

Enter & View Bi-Annual DCC Summary Report March 2019

For visits commissioned by Derbyshire County Council 2018-2019

WHAT IS ENTER AND VIEW? Healthwatch Derbyshire (HWD) is part of a network of local Healthwatch across the country established under the Health and Social Care Act 2012. HWD represents the consumer voice of those using local health and social services.

The statutory powers of all local Healthwatch include that of conducting Enter and View visits to any publicly funded adult health or social care services. Enter and View visits may be carried out if providers invite this, if Healthwatch Derbyshire receive information of concern about a service and/or equally when consistently positive feedback about services is presented. In this way we can learn about and share examples of the limitations and strengths of services visited from the perspective of people who experience the service at first hand.

Visits conducted are followed by the publication of formal reports where findings of good practice and recommendations to improve the service are made.

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1. The context

During 2018/2019, Healthwatch Derbyshire were re-commissioned by Derbyshire County Council (DCC) to conduct a range of unannounced visits to 13 of their 26 residential services across the county. The service profile and range included 11 services supporting older persons and two services supporting people who have learning disabilities/ difficulties.

Visits have been managed by the Healthwatch Enter and View Officer and the principles of the visiting schedule agreed with the DCC Service Manager (Direct Care) Quality and Compliance, Emma Benton. These respective officers maintained regular communications concerning visits and reports through a quarterly cycle of meetings.

This is the second and final summary report for the commissioning period, the first being published on 21st September 2018 (<https://healthwatchderbyshire.co.uk/2018/09/enterview-bi-annual-derbyshire-county-council-summary-report/>) and reported on the first six visits undertaken. This report represents the remaining seven visits undertaken from the end of July until late November 2018 when all visits had been fully completed.

All of these Enter and View visits were commissioned to complement DCC's own internal quality audit system, hence individual reports have only been made available to DCC and not

placed in the public domain. However, the summary reports, reflecting the findings of the individual visit reports had been agreed to be made public.

The schedule of visits were co-ordinated with Care Quality Commission (CQC) local inspectors to ensure that visits by either organisation were not too close in proximity to one another. Visits were undertaken by Healthwatch Derbyshire Enter and View Authorised Representatives (ARs) who are volunteers fully trained to undertake such activities.

2. Completed visits

No.	Service visited	Type of service	Date of visit	Authorised representatives (ARs)
1	Florence Shipley Residential & Community Care Centre	Older persons	27 th July 2018	David Mines, Barbara Arrandale & Helen Barker
2	Holmlea Care Home	Older persons	30 th August 2018	Caroline Hardwick, David Weinrabe & Keith Eaton
3	The Bungalow	Learning disabilities	28 th September 2018	Denise Bowles (Specialist Authorised Representative supported by Daniel Pidkorczemny), Mary Beale & Hannah Morton
4	The Leys	Older persons	10 th October 2018	Ruth Barratt & Mary Beale
5	Oakland Village Residential & Community Care Centre	Older persons	24 th October 2018	Keith Eaton & Brian Cavanagh
6	Meadow View Residential & Community Care Centre	Older persons	29 th October 2018 & 21 st November 2018	First visit: Helen Barker, Kay Durrant & Craig Dunstan Second visit: Daniel Pidkorczemny & Megan Martin
7	The Spinney	Older Persons	7 th November 2018	Jacquie Kirk, Shirley Cutts, Denise Bowles (Specialist Authorised Representative supported by Margaret Morrison)

Some visits are attended by Healthwatch Derbyshire specialist authorised representatives (SARs) who are people who have learning disabilities. They have been trained since 2016 and

whilst initially using their expertise with visits only to learning disability services, they now act as ARs across all services.

The SARs require support by another AR during their visits, as identified above, and are equipped with an easy-read checklist based upon the checklist tool designed for the visits (Section 6 refers).

As indicated by the table above, six of the homes supported older persons who were living with varying degrees of dementia and commonly additional mobility problems. The service for people who have learning disabilities, some of whom had additional complex needs including mobility difficulties, offered short term/respite care and independent living assessment and training facilities.

3. Acknowledgements

Healthwatch Derbyshire would like to thank DCC, the care home unit managers, residents/clients, visitors and staff for their contributions to these Enter and View visits, and to those who have been involved subsequently.

4. Purpose of visits

- To enable Healthwatch Derbyshire ARs to see for themselves how services are being provided in terms of quality of life and quality of care principles
- To capture the views and experiences of residents/clients, family members/friends and staff
- To consider the practical experience of family/friends when visiting the service in terms of access, parking and other visitor facilities
- To identify areas of resident/client satisfaction, good practice within the service and any areas felt to be in need of improvement
- To support DCC Direct Care Services internal quality audit system.

