DERBYSHIRE DIGNITY AWARD – OPTION 1

SERVICE NAME AND ADDRESS Integrated Community Therapy Team,

DATE APPLICATION SENT Date sent for assessment

Name(s):
Designation: Integrated Community Team Lead

E-mail: Telephone:

Service: Explain here in a short sentence what your service is about. For example “We are a 20 bed residential home” also describe how your manager promotes a culture of dignity in the work place.
We are an integrated community based team consisting of nurses, therapy (Physio and Occupational therapy), care coordinators and community matrons. Our community therapy services are provided in the home for vulnerable, elderly or frail people and their carers. We work jointly with patients to establish goals and priorities.
Our manager promotes a culture of dignity in the work place in line with DCHS policies.

Name of your Registered Dignity Champion(s) List all the people registered as dignity champions at your service- this must include the manager and deputy – but also as many senior carers and staff as possible.

The Dignity Campaign – National Position

Launched nationally by the Department of Health in November 2006, the dignity in Care Campaign aims to put dignity and respect at the heart of services that care for people.

Thousands of people have now joined the campaign as Dignity Champions. They are part of a nationwide movement, working individually and collectively, to ensure people have a good experience of care when they need it.

The campaign is about winning hearts and minds, changing the climate of care services and placing emphasis on improving the quality of care and the experience of citizens using services including NHS hospitals, Medical Practices/Surgeries, Dentists, Pharmacies, Optimists, Community services and home care support services etc.

It includes action to:

- Raise awareness of dignity in the care of others;
- Inspire local people to take action;
- Share good practice and give impetus to positive innovation;
- Transform services by supporting people and organisations in providing dignified services;
- Reward and recognise those people who make a difference and go that extra mile

Events have been held around the country asking people what dignity in caring for people means to those providing services. This resulted in the development of the 10 point Dignity Challenge. The challenge depicts what high quality services that respect people's dignity should include. The award format below has 10 standards based on the national challenge.

The Derbyshire Dignity Campaign

This aims to ensure that staff teams in Derbyshire get started on the dignity campaign in the following ways:

- **Registering a Champion:** Making sure a Champion from every service team is registered on the National register. Champions receive updates and ideas about promotion of dignity. In Derbyshire we want you to be active in your Champion role as described on the website.

- **Team Involvement:** engaging all the staff team in working for the dignity award; taking time out as a team to check their practice against the 10 point dignity challenge.

The Derbyshire Dignity Award

- **What we are looking for: Evidence! Evidence! Evidence!** Below each question we have shown the sort of evidence the assessors are looking for.
- **Always give examples:** short written examples of how, when, whom and where will enhance your application.
- **Cross Referencing:** If you quote an example which also gives evidence for another standard it is helpful to cross reference.
- **No attachments please:** Just write on the dignity award format. The boxes expand as you write – no photo copies.
- **Assumptions:** Do not assume the assessor knows your service. Please avoid jargon and use of initials.
- **4th Question:** Each of the 10 standards ends with a question "is this the best we can do" here we want you to put a plan of action on how you can improve this particular standard. It is a key aim of the dignity award for improvements to be identified.
- **It's about your service:** The 10 point dignity challenge is generic but your application **must** reflect how your service depending on its purpose, contributes to promotion of dignity.

- **Not Applicable:** If you are not able to provide evidence because of the sort of service you provide, say so, but think of the outcome more widely as usually we believe the service you provide will relate in some way to the 10 point challenge.

A large majority of the applications we receive show very good practice but fail to achieve the award due to the lack of **real case examples provided.** I understand that completing the standards takes time and therefore it seems a shame to send back the application because of this.

When completing your application please refer to the guidance below the question as it is there to help you.

Assessment Ratings

- **Fully Evidenced –** complete answers with clear evidence.
- **Partially Evidenced –** answer missing some evidence or clarity.
- **Limited Evidence –** little relevant evidence.

Further Support Contacts:

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STANDARD	EVIDENCE
1. Have a zero tolerance of all forms of abuse.	
(1.1) Give a real case example of positive steps you have taken, where potential safeguarding concerns exist about a person who uses your service. • ***Provide a real case example*** *(anonymised) of a safeguarding issue that reached a satisfactory conclusion.* • ***Provide a real case example*** *of support provided for the victim and alleged perpetrator (if latter uses the service)* • *Examples showing that the team know the difference between abuse v cause for concern.* • *Example showing the team know the difference between complaint v safeguarding.*	**Therapy-** Son had privately purchased bed rails on the bed that had not been assessed for and patient lacked capacity to consent to them. Son refused to remove them. Contacted our safe guarding nurse. A capacity assessment was completed involving patient and all family and then a best interest decision was made as patient was deemed to lack capacity. Positive outcome for family as they said they felt involved with the decision and was able to understand the raised concerns. It showed good working relationships with district nurses, social services and family. The safe guarding nurse was kept fully updated and as a team we received positive feedback from her. **Care Coordinator-** Concerns had been expressed for some time regarding this patient. He self-discharged from hospital after a serious stroke. By the time I became involved he already had

	District Nurses visiting for pressure sores. He was unable to communicate much verbally, so everything came from his wife and it was never clear if these were his wishes or hers. Their living space was so cramped there was no room for equipment and without this he couldn't have carers. It was increasingly difficult for the nurses to care for him without equipment. Wife refused a hospital bed as they weren't prepared to move bed settee. There was an incident when the patient appeared so poorly it was concluded that hospital admission was essential. An ambulance was organised but the wife turned it away. As everyone thought he was in hospital and no one advised them otherwise, the District Nurses didn't visit over the weekend, resulting in even more serious pressure damage. There were then concerns about the state of the property, which was owned by a family member. The District Nurses had reported how difficult it was to care for the patient when surrounded by flies. With agreement of his wife I referred to environmental health and the fire safety officer who both concluded the place was unsafe for human habitation and a danger to the inhabitants, neighbours and general public. After discussion with adult safeguarding a VARM was called, attended by all agencies involved and including his wife. She explained that there was absolutely no room for any equipment and if they accepted a hospital bed the settee would have to be removed and she would have nowhere to sleep. The upshot of the VARM was that the patient and his wife were immediately removed from the property and the owner was charged by environmental health to make it safe. They were housed temporarily in adapted accommodation and within a month were rehomed in a bungalow allowing room for equipment and so provision of carers and easier access for District Nurses. The saga didn't end there and didn't end happily, but the initial coordination and cooperation of all the different services was extremely successful.

	Nursing- We had a lady who had deteriorated and was struggling to swallow. Her daughter was buying her baby food. Our nurses referred this to safe guarding as concerned about the patients weight loss and no other food in the house. There was a joint meeting with her daughter, social services and the nurses. Her daughter was buying her baby food as she felt this would be easier for her to swallow. We explained that there isn't the sufficient calories in baby food for an adult and Wiltshire Farm foods were arranged with daughters consent as patient lacked capacity. Organised modified diet meals and arranged SALT assessment. **Matron-** I had a lady on my caseload who had COPD (Chronic Obstructive Pulmonary Disease) and learning difficulties. She lived with her husband who was her main carer. The husband was not happy for me to be involved. I explained my role and he told me it wasn't needed and he provided all care for his wife and if she was unwell he would bypass myself and the GP's and ring 999. He would very often answer for his wife and when she did answer, she tended to agree with her husband and appeared nervous of him. He told me and the patient that she could not go out as she was too short of breath. The patient had home oxygen but he said that the tubing wasn't large enough. I asked the patient if she would like to go out and she said that she would but that she was not allowed. On my return to the office, I looked through the patient's notes and during a recent hospital admission, the patient told one of the nurses that she was afraid of her husband because he hit her. This confirmed my fears and that this may be a safeguarding issue. I discussed my concerns with the GP. I visited the patient again and was again told by the husband that he did not want my involvement. The patient also seemed quite angry about me being there, almost as though she had been 'groomed'. I attended a safeguarding meeting within the

	practice and the issue is now being discussed with the safeguarding team which is a satisfactory conclusion for now although still ongoing.
(1.2) Explain what training your team receives on safeguarding and how is this updated. • *What type/depth of safeguarding training is provided and by whom?* • *How often is training updated?* • *How are safeguarding issues shared within the team to maintain awareness?*	'Think family' mandatory training provided by the trust every three years. Safeguarding issues are shared within the team during handover and then in team meetings. Our safe guarding link is ST and she has come and spoken to us during team meetings when needed. We ensure we contact her and keep her up to date with any concerns.ST is willing to offer updated advice whenever is needed. We also now have a safeguarding Champion- AB who attends meetings and trainings and then shares information back to the team. She also updates the hard drive which all staff have access to for information as and when required.
(1.3) Explain how the safeguarding policy offers a strong foundation for day to day work. • *Does the service have an up to date policy cascaded to staff who read and understand what to do?* • *Is the policy available for staff to access?* • *How is the policy publicised to the people who use your service?* • ***Provide a real case example** where staff have notified concerns to managers.* • *The policy is consistent with Derbyshire/Derby City Adult Safeguarding Policy and Procedures.*	We have up to date policies (safe-guarding adults policy, mental capacity act policy, safe-guarding children policy, DOLS) and have a hard copy and they are also stored in the shared drive that all staff have access to. We are aware that there are other policies and these are available on the DCHS site. Information on these policies is explained to new staff upon induction. Staff expressed concerns to managers regarding cascade of communication and changes. This resulted in the set up of the secure shared drive for champions work one of which is the safe guarding role. This ensures all staff can access up to date information.

(1.4) For this standard when asking "is this the best we can do" please list any improvements or changes you will make. • *This is your plan of action on how you can improve how you deal with safeguarding issues i.e. add to team meeting agendas, supervision or 1-1s*	Safe guarding issues are already on the team meeting agendas, the team has supervision/debriefs as required with Mary Driver and one to ones are available as needed. The one thing to be aware of for the team in future is how we share information to wider agencies that may be on a different IT system. Again, this is guided by safe guarding advice.

