following questions in relation visiting will be considered when services are inspected:

- How are people supported to maintain good health, have access to healthcare services and receive ongoing healthcare support?
- How is people's privacy and dignity respected and promoted? Are people's relatives and friends able to visit without being unnecessarily restricted?
- How do people receive personalised care that is responsive to their needs? How are people encouraged and supported to develop and maintain relationships with people that matter to them and avoid social isolation?

It is noted that inspectors will expect to see:

- Where individuals lack capacity to make decisions regarding their care, their friends and family are involved as appropriate
- Staff are proactive, and make sure that individuals are able to keep relationships that matter to them
- Concerns and complaints are always taken seriously, explored thoroughly and responded to in good time
- Where the resident lacks capacity to make decisions in relation to who visits them
- The guidance states that visitors should be allowed unless there are compelling reasons that permitting such visits would not be in the resident's best interests. Decisions to restrict visits should be agreed through a Mental Capacity Act decision making process.
- Where visitors have concerns regarding the provider

Providers should note that the regulations state that people must be able to make complaints and complainants must not be discriminated against or victimised. A resident's care and treatment must not be affected if a complaint is made by them or by any other person on their behalf.

Providers have a duty to prevent those who are using their service from suffering abuse, from staff and others they have contact with including visitors. The guidance recommends providers should talk to the visitor in the first instance and if the behaviour giving rise to the concern continues, a provider should assess the level of risk and the impact upon the resident. There may of course sometimes be circumstances where the matter requires investigation and/or a referral to adult safeguarding becomes necessary.

4. Initial Research

Legislative background

Local authorities have a range of responsibilities towards care home residents, both as commissioners of services (with a 'duty of care' towards those residents) as a result of general statutory safeguarding and wellbeing duties under the Care Act 2014. This applies whether or not they run the homes themselves and regardless of whether a resident pays their own fees or not

The Care Act 2014 has created a single, modern law that makes it clear what kind of care and support people can expect. The Care Act builds on recent reviews and reforms, replacing numerous laws, to provide a coherent approach to adult social care in England. It modernises the framework for care and support and sets out new duties for local authorities and partners, and new rights for service users and carers. The Act aims to achieve;

- Clearer care and support
- Duty to promote wellbeing, prevent and delay the need for specialist services
- People having more control of their care

The Act includes a statutory requirement for Local Authorities to collaborate, co-operate and integrate with other public authorities, e.g. health and housing.

The Department of Health's 2014 fundamental standards for health and social care providers emphasise the importance of person-centred care, including the provision of 'meaningful' activities that promote mental stimulation and can improve general health. Such activities can also help avoid challenging behaviours

National context

The Care Quality Commission (CQC), the independent regulator of health and social care in England have recently published their ‘The state of adult social care services 2014 to 2017’. The report highlights key findings from over 33,000 inspections of around 24,000 adult social care locations. In summary these were:

- Four out of five adult social care services in England were rated as good or outstanding.
- Nearly a fifth of services were rated as requires improvement.

- Of the five key questions of all services, safe and well-led have the poorest ratings, with around a quarter that requires improvement and inadequate.
- Caring was the best rated question – 92% good and 3% outstanding.
- Community social care services (eg supported living and Share Lives) were rated the best overall.
- Nursing homes remained the biggest concern.

The National Institute of Clinical Excellent (NICE) published guidance on what local authorities achieve by helping the health and wellbeing of older people in care homes. The key recommendations were:

- Provide meaningful, person centred activities
- Reduce medication errors
- Monitor for malnutrition
- Prevent falls
- Reduce healthcare-related infections
- Avoid delirium and monitor for depression
- Help people retain their independence and identity
- Support people with dementia

The Better Care Fund

The Better Care Fund is the only mandatory policy to facilitate integration. It brings together health and social care funding, with a major injection of social care money announced at Spring Budget 2017 (£2bn).