5. Disclaimer

This bi-annual summary report collates the findings gathered across the range of visits undertaken on the specific dates as set out in Section 2. Such individual visit reports are not suggested to be a fully representative portrayal of the experiences of all residents/clients and/or staff and/or family members/friends associated with services, but do provide an account of what was observed and presented to HWD ARs at the time of their visits.

6. Methodology

During visits ARs are provided with a set of standardised evidence gathering tools and generally employed the following techniques in undertaking each visit:

- Direct observation of interactions between staff and residents/clients
- Participant observation within therapeutic/social activities where appropriate
- Assessing the suitability of the environment in which the service operates in supporting the needs of the residents/clients
- Observing the delivery and quality of care provided
- Talking to residents/clients, visitors and staff (where appropriate and available) about their thoughts and feelings regarding the service provided
- Observing the quality and adequacy of access, parking and other facilities for visitors.

7. Summary of key data & findings across all visits

- Each visit on average took approximately three and three-quarter hours to undertake
- Observations by ARs generally included the full range of residents/clients and staff present during the visit, plus any visitors who were present
- Due to the nature of the capacity limitations of many residents/clients, discussions and/or questionnaire-based interviews were restricted. In total:-
 - (i) 21 individual residents/clients were engaged with and participated within their capacity in responding to questionnaire-based interviews. Many other residents in each setting were observed
 - (ii) 13 relatives/friends participated in questionnaire-based interviews
 - (iii) 24 members of staff participated in questionnaire-based interviews.
- Healthwatch findings were generally comparable to the previous reports issued with good overall care standards maintained and a range of individual improvements noted (see 10.1)
- Healthwatch findings were mostly aligned with the current CQC's published reports positive findings (see 10.2)
- Residents and relatives continue to consistently express an appreciation of the high quality of care experienced and confidence in the staff delivering care
- Residents felt safe and both residents and relatives felt confident in raising concerns if they had any
- Building maintenance (internal and external) was generally noted to be of a high standard
- Home reports reflected some concerns with organised programmes of activity with five of the seven homes indicating the wish for a greater range and frequency to be offered
- Residents continue to speak positively about the quality of food/meals received and the choices offered
- Improvements in the maintenance of the garden areas were noted across the homes.

8. Detailed findings across all visits

8.1 Location, external appearance, ease of access, signage, parking

All homes were found to be well located and in close proximity to local facilities. Generally external signage was found to be adequate but improvement was suggested in three homes, two of which had actioned the recommendation. One was awaiting the outcome of the request whilst another had not been previously successful in obtaining additional signage as the DCC Highways Commission had refused the request.

Whilst homes visited represented builds from 1970's to contemporary constructions, all homes appeared well maintained externally. However, the issue of external security, previously noted in the September 2018 summary report, continues to be a potential issue in some homes (see 8.8.3).

On-site parking was available at all homes and generally satisfactory with designated disabled parking spaces available for most. Parking facilities were noted to be limited in some cases especially in establishments which shared this facility with other users.

8.2 Initial impressions (from a visitor's perspective on entering the home)

Across all homes, ARs reported positive impressions on entering the homes. Overall, the entrance areas were clean and fresh except for one visit where an unpleasant odour was noted and addressed positively by the service. The entrances to homes in the main provided a 'homely', welcoming space with a range of relevant information for visitors.

One home uniquely featured a "digni-tree" in the foyer area which was a cardboard tree displaying art work of clients. At the base of the tree was a range of toiletries which was explained as being for clients admitted more urgently and may not have brought such personal items with them.

Throughout the homes, it was highlighted that all staff were well-presented and in uniforms. In addition, all staff were noted to be polite, friendly and welcoming to ARs, residents and visitors.

All homes featured up-to-date CQC certificates which were prominently displayed within the entrance area of each home.

8.3 Facilities for and involvement with family/friends/community

Visiting times across all services were flexible and relatives met commented how welcomed they felt when visiting.

The majority of services provided good facilities for visitors to meet their loved ones in comfortable areas and if more privacy was required, they could use the resident's bedroom or designated quiet rooms, if available.

Refreshment facilities for visitors were generally good with the majority having dedicated kitchenettes where hot drinks and other refreshments could be taken. In the residential and community care centres on-site cafés, which were also open to the public, could be used.

Provision for overnight stays for relatives was available across all homes in the form of fold-up beds/reclining chairs or the use of a spare bedroom if available.