STANDARD	EVIDENCE
2. Support people with the same respect you would want for yourself or a member of your family.	
(2.1) How do you ensure that people who use your service are given information appropriate to their communication needs? • *How do prepare to communicate with the person at the initial assessment?* • *Please provide a full range of communication options available e.g. easy read formats, picture cards, translator etc.* • *How is information displayed?*	All staff evaluate communication needs based on the findings from their initial assessment. Very often needs are not apparent until staff actually arrive. Staff would log communication needs on the initial patient plan of care (care plan) for other staff to follow. Options available are easy read formats, picture cards for exercises, use of translator, adapted verbal and non-verbal communication strategies. The leaflets that we hand out to all new patients ask if 'we are accessible to you?' They then state that 'the publication is available on request in other formats (for example, large print, easy read,

	Braille or audio version) and languages. For free translation and/or other format, please call 01773525099 extension 5587, or email us at communication@dchs.nhs.uk'. We have recently had to use a translator for a Polish gentleman on our caseload who could not speak any English. We had to use a translator over the phone to arrange the Occupational Therapy appointment and then have a translator present on the visits. We also had to request for some of our information leaflets to be translated.
(2.2) How do managers set out a clear framework for high standards of dignity? • *What are manager's expectations about attitude, compassion and acting on feedback from the people who use your service, training and whistle blowing?* • *How do managers lead by their own practice i.e. by walking the floor, leading by example, addressing inappropriate behaviour?* • *How do managers know that staff are meeting their standards for use of language and behaviour- do they observe or discuss at team meetings etc.* • *Explain how this culture encourages staff to be positive, questioning and reflective.*	Leaders within the team expect a high standard of the team with regard to having a positive attitude and being compassionate with patients and their colleagues. All leaders are approachable, visible and encourage further development in their teams with regard to training. The band 6's within the team regularly double up with their teams to ensure that a high standard of care is being delivered and also offer any support required i.e. to junior members of the team, if there were any problems then these would escalated to the appropriate person and managed effectively. The band 6's also visit patients and gain feedback from patients about care being delivered. The band 7 for the team also carries out back to the floor mornings twice a month to work with the teams and also gain feedback from patients. The team hold integrated community team meetings once a month where the whole team gets together to share ideas and keep each other updated with any changes etc. The team also have a positivity jar where they add anything positive that the team has achieved and these are shared at the team meetings along with any patient feedback that has been given. This encourages the team to be positive and boosts morale and creates an open and reflective culture. When reviewing feedback this also gives the team to opportunity to make changes and learn from feedback

	given. The team also hold daily handovers/caseload reviews where this is also encouraged.
(2.3) How can you evidence that people who use your service are involved in how it is run? • *How is personalisation of services reflected in overall team practice- do they ask if something can be done in a different way?- who is involved in assessments and care reviews – you can cross reference this with 2.1.* • *How do staff engage/contribute to how the service is run and have their say i.e. would they speak up if something could be done better?* • ***Provide a real case example-** of how people who use your service and their families are meaningfully engaged/included in how things are running i.e. suggestion boxes, carer meetings, questionnaires' for feedback.* • ***Provide a real case example-** of how people who use your service their families and staff have influenced changes even small changes.*	All staff are issued with a yellow feedback form to issue to patients this includes information about scoring the service and offers space to suggest what we could do better and whether or not they would recommend our service to their family and friends. These are then sent onwards to be compiled and fed back to staff. Staff also adapt services according to individual preferences in terms of therapy. We seek ongoing feedback as treatment progresses, offer options for treatment which can help us determine onward referrals to other services in order to achieve goals. The nurses received feedback from patients that people preferred some indication of what time their visits were so that they can plan their days. Although giving a set time is impossible for the nurses, they have started saying whether the visit will either be morning or afternoon. We have now set up a feedback and positivity jar where staff can place comments and suggestions about the service. If the patients have feedback, this can also be placed in here for either praise of staff or for future learning. This is then read out and discussed at team meetings. Praise and feedback from colleagues to other colleages is also put in to highlight when staff members have seen positive working and goof practice from their fellow colleagues.
(2.4) For this standard when asking "is this the best we can do" please list any improvements or changes you will make.	We are in the process of devising a 'you said, we did' board based on the feedback we have received from the Friends and Family feedback.

• *Think about ways you can involve all concerned and how you can collect contributions of ideas and comments maybe introduce a quarterly newsletter.*	The 'You Said, We Did' board is now up and running in the form of a tree with coloured apples. This is updated on a 2 monthly basis. We will continue to feedback into team meetings and action any changes necessary. During the Covid 19 pandemic we have continued to have regular team meetings over Microsoft Teams to ensure that all staff members are kept up to date.

STANDARD	EVIDENCE
3. Treat each person as an individual by offering a personalised service.	
(3.1) How do you enable people who use your service to make choices? • *How are staff trained and supported to understand what giving choice and a personalised service means? i.e. explain what sort of training staff have to recognise and deal with choice even if it is more challenging.* • *How are the people who use your service involved in expressing their preferences? i.e. assessments, care plan reviews, discussions with key worker etc.* • *How do you record their choices and review them?*	Staff are supported regarding choice and personalised service by more experienced staff who are available for advice when needed. Service users are able to express preferences via the wide range of initial assessments that are completed. Care plans are reviewed at intervals as are therapy treatment plans. Discussions are held with patients and carers/family members as required. Community staff will also link in with staff from other agencies to help inform options for patient choice. Choices are recorded on system 1 within care plans and the analysis section of therapy notes. Changed circumstances would be documented in the plan outcome after individual treatment sessions.

• *How is information collated and updated to enable the people who use your service to make choices and then change their minds or meet changed circumstances.* • ***Provide a real case example** of where a person's choice has been enabled under challenging circumstances.*	**Therapy-** We were treating a palliative patient with metastatic cancer. His choice was to complete the stairs on a daily basis to enable him to be in the house communal areas with family. This was risky physically due to his overall health and did offer an element of risk of falls. Therapy linked in with social services regarding a stair lift and continued to provide updated transfer assessments to inform social services of what they needed to know for safety. Deterioration rate was unknown and it was challenging due to patient's denial of overall health status. **Nursing-** When visiting an end of life patient, significant pressure damage was found. The patient's mobility had deteriorated and they were assessed as requiring a high risk mattress. However, the patient did not want a mattress and wished to stay in their own bed and on their own mattress. The team had a very open and honest conversation with the patient who understood the risks and the team respected the patient's choice. **Matron-** I have a patient on my caseload who has Motor Neurone Disease. He had been admitted to hospital for bowel surgery and spent three months in a rehabilitation following this. During this time, his condition deteriorated rapidly and his nursing needs became very complex. I kept in touch with his wife and ward staff during his hospital stay for updates and I was told an MDT meeting was being held with the patient and his family to discuss his discharge. I attended this meeting. It was a very challenging situation and I had to explain to the family and the patient that his care/nursing needs were now so complex and that the district nurses did not have capacity to provide the same level of care as the nurses on the ward. I felt that it would be a great risk for him to be discharged home and that a placement in a specialised unit would be best. The family were angry about this and the patient was very disappointed which was difficult. With the support of the ward, we agreed as a team to work together and to try and get a

	care package at home. A plan was made for the family to be trained on his care needs. Patient was discharged home with a live-in care package. It is an ongoing, tense situation however the patient is happy to be home and is very grateful for my input. I have regained his trust which is important to me and enabled me to have a discussion with him and his wife about his end of life choices and wishes, hopefully resulting in the patient having the death he wants. **Therapy-** During the Covid 19 pandemic, we have contacted every person on our waiting list to see whether they would still like a visit or whether they would prefer to wait. We explained that we would be wearing full PPE but it was up to them whether they wanted to have us visit or not. For those that did not yet want a visit, we discussed the reason for referral and if it was for equipment, talked them through the types of equipment they could try and where they could self purchase if needed more urgently. We gave them our emergency contact details and also our team details and encouraged them to contact us for advice or if they changed their mind regarding visits. We also kept a log of all these patients and what we had advised and contacted them every few weeks to check on their situation and to ensure they remained safe. We also asked our Care Coordinator to contact all of those who had been advised to shield to ensure that they had all the support they needed and to signpost to other services if required.
(3.2) Provide a real case example of how a person who uses your service has been involved in initial and on-going risk assessment. • *Explain how a person who uses your service has the choice to take risks and contributes towards management plans to mitigate as many of possible consequences as possible.* • *Explain your understanding of positive risk taking.*	Risk assessment often needs to be dynamic and taken on a case by case basis, even for treating the same person. There might be risks on the initial assessment that are different to ones found on the third for example. Therapy service users are able to set their own goals even when these may seem too risky to staff. We would work towards what they wish to achieve, sometimes having to demonstrate the risks