The policy framework for the Fund covers two financial years to align with NHS planning timetables and to give areas the opportunity to plan more strategically. Details of the financial breakdown are below:

Better Care Fund funding contribution (£bn)	2017-18	2018-19
Minimum NHS (clinical commissioning groups) contribution	£3.582	£3.65
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.431	£0.468
New grant allocation for adult social care (Improved Better Care Fund)*	£1.115	£1.499
Total	£5.128 billion	£5.617 billion

*Combined amounts announced at Spending Review 2015 and Spring Budget 2017

Many areas choose to pool more than is required. For 2017-19, there are four national conditions, rather than the previous eight:

- Plans to be jointly agreed
- NHS contribution to adult social care is maintained in line with inflation
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care
- Managing Transfers of Care (a new condition to ensure people's care transfers smoothly between services and settings).

Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance in the following four metrics:

- Delayed transfers of care
- Non-elective admissions (General and Acute)
- Admissions to residential and care homes
- Effectiveness of reablement

Derbyshire context

It is the statutory responsibility of Derbyshire County Council (DCC) Adult Care Department under the Care Act 2014 to ensure there is a range of good-quality accommodation options available for older people. Over the last 10 years, the balance of care options has shifted from "traditional residential care" to more community-based options, including extra care.

Despite this shift, Derbyshire, in comparison to similar authorities, has a higher rate of permanent admissions of older people into residential and nursing care (in 2013-14 DCC admitted 715 people per 100,000 population compared to the East Midlands average of 690 people per 100,000 population).

As a result, Derbyshire has a higher level of additional expenditure (9.25%) on residential care services than its comparators. In Derbyshire, the breakdown of CQC ratings for registered care homes are:

- Good = 9
- Requires Improvement = 9
- Assessed as meeting all required standards = 1
- Not yet assessed (new service) = 3

5. Data and information on Residential Care Homes

Members noted the following data and information supplied by Adult Care in regard to individual residential care homes. This was used for preparation for each visit by Members.

Care Home information – beds and staffing

Number of beds

Beds		Beds				
		Total beds	Specialist Community Beds (with Therapy) Total number	Specialist Community Beds (without Therapy) Total number	Short term care beds Total number	Long term care beds Total number
AV	Ada Belfield	25	0	2	1	22
AV	Rowthorne	40	0	0	2	38
AV	Florence Shipley	32	8	0	8	16
ERE	Briar Close	40	0	0	2	38
ERE	Ladycross	35	0	1	4	30
ERE	Lacemaker Court	16	0	0	0	16
ERE	Hazelwood	30	0	1	2	27
ERE	Beechcroft	40	0	0	2	38
SD	Castle Court	41	0	0	3	38
SD	Oakland	32	8	0	4	20
DD	Gernon Manor	33	0	0	1	32
DD	The Leys	35	0	0	1	34
DD	Meadow View	32	0	6	10	16
BOL	Holmlea	40	1	0	4	35
BOL	Thomas Colledge	24	0	3	3	18
BOL	New Bassett House	40	0	0	4	36
BOL	East Clune	27	0	0	4	23
CHE	Staveley Centre	32	5	3	8	16
CHE	The Spinney	37	0	0	2	35
NED	The Grange	25	6	2	2	15
HP	Goyt Valley House	30	0	1	1	28
HP	Whitestones	41	0	2	3	36
	Average	**33.0**	**1.3**	**1.0**	**3.2**	**27.6**

Residents per staff

Members noted the total number of residents per head of staff, which has remained relatively stable overall (albeit with some larger fluctuations in some individual homes).