Relatives interviewed all felt involved in the care of their loved ones and comfortable with raising concerns if and when they arose (8.8.3 refers). Relatives interviewed appreciated the regular contact from the homes via telephone, and in one home the use of Skype and FaceTime by residents to maintain contact with their families. Relatives reported that they were invited to relatives/residents meetings and in one service regular coffee mornings were held. Relatives found in all homes that the staff were, “... **supportive, caring and reassuring.**”

Across a number of homes there was a clear involvement with the local community, examples of which in one or two homes were regular visits by a local scout troop to help with gardening, visits by local church members and schools.

8.4 Internal physical environment

8.4.1 Décor, lighting, heating, furnishing & floor coverings

Across the vast majority of homes, the décor and furnishing was noted to be in excellent condition and generally selected/designed to create a ‘homely’ atmosphere.

A few homes were in the midst of their rolling programme of refurbishment which was designed to include improving out-dated furnishing/décor. One of these was also addressing a problem with newly laid carpets which were causing some difficulties for residents using mobility aids.

Throughout the homes, it was found generally that it was warm enough in accordance with the outside temperature. Residents, staff and visitors indicated satisfaction with the internal temperature except in one instance in one of the residential and community care centres, where a member of staff suggested that the significant use of glass in the building made it particularly hot in the summer. The staff member did state however that air-conditioning was being considered to resolve this issue.

8.4.2 Freshness, cleanliness/hygiene & cross-infection measures

As indicated under 8.2 and 8.4.1, it was found that the standard of hygiene and general cleanliness of the homes visited was very good with the exception of one home noted under 8.2 where an unpleasant odour was sensed as one entered the building. An additional issue observed in two homes was that waste paper hand towel bins were overflowing in the communal toilet areas.

Hygiene measures to reduce cross-infection appeared to be well established across the homes. It is noted that staff hand hygiene is mainly addressed by staff carrying personal hand gel bottles rather than using any dispensers that may be sited around the home.

Issues across homes of the consistency in adopting routine hand hygiene was raised in the last, and previous reports. The last report (September 2018) recommended DCC consider strategies for educating staff and residents through poster displays on hand hygiene and DCC responded as follows:

‘A new poster is available in the Infection Prevention and Control Policy which has just been launched. Managers will be reminded to print off and laminate signs and place them at each communal sink. Staff will encourage residents to wash their hands before and after meals times. Hand wipes are provided for staff to offer to residents who do not want to or cannot easily wash their hands.’

Whilst for the majority of visits such posters were not commented on by ARs, at one home these were clearly evident in clear ‘easy read’ formats in bathrooms/toilets and where hand gel dispensers were located in communal areas. ARs also observed in one home the use of hand wipes for residents at a meal time, whilst at another home their use was not observed at the mealtime.

8.4.3 Suitability of design to meet needs of residents

As referred to under Section 2, all homes visited supported a number of people who had mobility difficulties and as indicated six of these provided care for older persons who were living with varying degrees of dementia. The other home supported comparatively younger people who have learning disabilities (some with additional physical disabilities).

Overall, it was found that each of the homes were designed well in meeting the needs of those using the services. However, the older homes had some challenges to space and layout which the newer buildings did not. It was noted that in one or two homes, refurbishment opportunities were being used to address some of these restrictions wherever possible e.g. providing a ramped access to the outside in one home and creating a quieter space away from the main communal areas in another. Nevertheless, some of these older homes continue to have structural constraints, for example size of bathrooms, bedrooms and limitations of available en-suite facilities, all of which have been raised and acknowledged in past reports. However, communal bathrooms were noted to be conveniently located next to the communal lounges, allowing for ease of access.

The majority of homes used the communal spaces well, creating a variety of areas for quieter or more interactive purposes and the ambience created was relaxed and sociable (8.7.4 refers). Observations reflected that residents with a variety of additional needs moved around their home environments with comfort and ease due to the size of corridors, doorways and adaptations available to aid mobility (8.5 refers).

Internal navigational and orienting signage had been identified previously by Healthwatch as an area to improve in some homes and whilst some perceived deficits were identified in two of the homes, one stated that this would be addressed after refurbishment. It is also acknowledged that DCC use the advice and guidance of Sterling University in equipping homes with suitable dementia-friendly design.

Hearing loop systems were found to be available in one of the homes and were recorded as not being available at another two but no further observations in the other homes were recorded by ARs.

8.5 Accessibility

8.5.1 Adaptations, environment and furnishings (visitors & residents)

As indicated under Section 2, all homes visited supported individuals who often had additional mobility difficulties. Overall homes were designed well to support the additional needs of residents who have mobility challenges and/or dementia. Corridors were equipped with appropriate hand rails and doorways tended to be sufficiently wide.

All communal bathrooms/toilets appeared to be well equipped with suitable aids available for moving and handling.