• *Who completes the risk assessments at your establishment?* • *How are risk assessments recorded and reviewed?* • *Do you have any leaflets or information you share detailing possible risks?* • *What would you do or have you done if a specialist assessor or other external advice was needed for a particular risk situation* • ***Provide a real case example** of how a person who uses your service have been involved in their initial and on-going risk assessment.*	so that they can see it for themselves. There can then be ongoing discussions around safety. Positive risk taking is weighing up the potential benefits and harms of exercises ones choice of action over another. Risk assessments are recorded on system 1 in the ongoing journal alongside discussions with patients. We have good working relationships with other outside agencies and if required can telephone to make use of specialist assessors where needed. A list of other agencies to refer onto can be found on the therapy shared drive for example. **Therapy-** A patient with Motor Neurone Disease had treatment for an ongoing progressive exercises regime. Initial risk assessment was completed and easier, safer exercises chosen. This was reviewed week by week and progressed with positive risk taking with the patient feeding in week by week what they felt confident to do. **Nursing**- We visited a patient that the team felt their environment was unsafe and they were concerned regarding fire risks and using the oven. The team discussed these concerns with the patient and within the Multi-disciplinary team meetings who decided to hold a VARM meeting (Vulnerable Adult Risk Management). The patient was invited to the meeting and involved with the risk assessment and the ongoing reassessment of this. **Therapy-** A patient who had mobility issues wished to use her cooker despite having had issues in the past which resulted in the fire service being called out who had then advised her to no longer cook her own meals. The patient had always enjoyed cooking and was now having ready meals but not eating well as a result. Therapists went out twice a week to practice cooking with her and a rehab support worker also went out twice a week to improve her mobility. The risks were explained each time when the patient was

	cooking and they continued to practice with her until she felt confident and was safe enough to be able to use the cooker on her own.
(3.3) Explain how your team understands what cultural diversity is and addresses this within a personalised service? • *Describe what training staff have for diversity and equal opportunities.* • *How often is training held?* • *Explain how your service addresses diversity- this might be for ethnicity, gender, occupational, religion etc. i.e. a person who has come from a farming background and is used to getting up early and going to bed early.* • *Explain what cultural events your service either holds or takes part in i.e. seasonal or religious celebrations, church visits or themed food nights, taking part in local cultural events.* • *What links does your service have with wider groups in the community – either the person using your service going out to join in services, meetings or local community visiting your establishment?* **(3.4) For this standard when asking "is this the best we can do" please list any improvements or changes you will make.** • *Comment on anything that you intend to start doing that would improve the range of cultural events or community involvement.*	'Equality, Diversity and Human Rights' mandatory training provided by the trust and renewed every 3 years. We explore diversity by the range of questions covered as part of the initial assessment. These are open questions that allow the patient to express their needs, backgrounds and choices. These do not have to be answered if a patient chooses not to. We now have a diversity, inclusion and dignity champion who attends regular meetoings and seminars where Trust initiatives are discussed and reviewed. A recent initiative is the 'Rainbow' lanyards which are aimed at signalling to the LGBT+ community that we are able to provide first point of contact heklp to any of our colleagues or service users who may need someone to talk to about their sexual identity. We are not expected, as staff, to have all of the answeres, but we are expected to listen and signpost or involve others who can help if needed. We also have rainbow pin badges for staff who make a pledge to be a 'friendly ear' for LGBT+ people and their families. This also helps to show that our trust and staff are inclusive of all identities, regardless of how people define themselves. We often link in with the care coordinators for each GP surgery regarding social outlets as this is their speciality and they have vast knowledge of what is going on in the surrounding area. As a service we cannot hold or take part in cultural celebrations/events etc.

	As for community involvement, the team have linked in recently to do a raffle and a bake sale with proceeds going to the local food bank and treetops hospice. Over Christmas, we did a food bank collection for O who sent out Christmas Day boxes for struggling families in the local area. We have continued this collection for their general food bank. DCHS also did their first trust-wide food bank collection with a collection box in every base. Our team also did a 'warm clothes' collection for The Salvation Army and donated hats, gloves, scarves, sleeping bags and blankets for local homeless people. This was very well received.

STANDARD	EVIDENCE
4. Enable people to maintain the maximum level of independence, choice and control.	
(4.1) Using an example explain how your service actively promotes the independence of people who use your service? • *How are people you work with involved in their own assessments?* • *How do you encourage a "can do" culture for the people you work with to improve independence, choice and control i.e. flexi meal times?* • ***Provide a real case example** of how a person who uses your service has their independence valued i.e. making appointment times, locations of meetings, maintenance of contacts, booking a taxi so the person can choose where to go.*	Patients are involved in their own assessments each step of the way by open communication between health professional and service user and their families. **Therapy-** Whilst making appointments, patients are asked when they would like the appointment and at what time, explaining that they would be contacted if the therapy staff member would be more than 15 minutes either side of the appointment. They are also encouraged to have family and friends present if they would prefer to do so during the visit. **Nursing-** It was fed back to the nursing team that patient's would prefer to know a rough time of when their visit would be. Although

• ***Provide a real case example*** *of how a person who uses your service has regained some independence through having your service i.e. are they now able to do something for themselves- such as walking to the dining room, washing and dressing. Has their confidence increased? Have they maintained links in the community with your support such as being able to go to their preferred hair dressers/barbers, local pub because a staff member will walk with them?*	it would be extremely difficult for a definitive time to be given to nursing patients due to emergency call outs and appointments changing daily, it was agreed that patient's would be offered a morning or afternoon appointment to suit them. **Care Coordinator -** An MDT meeting was scheduled. The patient was very keen to attend but was unable to leave her home. We arranged to hold the meeting at her home so that she could participate fully. **Therapy-** one patient who was coming into wound clinic weekly also had a physiotherapy referral. To make things easier for him, we arranged a physiotherapy clinic appointment with him for after his wound clinic appointment, using one of the available rooms on site. This meant that the patient could have his appointments in one place and was easier for him to remember what was happening and when. **Therapy-** Patient with reduced mobility following pneumonia had expressed the goal of being able to walk to the local pub and back as he used to do this regularly before becoming unwell. Outdoor mobility practice was completed with a suitable walking aid, progressing the distance each week until it was felt that patient would be able to safely walk the distance to the pub with a staff member. Patient was extremely happy to have been able to met this goal and his confidence was increased as such that he was then able to do this on his own. **Nursing-** Patient was struggling to perform their own blood sugar test. District Nurses were asked to visit and assess and found that patient could not read the result on the BM machine screen. A new BM testing kit was therefore ordered which had a larger screen, and after some supervision and confidence building, the patient felt happy to monitor her diabetes on her own.

	Care Coordinator- An elderly patient has seen the GP feeling very low. His main social contact was meeting others when he walked his dog several times a day, but his dog had recently died and he couldn't bring himself to consider another one. His only other social outlet was bowls and it was out of season. So he was never seeing anyone. After a long chat he agreed he needed something social to look forward to. We discussed a number of options and he decided to try walking football. He has continued to do this and is now back to bowls as well, feeling considerably less socially isolated and no longer being treated for depression. **Therapy-** A patient was referred to our team following a stroke and collapse which has left him wheelchair bound. After completing seated exercised and progressing to standing ones at the kitchen sink, the patient was able to stand with a gutter frame. This was then progressed to stepping practice and then mobilising with it 2-3 times a week until he was strong enough to progress to a standard wheeled zimmer frame. The patient is now able to mobilise with his wheeled zimmer frame independently and as a result, has been able to reduce the majority of his care calls and no longer has to remain in his wheelchair.
(4.2) Using a real case example explain how everyone has a plan which addresses their individual needs and choices. • *Explain how a person who uses your service has their independence, choice and control agreed i.e. does everyone have a personal care plan-when is it created and who by?* • *How does the support plan promote positive outcomes?* • *How do you ensure that staff read and constantly follow care plans?*	As mentioned above, every service user has their individual needs assessed on the first visit. This has goals, aims and treatments planned together and documented. This would be created by the most relevant health professional who visits first. The support plan promotes a positive outcome by aiming to have goals that better the overall health status of a person. All staff are responsible for reading and following care plans to ensure that they are delivering the right care. In therapy, the East Kent Outcome System (EKOS) has been introduced to support the care/goal planning process. This is a structured framework for teams to set goals with the patient and

• ***Provide a real case example*** *of where a client has been involved in creating their care plan with a positive outcome.* •	evaluate patient outcomes. Together, the therapist and patient identifies the patient's individual goals and these are then constantly reviewed, adapted and changed as the patient's personal goals and what they want to achieve and when, changes. This means that any staff member then involved with the patient can easily and quickly view the EKOS within the personalised care plan and treat accordingly to assist the patient in achieving these goals. The EKOS is beneficial as it is patient focused, individual and specific and focuses on overall outcomes and benefits for the patients. It is also standardised across all therapy services and demonstrates clinical effectiveness and the success of the interventions. It also helps to keep patients motivated as they see their goals being met. **Therapy-** A 60 year old gentleman with agoraphobia keen to get back to walking outside and exercising in the gym. He worked with the therapists to improve balance, posture, exercises tolerance and confidence eventually being referred on to supported gym sessions that he could attend with his wife. **Nursing-** We were visiting a patient to redress their legs which were in compression bandages. Patient asked whether she could remove her bandages, shower herself and cream her legs prior to our arrival. We agreed to this and this then enabled the patient to maintain her dignity at all times. **Care Coordinator-** As a care coordinator I take no action until I've spoken to the patient and discovered what is important to them. I had a lady on my caseload who broke her hip in the November. All the necessary care and therapy was organised and by the March she had improved as much as was thought to be possible, but she was feeling quite miserable. She still couldn't leave the house. Couldn't get upstairs to her bathroom, so carers were helping her to strip wash in the kitchen. It turned out that she had always been

	a very smart lady, who went to the hairdresser every week without fail – and no one had done anything to her hair for 6 months! I contacted the CVS who found that one of their workers also had a mobile hairdressing business and this lady now feels smarter, has the confidence to have some more therapy input and is now able to get outside. **Matron-** I have a patient who has lung fibrosis, she becomes very short of breath on minimal exertion. She has long term home oxygen but feels tired and weak a lot of the time and as a result didn't go out much. When I would visit she would be in her pyjamas and would often not have had a shower or done any household chores. The patient was on a low dose of maintenance oral steroids. Oral Steroids aren't always used in fibrosis as there is usually a restrictive pattern in the lungs, therefore steroids aren't always beneficial. I sat with the patient and asked her what she would like to be able to do and she told me that she wanted to go out again and to get some of her independence back. When I looked at her recent lung function tests from her recent hospital admission it showed that she had some inflammation. She told me that she had felt better when she was on a higher dose of steroids- this would make sense and so I discussed her at a palliative care meeting with the GP's and asked whether I could increase her maintenance dose of steroids and discuss all the risks and benefits with her and they agreed. I went through all the risks with the patient and she was happy to try a higher dose. At my next visit and every visit since, she was dressed, make up on and is going out again with her daughter and has even been away for the weekend! She is aware of the side effects and has gained some weight but she has told me that she would rather have a good quality of life than more quantity of life and this is her choice. We are now slowly reducing her maintenance dose a little gradually but a general positive outcome!