Residents per staff		2016-17	2015-16	2014-15	2013-14
		Total number of residents per head of staff	Total number of residents per head of staff	Total number of residents per head of staff	Total number of residents per head of staff
AV	Ada Belfield	2.2	2.6	2.5	3.0
AV	Rowthorne	2.5	2.9	3.0	3.1
AV	Florence Shipley	1.2	1.8	NA	NA
ERE	Briar Close	2.5	2.7	3.0	2.7
ERE	Ladycross	2.7	2.8	2.7	2.9
ERE	Lacemaker Court	1.2	1.7	NA	NA
ERE	Hazelwood	2.7	2.7	2.7	2.8
ERE	Beechcroft	3.0	3.0	3.1	2.7
SD	Castle Court	3.4	3.2	3.0	2.7
SD	Oakland	1.1	1.3	1.3	1.1
DD	Gernon Manor	2.5	3.1	3.2	3.1
DD	The Leys	2.2	2.9	3.2	NA
DD	Meadow View	1.1	NA	NA	NA
BOL	Holmlea	2.7	1.7	2.6	2.9
BOL	Thomas Colledge	2.6	4.3	2.8	2.8
BOL	New Bassett House	2.9	2.5	3.1	3.2
BOL	East Clune	3.8	5.6	2.9	2.9
CHE	Staveley Centre	1.0	1.3	1.1	1.0
CHE	The Spinney	2.3	5.9	2.7	2.7
NED	The Grange	2.7	3.8	2.8	2.8
HP	Goyt Valley House	2.4	3.1	2.7	2.7
HP	Whitestones	1.8	1.9	2.2	2.1
	Average	**2.3**	**2.9**	**2.7**	**2.6**

In addition, Members noted staffing hours. The information provided prior to and including 2015/16 covered previous years going back a minimum of 5 years. The staffing hours after 2015/16 were based on a restructured arrangement which included the introduction of a Senior Care role and the standardisation of rotas, with an additional “flexible” pot of hours.

Management per head of staff

Members noted the management per head of staff, which had some fluctuations between homes and years. Further analysis may be required, outside of this review, for the detailed reasons for these fluctuations.

Management per head of staff		2016-17	2015-16	2014-15	2013-14
		Management per head of staff	Management per head of staff	Management per head of staff	Management per head of staff
AV	Ada Belfield	7.3	6.2	2.8	2.2
AV	Rowthorne	6.5	13.6	3.7	3.5
AV	Florence Shipley	8.6	17.5	NA	NA
ERE	Briar Close	15.9	14.6	3.6	4.0
ERE	Ladycross	4.8	3.7	4.4	3.5
ERE	Lacemaker Court	5.1	4.6	NA	NA
ERE	Hazelwood	5.5	4.1	3.7	3.0
ERE	Beechcroft	6.7	3.6	3.3	3.7
SD	Castle Court	6.0	7.6	3.7	5.7
SD	Oakland	7.2	3.9	4.0	4.7
DD	Gernon Manor	6.5	4.2	2.8	2.9
DD	The Leys	7.9	3.4	3.0	NA
DD	Meadow View	9.3	NA	NA	NA
BOL	Holmlea	7.5	14.4	4.2	4.6
BOL	Thomas Colledge	4.7	2.6	4.3	1.7
BOL	New Bassett House	6.8	4.2	3.6	3.0
BOL	East Clune	3.0	2.4	2.6	2.5
CHE	Staveley Centre	10.4	6.7	4.6	4.7
CHE	The Spinney	7.9	0.2	4.3	3.7
NED	The Grange	5.1	4.3	2.4	3.1
HP	Goyt Valley House	6.4	13.0	3.0	3.1
HP	Whitestones	11.1	6.0	5.0	5.2
	Average	**7.3**	**6.7**	**3.6**	**3.6**

Average length of service

Members noted the average length of service, which has remained relatively stable overall (albeit with some larger fluctuations in some individual homes). Further analysis may be required, outside of this review, for the detailed reasons as to why there are large disparities between homes (sometimes 5+ years).