In 8.1, disability parking was mentioned and it was noted that this facility was not evident in one of the homes. In response to the resultant recommendation, the manager stated that,

‘The DCC Business Unit will be contacted to request the painting of lines in the car park to provide marked disabled parking.’

As referred to above in 8.4.3, hearing loop systems were only noted as being in-situ in one report and stated as not being so in definitely two of the homes. Healthwatch assume from having raised this as a concern previously that all homes, where relevant, have had or will be having these installed. DCC stated in the September summary report that,

‘A tender is to be drawn up for hearing loop services for Adult Care. Information has been requested from specialist social work staff to formulate the specification.’

8.6 Staff support skills & interaction

8.6.1 Affording dignity & respect and approach to care giving

A consistent and commendable feature of all past Enter & View visits and equally evident in those covered by this report, is the high level of satisfaction expressed by both residents and relatives on the quality and care offered by full-time staff within the homes. The one exception to this was a concern raised by a relative who considered that the care offered by agency staff members was not of equal quality to that of the permanent staff.

Across all homes, staff were noted to provide care in a manner to suit the individual’s needs. This was always observed to be caring, friendly and calm ensuring dignity and respect is offered within all interactions.

As indicated, appreciation was expressed by both residents and relatives across the range of visits undertaken. Comments from residents regarding the care and support delivered by staff included:

“supported well”

“get help at the right time”
“very nice here, staff are helpful”
“staff do anything for you”
“lovely people, staff are friendly”
“I can’t say a wrong word about the staff”
“... kind and caring - no complaints.”

The sentiments offered by family and friends of residents are encapsulated by this single comment, *“... they treat my relative as a human; that’s why I have full faith in the staff here.”*

8.7 Residents’ physical welfare

8.7.1 Appearance, dress & hygiene

Across all homes, residents were observed to be well groomed in terms of their appearance, dress and hygiene.

It was identified that residents within the older person’s services were able to access a hairdresser on a regular basis at an on-site salon facility.

During the visits, all residents were observed to be wearing clothing of their own choice and indicated that they had no pressure to get dressed by certain times.

8.7.2 Nutrition/mealtimes & hydration

Generally meals were found to be of a good standard with a variety of choice and alternatives available. In some isolated cases individual residents gave some minor criticisms about the menus but all homes appeared to have good systems for discussing individual choices with residents.

Comments from residents included:

“excellent”
“good choices available every day”
“very filling”
“desserts are not as appetising as they used to be; jelly and ice cream rather than sponge puddings”
“good choice, set mealtimes but like sitting in dining area together.”

All homes provided flexible breakfast times and choices of where residents wished to take their meals. The vast majority of residents used the communal dining areas which were always set out well and created a relaxed, unhurried, social environment in which to take meals. In one home a staff member said that alcoholic drinks could be served with meals if requested. In one home ARs did observe a resident having a small glass of whiskey before lunchtime.

Menu boards were displayed in most homes with some working toward having improved presentations in more ‘easy read/pictorial’ formats.

Across the homes, snacks and beverages were readily available for residents to help themselves and/or provided throughout the day.

8.7.3 Support with general & specialist health needs

Across all homes, it was found that residents were being supported well with any additional health needs. It was apparent that either local GPs or district nurses visited the homes on a regular basis attending to all residents who required medical assistance. At one home a district nurse (and a chiropodist) were present during the visit by ARs.

Other services such as chiropody, physiotherapy, sight and hearing services etc were also readily available. Only one resident interviewed across all services was not completely satisfied with the management of the health care provided. They conveyed to ARs that the communication between healthcare professionals involved and himself was lacking as he had no idea how he was progressing, or what the future plan was for his care. The resulting recommendation in this home's report led to a positive response as follows:

'This has been discussed in our joint meeting with health colleagues. All agreed this was an area where we could improve. It has been agreed that a simple, easy to read daily care plan will be developed for clients, carers and families to be involved in and to use to support a client's rehabilitation.'

Within the learning disability service visited, a staff member stated that, ***"All of our clients are under the SALT [speech and language therapy] teams and if they need access to any other services, we make sure they have it."***

Dental services were not mentioned specifically during any visits. However according to the findings of a separate Healthwatch report, *'Oral Hygiene in Care Homes across Derbyshire'* published in November 2018, it would appear that the needs of residents in this respect were being met quite satisfactorily albeit that local dental services are not offering to visit the homes. Whilst staff and residents appeared satisfied with oral hygiene standards provided staff indicated the need for further oral care training.