	Therapy- A patient who had recently been discharged with a fractured hip and was currently having to have a downstairs existence as a result, explained how important getting back upstairs to her bedroom, double bed and using the bathroom was to her. We put all of her goals into the EKOS, and worked with her, building up her exercise tolerance until she was able to practice the stairs. Once this was achieved safely and independently, we then practiced bed transfers and issued appropriate equipment to enable her to use the bathroom upstairs. We continued to practice with this equipment and doing bed transfers until she felt confident enough and was safe enough to go back to sleeping upstairs. **Nursing-** During the Covid 19 pandemic, we offered visits to those patients who would not normally be housebound, but as they had been told to shield/isolate they effectively were. Patients were involved in all aspects of their care plan and were fully supported in this very new and difficult times for some.
(4.3) Describe how the plan is a working document which is reviewed regularly. • *Explain the care plan review process including how often this is done-who is involved in the review.* • *When can a care plan be changed?* • *Explain how the changes to the care plan are communicated to the individual, the staff and family/carers.* • ***Provide a real case example** of where a support plan has provided a personalised service and promoted independence, choice and control.* •	Care plan review dates are set so that it is clear when this needs to be updated and reviewed. Care plans can be changed as required depending on the patient's health status alterations. Changes can also be communicated via case load review or handover. It will be done in conjunction with the patient and if they request it, individual feedback can be given to family and carers. The EKOS for therapy can be constantly changed and updated and is regularly reviewed with the patient to check that the golas are still what they are aiming for. The EKOS can be changed/updated whenever is required. **Therapy-** 80 year old gentleman with a gradual decline in mobility over the past year and no longer able to get out to local shop. Plan put in place to work on walking aid use indoors, exercise

	tolerance, option for outdoor walking aid and choice in overall functional improvement. **Nursing-** An end of life patient requested that she did not want to die in hospital and wanted to die with dignity in her own home environment with family members present. The care plan was then adapted for this and the right care plan was put in place. **Matron-** All of the patients on my caseload have a health and social care plan which I first do when I have seen the patient. This gives a brief but specific outline of the patient's social situation and their co-morbidities including all of their current medications. It outlines an action plan of what to do in the event of an exacerbation of any of their long term conditions and their wishes regarding hospital admission if needed. When completed, the form is sent to DHU (Derbyshire Health United), GP and the patient is also given a copy. If the patient has to ring DHU out of hours then they have a personalised plan for that patient which has been scanned onto their notes. This ensures the patient has the best care for them and their wishes are known. If the patient's circumstances change in any way or if they have any acute events i.e. stroke or new diagnosis, then the plan needs to be updated and sent to all concerned again. **Care Coordinator-** I was involved in a Vulnerable Adult Risk Management meeting called by the Local Area Coordinator. This elderly lady has tenure for life of a property owned by a family in Scotland who had done nothing to it for 40 years+. This lady is a hoarder and nothing could be done until some clearance was made. She had a rat infestation. She had been without heat for 3 years. The only access to the upper storey was a ladder, centrally placed in the hall, which she couldn't get up and which was difficult to manoeuvre around. The garage was falling down. This lady was supported to attend every VARM meeting. She was

	included in all arrangements to make some clearance to enable access to radiators, treatment by pest control to eradicate rats and provision of a new boiler. All concerned ensured she was happy at every stage.
(4.4) For this standard when asking "is this the best we can do" please list any improvements or changes you will make. • *Do you have a realistic idea that would improve the promotion of independence, choice and control?* • *Has there been a comment in any meetings that you could act on?* • *Could you have a standard item on all meetings asking if there is anything you could change or improve on and promote.*	Due to vast array of patient conditions seen, there is not one idea that would improve these elements for everybody. There is no one size fits all therefore this will need to continue to be assessed on an individual basis. Staff do feedback on any problems encountered with this via the monthly team meeting. The feedback received from staff and patients is discussed during team meetings. We also now have the 'You said, We did' tree so we can see what we as a team are constantly doing to improve our service and listening to suggestions of patients and their families. We will ensure that we continue to visit the newly housebound patients who have been advised to isolate during the Covid 19 pandemic.

STANDARD	EVIDENCE
5. Listen and support people to express their needs and wants.	
(5.1) Explain with a real case example an alternative method of communication and support used with people who receive your service. • *Explain how you engage with people who use your service to make a person- centred decision based on informed choice.*	**Therapy-** Patients are explained the information that they require to make an informed decision regarding their care and given our contact details for if they have any further questions. Every patient is supported to make decisions and if they wish, family and friends are also supported to assist in these decisions. Therapy options for wider services are always explained on the first visit so people have information to make their own choices.

• *How do you ensure that attention is given to the settings which support communication i.e. quiet room?* • *Demonstrate that sufficient time is given to providing support and listening.* • *Tell us what specialist equipment or staff with skills you have i.e. Makaton or Sign.* • *Say where you would get help with communication if it was needed i.e. Advocacy, Translation Team, Easy Read and Optician etc.* • ***Please provide a real case example** of where you have used an alternative format or communication method to enable communication such as body language, noise, picture books etc.*	Within a patient's home, the patient is always asked which room they would prefer discussions/treatment to be carried out in and where they would like the therapist to stand/sit. Sufficient time is blocked out for each visit, dependant on what treatment is required, should this over run for whatever reason, staff can notify other staff members or admin to notify their next patient appointment. DCHS have a translation service should this be required and we do have information leaflets available in large print. For patients who do have communication difficulties, they are always offered the opportunity to have friends and family present if required. **Therapy-** One patient who the therapy team were seeing was unable to verbally communicate due to severe dysphasia after a stroke. However, she was able to nod/shake her head in order to answer questions and could use certain nonsensical words to express her moods. The therapy team ensured that her husband was always present during visits as consented to by the patient as he was able to explain things but information was always explained to the patient herself and her body language and facial expressions were read to gage her views on each treatment plan. Written plans were also issued to patient and the certain words the patient used were learnt by staff to determine patient's opinion. When onward referrals were made, these communication barriers were explained as needed with patient's consent so that the best possible care could be provided for the patient, and for example, patient was not phoned etc to book in. **Nursing-** The team are seeing a patient at the moment and their eyesight is impaired. The patient is really keen to see progress of their leg ulcer and so at each visit the team are photographing the wound on the patient's ipad as she can see this. The patient is then monitoring the progress which is making her feel empowered and involved in her care.

	Therapy- We had a Polish gentleman on our caseload who required a translator for telephone conversations. In order to arrange this, we booked online through a translator service our Trust uses. This was very quick and easy to do and is available to any staff member who requires it. We were also able to order translated leaflets by emailing DCHS and requesting which we needed. These then took 5-7 working days to produce and be delivered.
(5.2) What training do your staff have on communication which enables them to communicate with people who use your service? • *Detail the training your staff receive which aids them in communication i.e. Dementia NVQs* • *How do you ensure that training is put into practice i.e. observations, supervisions, discussions at team meetings?*	During the corporate induction for all new staff there is dementia training and communication training. There is also conflict resolution training which is renewed every 3 years and this talks staff through how to effective communicate with patients, relatives and other members of the public, particularly in difficult and/or emotional situations. When new staff start, they are observed by qualified staff for a period to ensure that all competencies, including communication skills are completed and staff are supported if there are areas which they struggle in. Staff also regularly double up with other staff for visits and are able to request double ups if needed for any patient. Any issues that arise are fed back to the team and discussed which involves looking at how we could improve things in the future. There is always the opportunity for staff to request supervisions, either as 1:1's or group supervision if they require more support. The Trust recently ran a 'Quality Conversations' 2 part course for any staff who wished to attend. This was done at a variety of venues and times so that as many staff could attend as possible. The course looked at communication and provided staff with the skills to improve the way in which they communicate with patients, colleagues and also in their personal life. It also looked at ways of managing challenging behaviour and how to communicate in a way to limit the chance of challenging behaviour arising in the first

	place. The course allowed staff to practice what they had learned at reflect on it and a second date was arranged a few months later to review how staff had put their newly learned skilled into practice and how they felt it had gone. Staff reported that they felt that this course was very useful and gave them some good ideas for improving communication skills.
(5.3) How does staff supervision actively support dignity on a day to day basis with the people who use your service? • *How regular is supervision held both as 1-1 and as part of a team meeting?* • *Are dignity issues a standard item on the agenda?* • *Tell us how day to day practice supports dignity similar to standard 2.2* • *Explain your process for Personal Development Plans.*	1-1 supervision at least 4 times a year is required of all staff within the trust and are recorded by managers but staff are able and encouraged to organise 1-1 supervisions at any point if they feel they need it. Group supervisions are also available if needed as some people prefer this. Individual dignity issues are discussed on a patient by patient case basis within caseload reviews weekly. Any goals around dignity and staff development would be fed into staff's individual personal development plans as appropriate.
(5.4) For this standard when asking "is this the best we can do" please list any improvements or changes you will make. • *Think about any improvement you can make to your practice to improve communication or state that dignity is to be put on the agenda at each supervision if not already.*	If any issues arise, we would discuss this as part of a team and look at ways in which we could improve to avoid this. It is reiterated to staff not to assume regarding methods of communication. We recently cared for somebody who was unable to read and therefore offered support around prescription ordering via the care coordinator and pictorial exercises sheets with arrows so that he could understand the exercises prescribed by the therapist. Staff are also encouraged to attend the next Quality Conversations course if the wish to.

