healthwatch Derbyshire

Enter & View
Tri-annual Summary Report (May 2017)

Visits commissioned by Derbyshire County Council 2016-2017

WHAT IS ENTER AND VIEW? Healthwatch Derbyshire (HWD) is part of a network of 148 local Healthwatch across the country established under the Health and Social Care Act 2012. Healthwatch Derbyshire represents the consumer voice of those using local health and social services.

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

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

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1. The context

During 2016/2017, Healthwatch Derbyshire was commissioned by Derbyshire County Council (DCC) to conduct a range of unannounced visits to their residential services across the county. The service profile and range includes 22 services supporting older persons and four services supporting people who have learning disabilities/difficulties.

Visits have been managed by the Healthwatch Enter and View Officer and the principles of the annual schedule agreed with the DCC Service Manager (Direct Care) Quality and Compliance, Emma Benton. These respective officers maintain regular communications concerning visits and reports during an eight weekly cycle of meetings.

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

This is the third and final summary report agreed to be produced throughout the commissioning period. The first being published on 13th October 2016 and the second on 23rd February 2017. This report represents those visits undertaken from the end of October 2016 until 21st April 2017 when the final visit report was fully completed.

As the Enter and View reports were commissioned primarily to complement DCC's own internal quality audit system, individual reports are not placed in the public domain as is usually the case with Healthwatch Enter and View reports. However, a tri-annual summary

report was agreed to be made public and published at the end of September, January and March. However, this report has been delayed by final visits having to be arranged later in the schedule than anticipated and consequent finalisation of those visit reports occurring later than planned.

2. Completed visits

No.	Service Visited	Type of Service	Date of Visit	Authorised Representatives (ARs)
1	Morewood Centre	Learning Disabilities	14th December 2016	Ruth Barrett & Shirley Cutts
2	Oakland CCC	Older Persons	14th December 2016	Helen Barker & Brian Cavanagh
3	Meadow View	Older Persons	15th December 2016	Caroline Hardwick & Margaret Morrison
4	9, Victoria Street	Learning Disabilities	17th January 2017	Dave Mines, Shirley Cutts, Emma Kellett (supported by Carole Hodgson, McIntyre)
5	The Petersham Centre	Learning Disabilities	18th January 2017	Brian Cavanagh, Sharon Mellors, Denise Bowles (supported by Carole Hodgson, McIntyre)
6	The Spinney	Older Persons	31st January 2017	Philip Arrandale & Caroline Hardwick
7	Hazelwood	Older Persons	8th February 2017	Barbara Arrandale & Margaret Morrison
8	Beechcroft	Older Persons	8th February 2017	Patrick Ashcroft & Yvonne Price
9	The Grange	Older Persons	15th February 2017	Philip Arrandale & Dave Mines
10	The Bungalow	Learning Disabilities	21st February 2017	Ruth Barrett, Brian Cavanagh, Emma Kellett (supported by Tanya Nolan, Healthwatch)

In November 2016 Healthwatch Derbyshire, in partnership with the MacIntyre learning disability charity, recruited six people who have learning disabilities to undertake training to become Specialist Authorised Representatives (SARs) with a view to initially using their expertise with the visits to the for learning disability services. The training completed in mid-January 2017 and two of the six training participants (Denise Bowles and Emma Kellett) were appointed.

The SARs required support during their visits, as identified above, and had an easy read checklist developed for them (Appendix 2) to use whilst undertaking their visits and this was based upon that used by all other Authorised Representatives (ARs) – see Appendix 1.

3. Acknowledgements

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

4. Purpose of the visits

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

5. Disclaimer

This summary report collates the findings gathered across the range of visits undertaken on the specific dates as set out above. Such reports are not suggested to be a fully representative portrayal of the experiences of all residents/clients and/or staff and/or family members/friends encountered, but provide an account of what was observed and presented to HWD ARs at the time of their visits.