Stimulating exercise/mobility was only raised in the visit made to the learning disability service, where a staff member stated, ***"... we do encourage exercise here too. The other day, clients were watching exercise TV and we all joined in and copied their actions."***

8.7.4 Ensuring comfort

All homes visited provided a socially and physically comfortable environment of care. The vast majority of homes created an ambience which was calm but at the same time appropriately stimulating. All homes were designed in a manner which enabled residents to socialise but also having areas available in which to relax in greater peace and quiet.

A relative interviewed by ARs at one home said, ***"My mum is more than happy here; it's like a hotel."***

Residents were all observed to be relaxed and comfortable within environments visited and provided comments as follows:

“wouldn’t change a thing.”
“everything was worked out to my liking.”

In one instance however, one resident told ARs that they spend a lot of time in their bedroom and did get a sense of being **“isolated”** on occasion. It is noted that a similar individual response was elicited from the previous set of visits undertaken and reported in the first of this year’s summary reports. In this instance the recommendation made a very positive strategy by the home in appointing one of the care workers to monitor this aspect of wellbeing of residents who, for whatever reason, may require some focussed one-to-one time with staff.

8.8 Residents’ social, emotional and cultural welfare

8.8.1 Personalisation & personal possessions

Across the homes it was found that all promoted personalisation of residents’ bedrooms, but degrees of personalisation differed depending on whether individuals were admitted for short or long-term care. One individual told ARs, **“Lovely room, only staying briefly so haven’t got many possessions.”**

ARs were informed, and observed on one or two occasions, that residents’ bedrooms were encouraged to be personalised with ornaments, photographs, memorabilia/memory boxes, soft furnishing, TVs etc. Personal furniture was also able to be brought in within some homes and where this was not possible it was mainly due to the limited space of bedrooms. Bedroom decoration appeared to be individualised within the majority of homes.

Pets were able to be kept by residents in some homes and others encouraged families to bring in pets and one had arrangements with a local petting service who brought in pets from time to time for the residents to engage with.

Whilst only recorded in one visit, ARs observed that residents’ hobbies were also encouraged and supported.

8.8.2 Choice, control & identity

Generally, the promotion of choice, control, independence and supporting individuality of residents was clearly evident across all visits. The degrees to which these could be facilitated however, was dependant on the assessment of risk and the individual’s capacity.

Wherever possible residents were supported in managing their own monies and held their own keys to their bedrooms. However in one home, three residents told ARs that they were not aware of being able to have their own bedroom key. Some homes had double bedroom facilities for couples but these were not in use, where available, at the time of the visits.

Across the homes, residents reported that they were able to choose between having a bath or a shower. The frequency stated in one home was once a week although a resident said they could ask for this to be increased but this was dependant on staff availability. In one home a resident who preferred showers had only been having baths as they said they were not aware of the choice. The resultant recommendation regarding this elicited a positive response from the home in question who said:

‘Care plans do record resident choices. However, residents will be asked on each occasion of their preference for a bath or shower to ensure the option is offered or preferences reaffirmed.’

All residents spoken to appeared to have personal choices and wishes supported. One resident commented, ***“I go to bed and get up whenever I feel like it”***, whilst another said about maintaining their independence that they do such things as, ***“Changing and making my own bed; doing as much as I can myself.”***

Extending what long-stay residents were enabled to do for themselves to other daily living skills such as clothes washing, cleaning or cooking was only evident in one home visited. Within the summary report published in September 2018, this issue was raised and the subsequent recommendation responded to comprehensively including the following:

‘Staff are made aware that residents should be encouraged to maintain involvement in living tasks if they want to, and that they should talk to residents about their wishes and preference to be involved to help inform the updating of care plans.’

In one home, a resident had been supported to open a ‘shop’ to provide confectionary and toiletries. ARs observed the ‘shop’ in action and noted the immense pleasure that the resident gained from this venture.

The majority of homes were found to have facilities for residents who smoked, and some enabled alcohol consumption as indicated under 8.7.2.

8.8.3 Feeling safe and able to raise concerns

Throughout the homes, all residents reported feeling safe and all were observed to be speaking freely with staff during the visits. This was similarly reflected by relatives encountered during visits.

Both residents/clients and relatives felt able to raise concerns. In the few instances encountered where an issue had been raised, everyone involved was satisfied with the swift and supportive manner in which it was addressed. A relative of a client in the learning disability service said, ***“I wouldn’t feel awkward and I feel they would take it seriously.”***

One of the relatives of a resident in an older persons home service, mentioned that their loved one would be the first to raise any issues with staff and would feel confident in doing so, adding, ***“They [their loved one] are a bit fussy, but they seem happy here.”***

Regular meetings, in various forms, were held regularly across the vast majority of homes to involve both residents and relatives. In one home however some residents suggested they were not aware of these and at another a relative also said they were not aware. In one home such meetings had lapsed due to poor attendance by relatives but a newly appointed manager was reviewing this situation and planning to re-establish a forum for communications with relatives.