STANDARD	**EVIDENCE**

6. Respect people's right to privacy.	
(6.1) Explain with a real case example how team practice ensures appropriate privacy. • *Explain how privacy issues are addressed in your care setting such as how you discuss personal information in an area where others cannot hear, covering people during personal care.* • *How do you minimise interruptions when privacy is needed?* • ***Please provide a real case example** of how you ask permission to give care and how you are respectful of a person's property and space.*	If other people are present during a home visit we would always ask the patient whether or not they were comfortable with them being there or whether they would prefer us to go into another, more private room. We would then ask the patient this again before carrying out personal care. We would always ensure that people are covered as much as possible whilst carrying out any personal care and that people are not exposed more than or for longer than they need to be. We would also double check that the patient is not expecting any visitors or phone calls during the time that this personal care or personal conversations were taking place. Before carrying out any kind of personal care such as skin area checks etc it is always explained to the patient why we need to and that it is their choice as to whether or not they want us to. If the patient declines, the risks would then be explained to the patient, and in the case of a declined skin check we would explain what to look out for with regards to reddening skin etc and how to look after their skin and avoid pressure damage. This discussion is then recorded on System 1. A new pressure area care leaflet is now given to every new patient with coloured photos of what to look out for and how pressure sores develop. **Therapy-** A home visit to an elderly lady who had reduced mobility and was unable to get out of her chair without support. Her son was present during the visit which patient stated that she was happy with. During the visit the lady was asked whether or not she would like her skin to be checked and the reasoning for this was explained to the patient. Patient stated that she would like the therapist to check her skin. She was then asked whether she wanted her son to be present which she did not want and so it was politely requested that her son left the room which he was happy

	with and he closed the door. The curtains were then drawn and patient's skin was checked explaining each area to patient and what I was looking for. No body part was unnecessarily uncovered. Reddening on some skin areas was found and so a pressure cushion was suggested to patient whilst she was less mobile and pressure area care advice was also explained. With the patient's consent, this was also explained to her son. **Nursing-** Trying to discuss appropriate treatment plans but the wife was answering for her husband. She was politely asked to leave the room whilst the treatment was carried out to allow her husband (the patient) to have the privacy to discuss what he wanted from the treatment plan. **Matron-** One of my patients requested to speak with me (or in this case 'write' as the patient was unable to speak). He asked his wife to leave the room. The patient also had a full time carer who was also always present. The patient wrote down on his pad (his only means of communication) that he would like only myself to be present. I therefore asked the carer to leave the room and asked that we were not interrupted. This was kindly carried out by the carer and the patient's wife and the patient was then able to discuss with me what he wanted in privacy as he wished.
(6.2) Explain with a real case example how the environment in which the service is delivered manages dignity. • *Explain how people who use your service and their families will know that the environment offers privacy.* • *Explain how the culture of your service maintains dignity such as knocking on doors and waiting for a response before entering, providing a quiet room for private*	As a service, we visit people in their own homes. When certain private conversations or procedures take place, the patient is always asked whether or not they want certain friends or family present and if not are asked whether there is anywhere private that we can go. It is explained to the patient that they are able to have whoever present with them that they require during treatment and are asked how the patient would like staff to access their property either via key safes, to knock and enter or just to knock and wait to be let into the property. If a student is present

conversations, clinical room for medical professionals to use, end of life guest room etc. • ***Please provide real case examples of any of the above.***	shadowing, the patient is always asked before the visit via telephone for their consent for them to attend. **Therapy-** Therapist asked a patient whether or not she would like them to carry out a skin check and patient consented. Patient's daughter was in the room and so she was asked whether or not patient wanted to go somewhere private. Patient stated that she did and so moved into the bathroom and checked that the blinds were closed. Therapist explained to patient the areas of the body that she needed to check and explained why and patient was happy with this. **Therapy-** An elderly lady had a key safe by her door. Upon visiting to complete an initial assessment, it was noted that we did not have the key safe number and so the therapist knocked on the door and waited for her to answer. Once inside the lady was asked as to whether or not she wanted the therapists to use the key safe on future visits or not and she stated that she did and that she was happy for the number to recorded on the system and for any other health staff to use it and access her property via it. **Nursing-** we visit a patient who lives in a residential home for leg dressings. We use the clinical room in the care home whenever we treat her so that she has privacy away from the other residents/visitors. We also use this room if we need to talk to her regarding private matters. **Matron-** I visited a patient who was complaining of swelling in his testicles. His daughter was present during the visit and so I asked the patient if he would like to go to his bedroom whilst I carried out the examination. The patient stated that he would. I also had a student with me at the time and so I asked the patient whether he was okay to have the student present. The patient stated that this was fine and so we went into the patient's bedroom where a full

	clinical examination and diagnosis was carried out with dignity and the privacy as requested by the patient. **Therapy-** Therapists visited a gentleman for physiotherapy. Therapists were met by the patient in the garden and he asked for them to stay there as he was enjoying sitting out in the nice weather. Once the therapists started to discuss private/personal things, they asked whether the patient minded if they went into the house and explained that they did not want the neighbours etc to overhear the conversation. The patient agreed and the conversation was continued indoors in privacy.
(6.3) Explain with a real case example, practices which minimise risk for people who use your service whilst alone in a private place. • *How do you balance privacy with risk for a vulnerable person who has time alone?* • *Explain what equipment and aids you use for safety.* • ***Please provide a real case example** where you have mitigated a risk to enable a vulnerable person who uses your service to have some privacy i.e. someone who chooses to smoke in their room, someone who is at risk of falling or wandering, or someone who does not wish to be disturbed at all?*	As our patient's mainly live in their own homes, many of them are on their own a lot of the time. We ensure that they are as safe as they can possibly be and offer them information and advice regarding this. We have leaflets with information on pendant alarms for those who live alone and are vulnerable and at risk of falls. The therapy team also assess people within their own homes and can get equipment such as grab rails, shower stools etc. and also walking aids to ensure that a person is as safe as they can be under their own personal circumstances. We can also refer patients onwards to a number of other agencies such as the falls unit in order to limit risk to a vulnerable person. We also raise concerns to the appropriate agencies if we feel a person requires care calls and/ or further support at home. **Therapy-** Visited a patient with reduced mobility who was at high risk of falls. Therapy deemed her unsafe to walk outside. However, she had full capacity and decided to do this anyway. So, in order to mitigate the risk, we practiced outdoor mobility with appropriate aids and labelled these up so that it was clear which we advised her to use, and also provided a prompt sheet to back this up. Family were not keen on her choice, however her treatment was

	discussed away from family to allow her the privacy to make this decision independently. **Nursing-** we were visiting a patient with grade 3 pressure damage to her thighs which were caused by sitting on the toilet. Her husband would regularly refuse us entry as his wife was sleeping or was on the toilet. We discussed the importance of redressing the wounds weekly. We agreed with the patient and her husband to ring prior to our visit to see if it was a convenient time to visit and this enabled her to maintain her privacy. **Matron-** One of my patient's wanted to go into his garden. This patient was end of life and he spent a lot of time in bed but did sit out for a few hours in the morning. He had an armchair and a wheelchair. We would need to move the patient in his wheelchair as this had a safety harness, however he had a trail in this (which was customised especially for this patient) and his wife was concerned it would tip back. To reduce the risk of the patient being unsafe in his chair and minimise the risk of tipping or even the patient falling out as he wasn't able to support his body independently, we discussed what we wished to do and our concerns with wheelchair services who advised us accordingly on the correct, safe procedure. This enabled us to get the patient into his garden safely as he wished.
(6.4) For this standard when asking "is this the best we can do" please list any improvements or changes you will make. • *Include something here that your establishment or service could do to improve your provision of privacy.*	As a team we will continue to be aware of all the aspects mentioned above and give access to discuss their treatment plan, assuming they have capacity to do so.

STANDARD	EVIDENCE
7. Ensure people feel able to complain without fear of retribution.	
(7.1) Explain how people who use your service are made aware of how to complain and are enabled to do so. • *How do people who use your service know about the complaints policy and is it in an appropriate format?* • *How do you know that they are confident to raise a concern or complaint if they are dissatisfied?* • *Explain how your staff demonstrate that they understand the policy and have access to it.* • *Can people make complaints in their preferred way i.e. anonymously, verbally etc.?* • ***Please provide a real case example** where a person who uses your service has raised an issue informally and it has been acted on and resulted in a change i.e. someone saying they miss a particular meal and it being included on the menu or a particular brand of sauce or a person raising the point that they were thirsty during the night and now everyone is provided with a fresh jug of water in their rooms at night.*	The compliments and complaints leaflet is given in every admission pack to the patient and the procedure explained. If a patient raises concerns then this would be followed up by the band 6 visiting and discussing further and if it could not be resolved then the patient would be encouraged to follow the process which is in the complaints leaflet which would make it formal. They are able to make complaints however they wish, be it anonymously, verbally either over the phone or to visiting staff members or written. When a complaint made is more serious or complicated, then an investigation will be carried out under the NHS Complaints Procedure. The trust will write to the person who raised the concern within three working days to acknowledge that it has been received and to explain the process that will be followed. We also have a Complaints and Concerns policy which describes our complaints handling processes. **Nursing-** A previous complaint we have had is patient's son contacted us to say they were unhappy with the care being provided to his mother's leg as the hospital had given different information when she had been discharged. The team had altered the patient's care which was in their best interests and so this was about ensuring that this was communicated to the patient and their son so they understood the reasons why.