6. Methodology

During visits ARs are provided with a set of standardised evidence gathering tools developed by Healthwatch Derbyshire especially for the DCC commission of visits (Appendices 1-5).

The following techniques were generally used by ARs in undertaking each visit:

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

7. Summary of key data and findings across all visits

- Each visit on average took approximately 3 hours and 20 minutes to undertake
- Observations by ARs generally included the full range of residents/clients and staff present during the visit plus any visitors who were present

- Due to the nature of the capacity limitations of many residents/clients, discussions and/or questionnaire based interviews were restricted. In total:

  (i) 21 individual residents/clients were engaged with and participated within their capacity in responding to questionnaire based interviews

  (ii) 16 relatives/friends participated in questionnaire based interviews

  (iii) 25 members of staff participated in questionnaire based interviews

- Services provided homely, welcoming, clean and pleasant environments of care
- The homes demonstrated a very good standard of care being delivered by committed, enthusiastic and skilled staff
- There is a high degree of satisfaction with the quality of care experienced and confidence in the staff expressed by both residents and relatives encountered
- Eight of the ten services were recommended to consider some improvements to either signage to assist visitors (three services) or internal signage (five services) to improve orientation and/or navigation of buildings by residents
- About half the homes had on-going or planned internal decorative refurbishment schedules in place
- Attention to the external state, mainly garden areas of homes, was recommended at five of the services
- Health and safety type issues formed recommendations for five services
- Reviews of bathing/showering opportunities for residents was recommended in two services
- Social and therapeutic activities for residents in the main operated satisfactorily but with recommendations to four services to consider how to enhance the opportunities which were available
- Staff in two services expressed the wish to have more time to interact socially and therapeutically with residents
- Both physical access and social accessibility via appropriate communication systems was mostly very good. Recommendations were made in two services regarding physical access issues and two recommended to enhance visual/easy read communications.

8. Detailed findings across all visits

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

All services were noted to be sited in good locations in proximity to their local communities. About half of the services visited were homes of an older type/style with one representing a modern development about three years old and a “state of the art” type provision opened in 2016.

The challenges of some of the older buildings continues to be evident such as general maintenance, some restricted parking, some smaller sized bedrooms, limited en-suite facilities and in some builds corridors were considered by ARs to be somewhat narrow **(see 8.6.6 for further details).**

Improved signage for visitors was recommended at three homes visited and the service response indicated that this had subsequently been addressed:

"Requested additional signage to be displayed."

"Additional information and signage is being introduced for visitors."

"The new front door is now in place making the front entrance clearer."

In one service visited, which regularly supported wheelchair users for short term care, it was observed that the front door bell was not sufficiently accessible for a wheelchair user. The report recommendation received the following response:

"We will be seeking quotes to facilitate this."

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

Regardless of the variable ages of buildings, ARs reported consistently positive impressions when visiting services where they always felt warmly welcomed.

All services entered were generally described by ARs as pleasant, homely and relaxed environments which appeared clean and fresh.

8.3 **Facilities for and involvement with family/friends**

All except one of the services provided good facilities for visitors with private areas where visitors could meet their loved ones, alternatively the communal areas were used or the option to use the bedrooms of the resident if wished. Freely available refreshment facilities were available for visitors to use and services were able to offer visitors overnight stays especially where their loved ones were unwell or in the period of end of life.

Only one service seemed not to have adequate private areas or refreshment facilities or overnight stay provision, but relatives at this service did not present these as problems.

Visiting times were flexible and all relatives/friends of residents tended to speak with evident satisfaction with the overall care that their loved ones were receiving. They felt adequately involved in the support of their loved ones acknowledging invitations to Relatives/Residents' Meetings when they occurred. All relatives felt comfortable with raising concerns if and when they arose.

8.4 **Internal physical environment**

8.4.1 **Décor, lighting, heating, furnishing & floor coverings**

This was considered very satisfactory across the homes visited. About half the homes visited were having or had recently had varying types of redecoration carried out. Two of the services visited were having some general refurbishment done whilst another had had one area redecorated but the remainder of the home was in evident need of equal attention. One other service had just had some re-roofing completed.