Physical security within the homes was evident with buzzer alarm systems and sensor mats being commonly available. External physical security however, as referred to in 8.1, continues to pose some potential risks to two homes albeit that it was not raised by staff, residents or relatives.

The issue of external security formed part of the recommendations within the summary report published in September 2018 to which DCC responded as follows:

‘Some work has already been approved to improve the security of outside areas. This issue was also raised as part of a review by the council’s Scrutiny Committee. A review of external security fencing and gates is taking place. Once the outcome of the review is known a plan can be made in accordance with available funding.’

Within the visits covered by this report, the two homes concerned responded positively to the recommendations. In one, the home which was undergoing extensive refurbishment during the visit, staff reported that the public (mainly revellers from the local pub) often at night took a short-cut across the grounds and, additionally, the grounds suffered from deposits of animal excrement. The responses to the recommendation for this and the other home were as follows:

‘... currently has extensive refurbishment work being undertaken. Where the temporary tunnel is currently in place to provide access for the refurbishment work is the area to be securely and privately fenced. This fencing will be in place either at the end of December or early in the New Year. Fencing for the wider perimeter will continue to be pursued by the manager.’

Consideration to be given to further fencing/security measures and discussed with Property Services.’

8.8.4 Structured and unstructured activities/stimulation

The issue of how homes effectively offer a range of stimulating activities for residents has been a consistent feature of reports for more than two years and featured within the first summary reports in 2016. During this period DCC were introducing a new strategy for managing activities for residents by withdrawing the established activities co-ordinator positions within each home and introducing a newly defined senior care worker post which included a lead role in the organisation of activities within the job description.

In summary reports over 2018, evidence was generally indicative that the arrangement of activities across homes remained ‘patchy’. DCC provided responses to recommendations in the March and September summary reports concerning the senior care worker role as follows:

‘An ongoing monitoring process is in place to assess the success of the changes whose aim is to provide staff time to offer a programme of activities. Where the senior care worker post is in place informal feedback is that they have allowed for a clear definition of roles and responsibilities and variety of activities are taking place as a result.’

(March 2018)

‘A review of the implementation and impact of the introduction of the senior care worker role is already planned and aims to be completed by February 2019. Currently, we have 111 senior care worker posts and of these we have 15 vacancies.’ (September 2018)

During the set of visits that this report represents, six of the seven homes had recommendations recorded regarding activities organisation although two of these in the main appeared to have a relatively satisfactory range on offer, whilst another maintained that they had a full programme of activity (although there was limited evidence of this during the visit). The response to the recommendation with respect to this home was as follows:

‘Activities are planned and unplanned. Activities offered on a daily basis include; art and crafts, baking, hand and foot massage, beauty therapy, reminiscence therapy, 1:1 talking etc. These activities are recorded in an activity file and this includes some photographs. An activity file is maintained for each floor. Families are emailed by the manager notifying them of activities. Suggestions for future activities or events can be raised at resident/family meetings, in response to the manager emails or by approaching the manager in person.’

The learning disability service, being primarily short term/respite care, had a bespoke arrangement approach in supporting individuals in their leisure/recreational pursuits.

Three of the homes were in the midst of establishing the senior care worker position and programmes of activities were waiting to be introduced. Responses to recommendations in these instances requesting confirmation of the management of activities were:

‘This has been discussed and two senior care workers have co-ordinated a planned activities programme. The programme has been displayed within the care centre since August 2018.’

‘Planned activities and outings will be discussed at Resident Meetings.’

‘A rota is currently being devised to provide a more robust activity programme within the home. We do have two volunteers, one who visits to play the piano and one who provides the bingo activity which is popular. A poster will be displayed in reception on the resident and visitor board to try and recruit more volunteers.’

Through conversations with staff and residents, it was apparent that in many cases there was a mutual desire for more varied and personalised activities and outings for residents plus time for staff to socialise more with residents.

Comments from residents included:

“I used to enjoy art, creativity and exercises when we had our co-ordinator.”

“We used to go to a church ... to see pantomimes, but we don’t have outings now.”

“... limited activities taking place since that change.” (Referring to withdrawal of activities coordinator post).

A resident commented that they ***“love quizzes”*** but that there had not been any organised for some time.

In one home some of the short-term care residents expressed a sense of boredom,

“... very little to do other than talk to visitors or read books.”

However, it was made clear following the response to the recommendation that,

‘All short term clients are welcome to join in with entertainment in the residential unit. We will ensure forthcoming events are advertised in the units. We are also purchased a range of board games/quizzes etc, to be used by staff to offer another means of activity with clients.’