	We have also had informal complaints about not giving a time for visits and so the team are now offering morning or afternoon appointments. **Therapy-** A patient's husband was complaining on her behalf regarding the amount of therapy input given at home. There were unrealistic expectations given how much community therapy can offer within the home environment. As such the band 6 discussed with the husband, took guidance from the band 7 and with the patient and husbands agreement, referred her on to the specialist rehab unit at London Road, Derby. **Care coordinator-** Care Coordinators provide a service to the GPs and practice staff as well at patients. Social workers have a tendency to use Care Coordinators as a go between avoiding the need to talk to clinical staff. One GP pointed out that this is really not appropriate for issues of medication or treatment – it delays the desired outcome for the patient. All issues regarding medication or treatment are now referred directly to a clinician, benefitting all concerned. **Matron-** A patient I was visiting complained to me about an incident which occurred when she had a District Nurse visit. The nurse had visited as planned to change dressings to both the patient's legs. The patient had also asked the nurse if she could do a blood test on her which had been requested by the heart failure nurse. The patient usually had both of her legs washed when she is having her dressings changed. The patient was upset as she had been told by the nurse that she did not have the time to wash her legs today or do the blood test. The patient did not want me to speak to the nurse involved. During my visit I did the blood test and washed and changed both leg dressings. Whilst doing this I asked a bit more about the incident. It turned out that the first time the nurse had called, the patient had been out which meant that

	the nurse had had to come back later on in the day at the end of her shift. I explained this to the patient and that this would have been late in the day to take bloods (and explained why regarding getting them sent off on time) and that it was likely that the nurse did then not have the time to wash both legs. The patient was happy with the explanation and no further action was taken. The patient was happy that she had discussed it verbally with me and I assured her that I would discuss it with the sister but that she would remain anonymous.
(7.2) Explain how complaints both formal and informal are investigated and responded to. • *What are the timescales of the process?* • *Explain how complaints are investigated-who does what and when* • *How do ensure that a person has been listened to?* • *How do you monitor complaints?* • *How a complaint about another service is resolved i.e. Taxi driving too fast or always late, only wanting to see a certain Doctor?* • ***Please provide a real case example** of where you have supported a person who uses your service to complain.*	After receiving a complaint, the trust will write to the person within three working days to acknowledge the concerns raised and to explain the process which will be followed. A complaint is investigated by a investigating officer band 7 if it is formal and we have a form to complete after investigating this which highlights the concerns, what learning has been found from this and what actions will need to be taken to prevent this from happening again. An action plan is then formulated which is then share at monthly ICT meetings with the team. This is then sent to the complaints manager and they formulate a response for the person making the complaint and our policy is they should have a response within 40 working days. We have a 'Compliments, Comments, Concerns and Complaints' leaflet that is available in different communication formats and this explains the process and also lists the ways in which the trust can receive feedback and how a person can share their feedback about our service. **Therapy-** A patient was unhappy with referral pathway and waiting list times. These were in line with national targets which was explained to patient, however, contact details to the Patient

	Experience Team given and encouraged to contact to discuss further. **Nursing-** A patient's sister contacted the team lead wanting to complain about an element of the care they had received after receiving the investigation outcome letter from the duty of candour process. Patient experience team information given and the leaflet for this team explaining the process sent out in the post. **Care Coordinator-** A patient had just returned from hospital. He had been discharged with a very small number of continence items. The daughter had contacted the continence team who had provided some products to tide him over until he could be assessed. During my normal post discharge courtesy call it was obvious the family were extremely concerned that the products supplied were just far too small and they had not been able to get back in touch with the continence nurse, and it was Friday afternoon! I was able to have a quick chat face to face with the continence team who rang the daughter immediately and resolved the issue.
(7.3) Explain with an example the process of learning from complaints. • *How and where do you report on complaints i.e. corporately and/or local?* • *How do you share outcomes of complaints with your staff?* • ***Please provide a couple of real case examples** of how you have learnt from a complaint formal and informal.*	Learning from corporate complaints is sent via email to all staff as updated guidance. If there are patterns developing e.g. patient's concern about waiting list time, then further explanations are given at the point of initial contact with the patient. Local learning such as this is an ongoing process according to changing pressures of the time. **Formal complaint-** safe guarding concerns. Family had complained to the both the nursing and therapy team regarding pressure damage. Multiple services involved at the time including GP, care coordinator, adult care. Concerns regarding non-compliance of family and strained husband wife relationship.

	Vulnerable Adult Review Meeting (VARM) held with all members of the team present led by Mary Driver from safe guarding. Learning to be taken forward was greater summary of concerns as they developed and more regular review meetings than those that were held. It was also highlighted that when staff contact the safe guarding team, they cannot always seem everything that we can on System 1. However, this has now been improved. **Informal complaint-** Complaint from family members regarding out of hours calls to the nursing team and referral over to District Nurse Liaison. Nursing team now make it clear to relevant patients who may potentially need out of hours calls where this will be directed to. This ensures that they are aware this could happen before the need arises. **Nursing-** we have highlighted learning from a Root Cause Analysis recently and our band 7 KM has met with all the nursing team to share this learning. K also completed a Duty of Candour with the patient and they have received the outcome of this investigation in writing.
(7.4) For this standard when asking "is this the best we can do" please list any improvements or changes you will make. • *Have complaints on staff meeting agendas?* • *Meetings with people who use your service as an opportunity to discuss any issues.* • *Maybe easy read complaints policy on show.*	We discuss any complaints that we receive in the monthly team meetings and discuss any improvements and things we have learned from them. There are plans to gather more patient stories in the future. As we are community based, we cannot have a complaints policy on show as patients do not come in to our place of work. During the Covid 19 Pandemic we have continued to have regular meetings and ensured that any learning has been shared. We have done this through Microsoft Teams and ensured that all meetings have been kept as regular and up to date as they were prior to the pandemic.

STANDARD	EVIDENCE
8. Engage with family members and carers as care partners.	
(8.1) Using a real case example describe how you enable people who use your service to involve family and friends as care partners. • *Explain how you ensure that the person who uses your service consents to family/carer involvement in their care.* • *How do you ensure that family/carer are involved i.e. carer meetings, newsletters, telephone contact, shopping days out, hair dressing etc.* • ***Please provide a real case example** of where a carer or family member is involved in the care of the person i.e. helps with meal times*, washes hair weekly, takes out to a group or shopping etc.	Patients using our service are always made aware at initial visit that they can have family and carer involvement if they choose. Very often they wish us to discuss their care plan with another member of the family at which point staff will contact them to update family of the outcome of the treatment on that day. Again if patients choose, we can let family members know appointment times so that they can come and join as well. **Therapy-** An elderly lady with deteriorating mobility was referred to our physiotherapy service in order for us to try and increase her muscle strength and her confidence. She had issues with exercises but was anxious about completing them herself, and so with her consent, we showed her daughters the exercises and they completed them with her daily. As patient progressed to outdoor mobility practice her daughters again practiced with her and took her up to the shops and back with her walking aid until she had the confidence and ability to do this by herself. **Nursing-** We were seeing a patient who was struggling to take her own blood glucose measurements and give herself insulin. After speaking to the patient and her family, it was suggested that with education and support, her family could help her with this. We visited and taught family members how to do so and she then no longer required our input.
(8.2) Describe how you ensure that appropriate information is provided to family/carers.	We always give out 'new patient packs' upon initial visits which details our team, our contact details and the treatment we give.

• *How do you keep family/carers informed i.e. newsletters, meetings etc.* • *How do you develop a sense of partnership with family/carer informing them about hospital visits or Doctor visits?* • *Do you have any leaflets available about health and well-being you can give out to family/carer?*	With a patient's consent we are happy to speak to family members and for them to contact us if they have any questions or requests. With consent from the patient, we inform family/ carers of any visits and progress etc and if they need equipment delivered to the house, this is often arranged with family so that someone is present to accept the delivery. We are happy to provide discharge summaries for families explaining our therapy input if the patient's request this. **Therapy-** An elderly lady we were visiting for physio had memory problems and was worried that she would not be able to relay to her son what we had advised/done on each visit. We agreed to do a 'care log' and write our interventions and advice given on each visit. We would always read back what we had written back to the patient to ensure that she was happy with the information in it.
(8.3) Using a real case example describe how your team extends principles of dignity and respect to family or friends of people who use your service. • *How can family/carers contact the service i.e. telephone, email and text, face to face?* • *How do you put into practice how family/carers and visiting friends with children are welcomed and catered for?* • *How are visitors welcomed?* • ***Please provide a real case example** of when your service has done something to ensure that the principle of dignity and respect have been extended to family/carer.*	Family and carers are given the teams contact details upon an initial visit. The therapy team have a contact details sheet which is printed on bright yellow paper to make it easier to find and has all the contact details about the team that a patient may need. On the back of this is an appointment sheet so that any appointments can be clearly written down and patients are advised that if they need to change this then they can give the team a call. We have a personalised answering machine and advise patients that as we are out and about in the community, we may not always be able to answer the phone, but if they leave a message, someone will get back to them as soon as possible. All staff have a work mobile phone and if a patient needs to they can contact a staff member via this. If a patient's wider family are present during the visit, we always ensure we introduce ourselves to them and that they are happy for us to be there. If a family member is unable to be present at visits but would like to be kept informed of interventions, with the patient's consent, we can leave a care log in the property where each staff member

	writes down what they did on each visit. With the patient's consent, family members can call us after visits for updates. This has worked particularly well in therapy. **Therapy-** A lady with reduced mobility and confidence lived with her daughter who was a farmer. The daughter arranged all of the patient's appointments for her but was not always available to answer the phone due to being busy on the farm. The daughter asked for the therapist to text her with appointments rather than to call and she also asked for us to text her before we set off as she could then open the farm gate to let the car through. Daughter always liked to be present (with patient's consent) during the visit as she liked to be able to be involved to continue therapy with her mum once we had left. The patient struggled to remember things and so her daughter was able to help with this. **Nursing-** A patient's daughter was not happy that we visited whilst she was out. Telephone contact was therefore made with daughter and we explained that it was hard to give an exact time of visit due to our workload. We explained that we could make telephone contact whilst we were visiting her mum to explain what we had done and how the wound was progressing. Verbal consent was gained from the patient to discuss her care with her daughter. The daughter was happy with the communication she then received regarding her mother's care. **Care Coordinator-** We have a patient with advanced dementia, who has been cared for by his wife since he was diagnosed with early onset almost 20 years ago. He is now bed bound and whilst he has carers twice daily his wife still provides all meals and most care 24 hours a day. I have been unable to talk to this lady as she doesn't speak English, but have had several discussion with her daughter and we have been able to arrange a weekly day sit for this gentleman so his wife can attend a temple and have a few

	hours of contemplation and prayer (and friendship within the temple). **Matron-** One of my patients who lives on her own but her daughter visits approximately 2-3 times per week and takes her to any appointments she has and also arranges her hospital and GP appointments. On her first review visit, the patient's daughter was present and asked whether I could possibly liaise with her any concerns I had and of any reviews I had with the patient. The patient agreed to this and so I took the daughters telephone number and as requested by the patient and daughter, I liaised with the daughter any concerns I had and let her know when I would be visiting. **Therapy-** a gentleman who had memory difficulties had a daughter who he was close to but she worked full time and so was unable to be present during visits. The patient asked if we could write down what we had done and said to him on each visit so that he could show her rather than telling her incorrect information. We created a care log that each staff member filled in on each visit. This remained in the property and also had our services contact details clearly on it so that the daughter or patient could contact us to discuss if required.
(8.4) For this standard when asking "is this the best we can do" please list any improvements or changes you will make. • *Think about how you could improve how you respect visitors with maybe a children's corner or facility to make a drink.*	This is not relevant to our service.