Average length of service		2016-17	2015-16	2014-15	2013-14
		Average length of service of staff	Average length of service of staff	Average length of service of staff	Average length of service of staff
AV	Ada Belfield	5.8	9.2	10.4	14.0
AV	Rowthorne	10.1	9.4	8.5	9.5
AV	Florence Shipley	5.0	2.0	NA	NA
ERE	Briar Close	8.5	11.8	11.4	10.1
ERE	Ladycross	9.4	10.2	10.0	10.8
ERE	Lacemaker Court	7.9	8.8	NA	NA
ERE	Hazelwood	6.9	6.4	7.7	7.9
ERE	Beechcroft	12.9	10.0	9.8	8.6
SD	Castle Court	11.4	12.2	11.3	10.6
SD	Oakland	6.2	5.1	4.5	3.7
DD	Gernon Manor	8.8	10.4	11.2	10.3
DD	The Leys	5.5	5.8	12.3	4.9
DD	Meadow View	10.6	NA	NA	NA
BOL	Holmlea	11.8	13.1	12.0	12.8
BOL	Thomas Colledge	15.0	16.2	15.2	14.4
BOL	New Bassett House	11.5	15.5	15.0	14.7
BOL	East Clune	9.1	11.8	12.0	13.5
CHE	Staveley Centre	7.6	9.0	9.4	8.1
CHE	The Spinney	14.6	13.3	12.3	11.5
NED	The Grange	16.3	16.3	4.7	14.2
HP	Goyt Valley House	9.6	8.5	7.3	7.8
HP	Whitestones	6.8	8.1	8.9	9.6
	Average	**9.6**	**10.1**	**10.2**	**10.4**

During care home visits, Members discussed with Care Home Managers staffing, including vacancy rates, use of agency staff and general staff turnover. The outcome of these discussions is reflected in the key observations.

Care Home information – Medication Errors/Slips and Trips/Falls:

The following information and data has been summarised for further scrutiny:

Medication Errors:

The total amount of medication errors recorded between 2015 and 2017 was 698 across all the authority's residential care homes. The vast majority of these (87%) was attributed to recording errors – therefore more administrational issues than dispensing to residents.

Type of med error	Number of errors	% of all errors
TOTAL MED ERRORS	**698**	
Recording Error	605	86.7
Dose omitted	43	6.2
Wrong quantity given	17	2.4
Medication given at wrong time	13	1.9
Double dosed	5	0.7
Wrong client	5	0.7
Wrong medication given	4	0.6
Medication dropped or found out of place	2	0.3
Medication given but not needed	2	0.3
Medication given from wrong packet	1	0.1
Medication missing	1	0.1

In terms of causes of medication error, nearly half (43%) was because of interruptions. Indeed, of all recording errors, the most came from being interrupted. Forgetting to sign was the second highest cause of medication error, with just over a quarter (27%).

Cause of med error	Number of errors	% of all errors
TOTAL MED ERRORS	**698**	
Interruptions	302	43.3
Forgot to sign	186	26.6
Unknown	89	12.8
Human error	76	10.9
Unclear labelling instructions caused confusion	17	2.4
Misread MAR	11	1.6
Other	17	2.4

Slips and Trips

The number of slips and trips in the last three years which have been recorded is 4,186. However, the vast majority were not considered a reportable incident (81%). The data does state that in 11% of causes, a head injury did occur and head injury guidance was followed. In nearly half (48%) of recorded slips and trips, the injury was considered as a result of it. The tables below summarise this data.

Type of med error	Total	Yes	%	No / Not recorded	%	Not found / other	%
TOTAL SLIPS AND TRIPS	**4,186**						
Was it a reportable incident?		22	0.5	3,409	81.4	755	18.0
Did a head injury occur?		459	11.0	3,727	89.0	n/a	n/a
Was the injury result of a fall?		2,008	48.0	1,969	47.0	209	5.0

Falls data:

There have been 22 recorded falls in residential care homes from April 2014 to September 2017. Nine had occurred in the resident's bedroom, with a further 7 in the Lounge. Fractures resulted in half of the falls. Out of the 22 recorded falls, 12 resulted in the resident going to hospital (although it is unclear what 'major injury' means in terms of whether they had to attend A&E).