Some of the staff views reflected those being expressed by residents who wished to see more activities organised and more time for them to spend with residents in this social context.

In one instance the home recognised this and responded to the recommendation as follows:

‘The home is now fully staffed enabling more time to be spent socially with residents. Staff are able to sit with residents at meals times, have a cup of tea, do more one-to-one activities with them, and generally chat in addition to the group activities provided.’

8.8.5 Cultural, religious/spiritual needs

Most of the homes had either local churches or non-denominational sessions held within the homes or facilitated residents to attend a local church. Two homes had designated faith rooms on site but ARs were informed that these tended to be primarily used by staff. All homes confirmed that they would meet cultural needs of residents as and when it was required.

8.8.6 Gardens - maintenance & design/suitability for use/enjoyment

All the homes were found to have well designed and maintained garden areas which were enjoyed by residents with some having an opportunity to be involved with gardening activities in the good weather.

9. Additional issues

No other significant issues or themes of note.

10. Comparisons with previous Healthwatch & CQC reports

10.1 Comparisons with previous Enter & View visits

Generally, the individual Healthwatch reports of the homes from previous visits undertaken were comparable to the findings from this set of visits. It was pleasing to note that in most cases good standards had been maintained and in many instances improvements were noted within areas previously raised as part of the recommendations. This was noted with particular reference to:

- an overall improved standard in garden care/maintenance
- attention to address heating problems in three homes
- the introduction of better systems of communication to residents and relatives with also greater use of easy read literature
- some improved parking facilities at two homes.

In one or two reports, there had been no evident changes made with respect to some previous recommendations which, where appropriate, were repeated within the visit report issued.

10.2 Comparisons with most recent CQC reports

In comparing Healthwatch reports with those from CQC inspections, it is important to note that the Healthwatch visits do not operate in the same way and/or cover exactly the same range of issues which the CQC address. However, there are similarities which tend to relate especially to the CQC domains of 'effective', 'caring' and 'responsive' which are observable or can be judged by resident and visitor feedback during the Healthwatch visits. The other CQC domains of 'safe' and 'well-led' are generally based on a number of areas which are not the jurisdiction of Healthwatch and so our reports tend not to reflect or are able to be compared to such findings.

The CQC ratings for the homes highlighted in this report included four rated as being 'good' and three which 'requires improvement', two of these were 'below standard' in all five CQC domains. Further to this, it is noted that the CQC assessment of 'requires improvement' applies to the residential & community care centres which are two of the most recently opened DCC services.

Regardless of the CQC rating, the Healthwatch visits concurred with the CQC across the vast majority of positive findings that were commonly identified and also agreed with respect to one home of the limited range of activities that appeared to be on offer.

10.3 Comparisons with previous summary report

Generally, this report compares similarly with respect to the core elements of care provision and levels of resident/relative/staff satisfaction to that outlined in the previously published summary report of September 2018. This is reflected in the first eight bullet points under Section 11 of this report (Elements of good practice/standards of care) which were similarly highlighted in the September 2018 publication.

The September 2018 report resulted in nine recommendations capturing the key issues and themes across the set of visits undertaken. The following table illustrates whether and to

what extent these issues were evident in those visits undertaken which inform this summary report.

Issues outlined in summary report September 2018	Evidence within visits undertaken for March 2019 report
Maintenance of external signage	None recorded as needing attention
Promotion of hand washing/hygiene	Use of hand wipes prior to meal observed in one home and not in another. DCC newly issued hand washing posters not recorded as having been observed by ARs
Installation of hearing loops	Evident in one home but not in two others
Inviting advocacy services into all homes	No evidence gathered regarding this but full confidence expressed, across services, in raising any issues with staff
Availability of Wi-Fi facilities	Evident in some visits but not identified in others
Evaluation of senior care worker role in providing programmes of activities	Various issues identified across a number of homes indicating limitations in activity programmes currently offered
Promotion of animal petting service	One home used such a service
Difficulties in providing religious/spiritual services in homes	Most homes appeared to have satisfactory arrangements in place
Consistency of garden maintenance	All homes appeared to have well maintained garden areas

As illustrated within the table, the vast majority of issues identified in the previous summary report have not featured highly within the visits to which this one refers. However, some new issues have arisen and/or aspects which would benefit from clarification which, along with on-going monitoring of previously stated DCC actions, inform the recommendations outlined under Section 12 of this report.