STANDARD	EVIDENCE
9. Assist people to maintain confidence and self Esteem.	
(9.1) How do your staff practice in a way that enables the people who use your service to achieve/maintain their confidence and self-esteem. • *Explain how you have found imaginative ways to really get to know and value a person who uses your service i.e. life books, memory box, this is me etc.* • *Give an example of where a person who uses your service has said they feel better about themselves as a result of your service.* • *How do you measure self-esteem- record changes in observed behaviour or morale?* • ***Please provide a real case example** of where you have seen a positive change in a person who uses your service as a result of what you provide for them, this could be joining in activities, helping with small tasks, gardening etc.*	Our initial contact asks a wide range of questions that helps us get to know a person. We ask patients their hobbies, past times and what is important to them in order to provide them with the best possible care. This is particularly important with therapy where personal goals are set of what is important to that particular person and what they want to achieve from their therapy sessions. All the information is then entered onto the patient's record on System 1. Any observed changes in behaviour or morale is also recorded on the system within the patient's notes. This is now recorded in the EKOS for therapy and updated regularly. **Therapy-** Many of our patients report that they feel better about themselves after our input as we give them the confidence and ability to get back to what they used to do and what was important to them. We work to an individual's set goals (for example, being able to get back out to walking to the shop) and when this is a achieved it can have a huge positive impact on that person and their morale. **Therapy-** I was seeing a lady who had lost confidence in her mobility following a fall. During my visits she expressed that she feels down due to feeling like she was trapped in the house whereas she used to be able to get up to the corner shop and back. I changed her mobility aid to something more suitable and sturdy for her and also gave her some exercises to do in between my visits in order to build up her muscle strength and tolerance.

	We then progressed to outdoor mobility practice, building up distance and tolerance each time until we could eventually walk up to the shop. I then practiced shopping with her a few times until she felt she would be confident to try to do so herself. I then followed this up with a telephone call where the patient reported that she had managed to get to the shop and back and that she felt extremely happy and relieved to be able to get back to doing her own shopping weekly and that she did not feel so trapped in her own house anymore. **Nursing-** Whilst visiting a patient on a regular basis I noticed that she was becoming more and more withdrawn. The lady had minimal social interaction with others and looked forwards to our visits and did not want them to stop. I spoke to her about going to a luncheon club. She declined straight away but when I explained further what happened there she accepted the offer. I contacted the luncheon club and referred the patient to them. I visited the day after she had been and she was smiling and very chatty and she said that she had thoroughly enjoyed herself and had even booked to go again the week after. **Care Coordinator-** I received a hospital discharge stating a 90+ year old lady had been on a DOLs for 5 days due to severe delirium and was then discharged home with a care package. When I rang her there were no carers involved, just the hospital discharge team. I spoke to them and they were very worried that she still had some residual delirium and her mobility was really quite poor, with no walking aids or equipment at all (although this hadn't been picked up on the ward). The community therapy team visited urgently and sorted her out with some equipment and physio. She liked to read, but couldn't get to the library and was a little fed up with the romances with which a well-meaning neighbour regularly supplied her, so I referred her to the home library service. The last time I spoke to her she was cooking

	Barnsley chops for her older brother who was visiting and she was very contented. **Matron-** One of my patients was struggling with increased shortness of breath which was very debilitating for her. She lived with her husband who was terminally ill. The patient herself and lung fibrosis and due to her oxygen levels, she wasn't an ideal candidate for home oxygen. However I discussed it with the home oxygen service nurse who advised me to measure her oxygen levels whilst she was mobilising and if she fits the criteria then to refer her to their service. I visited the patient again and did this which showed that the patient's oxygen level decreased when mobilising but returned to normal once she had sat down. I arranged a joint visit with the oxygen nurse. The patient was then given oxygen for mobilising and this made a huge difference to the patient's quality of life. She can now go in her garden and potter around. She is also able to do more in the house which she likes. We are now in the process of getting her assessed for a 4 wheeled walker to enable her to go out with her daughter when she visits. **Therapy-** whilst visiting a gentleman for physiotherapy, he reported that he felt trapped within his home since his diagnosis. He stated that he would like to be able to join a group of some sort in order to interact with other people but did not want a luncheon type group. He was relatively young and so he wanted something more age appropriate and ideally, doing a hobby he enjoyed. He stated that he had previously been a keen gardener and also liked to do 'handy' DIY tasks. I looked up groups within his local area and found the 'Men in Sheds' scheme. This was run by a group of men of similar age to the patient and supported them to do woodwork and gardening etc. This seemed ideal for this gentleman. I contacted them to find out more information and put a sheet together for him with this information on and their contact

	details. I later contacted him to see whether or not he had been able to attend and he confirmed that he had and stated that it was brilliant and had given him something to look forwards to. It had also enabled him to meet people who were in a similar situation to him which he said had really helped him overall and had helped him to better come to terms with his diagnosis.
(9.2) Explain and provide a real case example of how you assess if people who use your service are able to make their own decisions, even unwise decisions. • *Explain your assessment process.* • *How do you obtain information about a person who uses your service?* • *How is this updated?* • *Do you use advocacy?* • ***Please provide a real case example** of where a person who uses your service has the capacity to make their own decision but it is an unwise one with some risk? This could be refusing to take their medication or dressing inappropriate.*	Within our service, all patients are presumed to have capacity unless proven otherwise. If they have been assessed for capacity then it is recorded on the patient's records on System 1 and so is available to the staff who are involved in that patient's care. GP's will sometimes refer through to the therapy team for a MOCA assessment (Montreal Cognitive Assessment) if they have concerns about a patient's capacity to look at this in more detail. The therapists will then feed back to the GP's who will then decide and MDT (multi- disciplinary team) approach. An MDT capacity assessment can also be carried out- to look at specific information given, if the person can weigh it up, if they can repeat it and if they can recall it later. Information about patients is gathered via System 1 including consents once patients have agreed that we can share their record with other health agencies. System 1 is updated all the time. We explore individual advocates for those who lack capacity. Sometimes this means linking in with lasting power of attorney for health or finances. **Therapy-** We were visiting a lady who had a history of falls, one of which resulting in a very bad break to her leg. Everything is set up for her to have a downstairs existence and she has had for the past 3 years. However, despite having the risks explained to her, she is adamant that she wants to get back to going up and down stairs. She has capacity and understands the risks of doing the stairs (the muscles in her legs are weak and she does struggle to get up and downstairs and is at risk of falling and re-fracturing).

	Therefore we have provided exercises for her to build up her muscle strength and tolerance and have also completed stair practice with her. We have discussed the provision of a stair lift as feel that this would be much safer for the patient and would allow her to have the energy to complete tasks upstairs rather than using all of this solely managing the stairs but she is adamant that this is what she wants to do. Therefore we have helped to facilitate this despite the risks. **Nursing-** We were visiting an end of life patient who was being nursed in bed on an alternating pressure mattress. The patient did not like the mattress and stated that it was uncomfortable and very noisy which was causing her distress due to her disturbed sleep. We had a discussion with the patient regarding the level of pressure care she required and the pressure area care leaflet was discussed to explain things further. However, the patient still requested to change the mattress. A high specification mattress was sourced and patient was advised to alternate her position hourly to which she agreed to and was happy with. **Therapy-** we were visiting a lady who was getting into bed using a small step. We advised her that this was not the safest option and why. We explained that we could look at alternatives that might help, all of which she declined. She had capacity and fully understood the risks that we had explained to her. She demonstrated that she could use the step as safely as possible and so we left her with our contact details and advised that she could contact us at any point if she changed her mind or if she felt her bed transfers became unsafe. **Therapy-** During the Covid 19 Pandemic, we have contacted every person on our waiting list and respected their decision of they did not want to be seen currently. We have then kept in touch via telephone if they consented or discharged from the service if

	the patient wished to be and given them with all the contact details of how to re refer themselves back to the service once they were happy with us visiting.
(9.3) Explain with a real case example how you ensure that the decisions for people who use your service who lack capacity promote confidence, self-esteem and are in their best interests. • *Explain how staff have access to information on the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DOLS) and the training for this.* • *Explain how the staff understand the principles behind Best Interest Decision making.* • ***Please provide a real case example** of where the manager has demonstrated and actioned MCA.* • ***Please provide a real case example** of where a DOLS referral has been made.*	All policies such as the Mental Capacity Act and the DOLS are readily available to all staff on the DCHS intranet. There is training for this during the staff induction for all new staff and then mandatory Safeguarding training from the Trust which is renewed every 3 years. Staff would follow all points on the MCA before making a best interest decision. Any best interest decision made would be in conjunction with the whole MDT as well as family where appropriate. This decision would have to be the least restrictive for the patient's health and well-being. We regularly treat patients who have a DOLS in place who reside in care homes. This might be because they are fully mobile and wish to leave but it is not in their best interest as this would be unsafe for them. Often DOLS for this sort of thing are already made before therapy go in to treat. **Nursing-** We have dealt with a complex patient that did building work to his own house all day and night, he took windows out and doors and there were holes in the floor etc. Our team were concerned for his safety and arranged multiple MDT meetings to discuss our concerns as his house was a fire risk due to all the wood in the house and we were concerned if it was structurally safe as he had made his own adjustments independently and it was semi-detached. One particular day the gentlemen fell and had been on the floor for a long time when our team found him and he was admitted to hospital, whilst in hospital we liaised with the ward manager regarding our concerns and the patient had been assessed as having capacity whilst at home however we requested another capacity assessment whilst in hospital. This assessment deemed