11. Elements of good practice/standards of care

- the services providing a homely and welcoming environment
- good visitor facilities and relatives feeling involved in their loved one's care with one service holding regular coffee mornings for relatives

- overall high standards of cleanliness present across the homes
- the excellent qualities of staff who conveyed a caring, friendly and calm approach to residents ensuring dignity and respect is offered within all interactions
- residents reporting to feel safe and secure within the homes
- the food being generally considered very good in the majority of homes
- involvement with local community and voluntary sector groups for the benefit of residents e.g. some homes have regular visits by local scout troops, schools and church representatives
- well designed and maintained garden areas consistently evident
- the involvement of an animal petting service in one home
- the proposed development of a dedicated activities room in one home
- the use of easy read formats for care plans, menus and hand hygiene communications in one or two homes
- the introduction in one home of consistently reaffirming residents' bathing preferences
- the support for a resident in one home to open her own 'shop' to provide confectionary and toiletries.

12. Recommendations

Individual reports for each home/service included recommendations at the time they were issued and have already been responded to. This summary report therefore is not intending to repeat these but place them into a broader context where DCC may lead in responding to the following recommendations across all relevant services:

- 12.1 To provide an update on the progress of the tender for hearing loop services (8.4.3 & 8.5)
- 12.2 To advise on the provision of staff training with respect to resident's oral hygiene care needs (8.7.3)
- 12.3 To advise how residents are ensured of regular therapeutic mobility and exercise programmes (8.7.3)
- 12.4 To advise of strategies in place to ensure that residents 'at risk' of becoming isolated are suitably monitored (8.7.4)
- 12.5 To confirm that practices are consistently in place to ensure that residents are reminded of their care choices and rights (8.8.2)
- 12.6 To provide a progress update and actions further to the review conducted of external security fencing and gates across the service provision (8.8.3)
- 12.7 To provide an update on the senior care worker role implementation review with particular reference to the effectiveness in ensuring residents receive an adequate and stimulating programme of leisure, recreational and therapeutic activities (8.8.4)

- 12.8 To advise of actions in place to address the CQC rating of 'requires improvement', particularly where this applied to all five CQC domains, which included one of the newest residential & Community care centre services (10.2).

13. Service provider response

No.	Recommendation	Response from provider
12.1	To provide an update on the progress of the tender for hearing loop services (8.4.3 & 8.5)	The Tender went out on 13 March and will be returned on 11 April.
12.2	To advise on the provision of staff training with respect to residents oral hygiene care needs (8.7.3)	A training course had been developed to cover a number of care subjects including oral care, entitled 'Promoting Peoples Identity and Personal Care'. This will be a mandatory training course for care staff. An awareness session and activities have been held at the Unit Managers Leadership Workshop held on 14 March 2019.
12.3	To advise how residents are ensured of regular therapeutic mobility and exercise programmes (8.7.3)	This item particularly related to learning disability establishment. All learning disability establishments have a programme of activities that ensures residents have regular mobility and exercise. The form this takes is tailored to suit the location and client group of each establishment.
12.4	To advise of strategies in place to ensure that residents at risk of becoming isolated are suitably monitored (8.7.4)	A key worker system is in place to ensure that residents have a particular member of staff who focusses on them. They, or any member of staff, can initiate updates to a residents personal service plan if they have concerns about isolation, so that action can be taken to address the issue.

No.	Recommendation	Response from provider
12.5	To confirm that practices are consistently in place to ensure that residents are reminded of their care choices and rights (8.8.2)	<p>Personal service plans are updated at least annually, but can be updated at any point should a resident's preferences be changed. Resident meetings provide a forum for reminding people of their rights.</p> <p>Quality questionnaires are circulated twice yearly and provide a confidential means of raising concerns and expressing opinion.</p>
12.6	To provide a progress update and actions further to the review conducted of external security fencing and gates across the service provision (8.8.3)	<p>Fencing for a secure area at establishments identified by Healthwatch and the scrutiny review, some have been completed and a few are still being pursued.</p> <p>Once concluded all establishments will have a secure area for residents to enjoy. The fencing of wider areas of establishment grounds will be dependent on the availability of budget when weighed against other priorities.</p>
12.7	To provide an update on the senior care worker role implementation review with particular reference to the effectiveness in ensuring residents receive an adequate and stimulating programme of leisure, recreational and therapeutic activities (8.8.4)	This review is nearing completion. The report to Cabinet is now scheduled for May 2019.
12.8	To advise of actions in place to address the CQC rating of 'requires improvement', particularly where this applied to all five CQC domains, which included one of the newest residential & community care centre services (10.2)	An action plan is submitted to CQC detailing how issues will be addressed as a result of any report showing a 'requires improvement' rating. The actions identified by any CQC reports are addressed as a matter of priority regardless of the age of the facility.