	that this patient did not have capacity and had no insight into the living conditions at his home. The patient was adamant that he wanted to return home so therefore a DOL's was implemented to keep him in hospital whilst a decision was made as to whether he could return home safely or not. This patient did not return home and instead went to live with his daughter. **Therapy-** I was asked to visit a lady to complete some strengthening practice and mobility practice with her. The daughter had asked that I meet her at the property. However, when I got there, I noticed that there was a big padlocked gate stopping access to the front door. Once daughter arrived, she unlocked the padlock and told me that she locked the patient in as she had been found wandering a few times. She reported that patient did not have capacity. Once in the property, I noticed that there was CCTV in every room including the bathroom. Daughter stated she had put these in place after patient had fallen a few times. Patient also was in the early stages of dementia and so she wanted to check where the patient was and what time she went to bed etc. I discussed the cameras and padlock with patient when daughter was not within earshot and she stated that the family had just put them in and not given her the choice. She also said that she did not really like them. Upon returning back to the office, I discussed this with my team and a Safeguarding referral was raised along with a DOL's referral. When I looked through the patient's record, I found that she had actually never had a mental capacity assessment and so I rang the GP to request this. The band 7 then took over this case and contacted the daughter to discuss other alternatives of keeping the patient safe that was less restrictive such as pendant alarms, falls sensors and key safes.
(9.4) For this standard when asking "is this the best we can do" please list any improvements or changes you will make.	All staff have a high level of awareness of MCA and DOLS but often do not act alone to action these things. They are often

• *Record here any improvements you think you could make to your service regarding MCA and DOLS, could be more in house training or scenarios of Best Practice monthly.*	actioned by other agencies such as social service or care home staff, and our staff contribute as necessary. We ensure that all staff training regarding MCA and DOLS is always kept up to date

STANDARD	EVIDENCE
10. Act to alleviate people's loneliness and isolation.	
(10.1) How do you involve people who use your service in the wider community? • *How do you involve your service in the wider community?* • *Do people or groups come to your establishment?* • *Do you take part in community events?* • *Do you have volunteers?* • *This is asking if you have entertainment, volunteers etc. with specific tasks or events that come to your service.*	We refer patients who are isolated and lonely to the care coordinators who have a vast knowledge on the services available within the wider community. We also have some leaflets of community groups and have a folder in the office of different types of activities/groups that are available for people to access locally such as swimming sessions, gym sessions, men in sheds etc and these are updated regularly. We also held a cake and coffee morning in the GP surgery to raise money for Treetops Hospice. Some staff recently attended an event ran by Derbyshire County Council which advertised and explained community services, events and groups that they were running that people may not be aware of. These included new groups such as dancing groups. Staff were able to bring back leaflets and information for the wider team and an email was sent out to make all staff members aware of them so that they could let patients know where relevant.
• *Do you hold coffee mornings or garden fetes?* • *Do you have schools or nurseries carrying out projects?*	

(10.2) Explain with an example how your team alleviates isolation of individuals. • *How do you reduce isolation for people who use your service?* • *Explain how you measure your effectiveness.* • *Do you signpost people who use your service to occupational activity, befriending, local clubs or services such as advocacy?* • ***Please provide a real case example** of how you have alleviated isolation for one or two people who use your service in different ways.*	During the initial assessment, the questions that we ask would help determine whether or not a person could potentially feel lonely and isolated and we also encourage them to discuss this with us if they wish. We can then refer them to the care coordinator with consent who can then call them and refer them on to other agencies such as befriending services and social groups. Therapy also encourages and enables people to become as capable as possible via the use of exercises to build up strength, tolerance and confidence and equipment such as walking aids and grab rails for the patient to be able to access other services within the community. Measuring effectiveness comes in the form of feedback from patients themselves and family and friends. **Therapy-** A gentleman who had had a fall and fractured his hip stated that he felt lonely after his wife had died a few months ago and with his injury on top. He stated that he previously enjoyed pottering about in his shed and doing woodwork but was unable to do this now without support. He had very little input from friends and family. The 'Men in Sheds' group was suggested to him which patient was very keen on. The therapist rang the group to ensure that he would be able to access it and transport was arranged to take and collect the patient. Patient was extremely happy with this and stated that just that one thing a week to look forwards to made a huge difference to his overall happiness. **Nursing-** we were visiting a lady for leg ulcer dressings. She was struggling with mobility due to her shoes not fitting correctly with the bandages. This was causing the patient to become isolated as she was unable to go out and her mood was beginning to drop. We discussed ordering karraped boots with the patient which would enable her to mobilise safely and to keep her bandages in place correctly. Once the boots arrived, she wore them straight

	away and was able to potter about in her garden safely and to attend luncheon clubs again. **Care Coordinator-** Extremely elderly gentleman living alone, saw his daughter about once a week, otherwise on his own. I referred him to VSPA as his interests were quite specialised. They managed to organise a befriender who enjoyed the same classical music as he did and found him someone who would take him to an art appreciation society in Ashbourne once a week. I may not have actually done the organising, but I knew a woman who had the local knowledge and ability to provide a perfect answer! **Therapy-** a gentleman we were seeing had mental health issues and would become withdrawn and depressed at times. I noticed that he had become less and less engaged with therapy and so asked him if he was okay. He disclosed that he had been being seen by a mental health nurse who had been taking him out and encouraging him to practice his photography which was something he really enjoyed. He said that this had stopped recently and he was not sure why but he felt that it had made him take a few steps back. With his consent, I agreed to chase this up and see what had happened. I got in touch with the team that had been seeing him, voiced my concerns and got his home visits reinstated. Once they started to see him again, I noticed that he began to become more engaged in my therapy sessions with him also and began to progress quickly. During the Covid 19 pandemic, we have kept in touch regularly with patients, even those who did not want a visit to ensure that they remained safe in their homes and that they had some support. Our care coordinator also kept in touch with those who had been advised to isolate in order to ensure that they knew how to access the services that they may require.

(10.3) How do you ensure that people who use your service "have their say" in how your service is run. • *Explain how you seek customer opinion i.e. suggestion box, open door policy or NHS Choices reviews.* • *What consultation exercises do you undertake i.e. meetings, questionnaires or surveys.* • *How do you help the people who use your service to be involved?* • *Explain how you action any issues raised.* • *Do you have any focus groups if so how often?* • ***Please provide a real case example** where as a result of a meeting or consultation you have taken an action to implement a change.*	Every staff member is given yellow prepaid feedback forms to give to patients which allows them to score our service out of 10 on aspects such as whether or not they would recommend our services and also allows them to make their suggestions on how we could improve. These are then posted back to us and the Quality Always team collates the information and can give us feedback on request. We also record any verbal feedback we receive and keep any cards and these are then read out in the monthly team meetings. At the end of every appointment, the patient is asked whether or not they are happy with the plan for future appointments or whether they have any questions or suggestions. Focus groups and meetings are not relevant to our patients as they are mostly housebound. Feedback from care homes showed us that they were struggling to differentiate between pressure damage and moisture damage and they were also finding it difficult to grade pressure ulcers. One of our nurses designed a leaflet with photographs to try and assist with this and also went into the local care homes to deliver some training surrounding this. We got very positive feedback about this and the nurse who initiated it and designed the leaflet and delivered the training was nominated for an 'Extra Mile' award through the trust.
(10.4) For this standard when asking "is this the best we can do" please list any improvements or changes you will make. • *Include here anything you want to change or add to ensure the people who use your service and their family/carer have their say.*	We ensure that we keep the shared drive where we store all the information about local groups, updated on a monthly basis. The paper leaflets are also monitored to ensure that they are up to date and fit for purpose. Any new information regarding groups and services is put onto the shared drive for all staff to access. We update the 'You Said, We Did' tree every two months which indicates things that we have changed within our service due to feedback from patients, carers and staff.

	We recently had a care home who for their CQC inspection, required written evidence of the input received from Physiotherapy for their patient who had repeat falls. We agreed to provide a discharge summary of each patient for the care homes records, highlighting the input received and the continuing advice needed. The care home were really grateful of these and stated they were very useful and so we will continue to provide these and do so for any other care home who may require them.

Derbyshire D&R Application **Controlled**

Option 1 application is a “desk top” assessment, we require assurances that important Policies and Procedures that underpin good practice are in place.

Please confirm that the Policies and Procedures listed below are in place in your service and include the last review date.

	Policies & Procedures	Last review date	Managers Signature	Todays Date

1.	Safeguarding Policy & Procedures amended in line with the Care Act 2014 “6” Principals and all types of abuse. (See below)	20/05/2020	Kayleigh Mansfield	08/10/2020
2.	Dignity & Respect	17/08/2018	Kayleigh Mansfield	08/10/2020
3.	Health & Safety	16/07/2019	Kayleigh Mansfield	08/10/2020
4.	Mental Capacity Act & DOLS	02/02/2018	Kayleigh Mansfield	08/10/2020
5.	Information Governance	11/06/2020	Kayleigh Mansfield	08/10/2020
6.	Supervision Policy	10/06/2019	Kayleigh Mansfield	08/10/2020
7.	Complaints Procedure	31/01/2020	Kayleigh Mansfield	08/10/2020
8.	Code of Conduct for Employees	20/11/2019	Kayleigh Mansfield	08/10/2020
9.	Data Protection	03/09/2019	Kayleigh Mansfield	08/10/2020

6 principles

1. Empowerment

All types of abuse and neglect and how to respond

1. Physical abuse

2. Prevention
3. Proportionality
4. Protection
5. Partnership
6. Accountability

2. Domestic Violence
3. Sexual abuse
4. Psychological abuse
5. Financial or material abuse
6. Discriminatory abuse
7. Organisational abuse
8. Neglect and acts of omission
9. Self-neglect

All the information that has been submitted for our Dignity and Respect application to my knowledge is current and correct to date.

By signing to the Policies and Procedures above I wish to confirm that these are in place at this establishment/ward and accessible to all staff members.

Signed……