In all homes it was evident that thought had gone into trying to achieve as 'homely' an atmosphere as possible through the selection of décor/furnishings used and their arrangement within the communal spaces.

8.4.2 **Freshness, cleanliness/hygiene & cross infection measures**

In the vast majority of homes ARs often noted the absence of offensive odours which reflects well on the standards of cleanliness and freshness within them. However, one home had carpets that promoted a slight "fusty" smell, the unit manager stated that the carpets were due to be replaced.

Most homes seemed to have adequate hand sanitiser facilities for both visitors and staff. In one or two visits the location of hand sanitisers for visitors was in need of review. The response from the service to the resultant recommendation stated:

"There is a hand sanitiser in the signing in area to the right of the door and there are hand washing facilities in each kitchenette opposite each of the lounges. Additionally we have placed a bottle of hand wash gel by the signing in book. We will alert visitors to these facilities with extra signage."

The last summary report raised the issue of resident hand-hygiene prior to meals. Where ARs visited at mealtimes there was one particular visit where it was not clear whether this had been carried out. The report raised a recommendation concerning this and the services stated that this had been addressed:

"Antiseptic hand wipes have been purchased to assist residents who are reluctant to wash their hands. Staff have been made aware that hand hygiene is carried out before meals and after using the bathroom. Staff regularly support (clients) ***with nail care."***

8.4.3 **Suitability of design to meet needs of residents**

Six of the homes visited were supporting older persons who commonly were living with varying degrees of dementia and mobility problems. The other four homes supported people who have learning disabilities and some with additional physical disabilities, offering short term/respite care plus some assessment/life skills training facilities. The homes in many respects were designed well in meeting the needs of those using the services.

However, in some of the homes some internal navigational and orienting signage could be improved a little. Such signage was satisfactorily evident in the older person's homes as dementia friendly decorative design and signage but equivalent signage was sometimes less evident within the learning disability services, Whilst one home explained that the ethos was to reflect a more 'normal' home environment where such signage would not be present, the recommendations made to these learning disability services were responded to positively, one home stated:

"We have implemented this recommendation and have now person centred signs and symbols highlighting each area within the unit."

and another said:

"With regards to signage around the building we are currently having this reviewed and orders are being placed."

As referred to under 8.1, older homes tended to present specific challenges in terms of smaller bedroom sizes and a lack of en-suite facilities however this was not commented upon adversely by either residents or relatives.

8.5 Staff support skills & interaction

8.5.1 Staff appearance/presentation

The impressions given by all staff encountered was of appearing both physically smart and professional in their approaches as well as being polite and cheerful as they went about their work. They all appeared to know the residents/clients well and were able to engage meaningfully with individuals accordingly.

The following sub-sections **(8.5.2 - 8.5.4)** reflect the overall quality of the care staff and care delivery across the homes visited and which was often reinforced by the testimony of residents spoken to as well as relatives.

8.5.2 Affording dignity & respect

Staff were considered by ARs to be constantly providing practical care in a highly skilled manner to support each individual's dignity and respect. However, in one home it was noted that communal bathrooms located off of a main corridor did not appear to have adequate methods, such as the use of "dignity curtaining" for ensuring absolute privacy of residents whilst receiving assistance to and from or within the bathrooms. This was raised as a recommendation in the report and the Unit Manager stated it had been referred for discussion with the Service Manager.

Appropriate consent was obtained by staff during all interactions with residents/clients. Conversations with residents were often conducted using a quiet tone to promote privacy.

Some further elements of good practice and initiatives to support dignity and respect were observed in one or two homes such as the use of an A4 reference sheet of information for staff outlining key likes/dislikes, needs and preferences of individual clients. In another home staff undertake some experiential learning activities to see what it might feel like to be in the home and looked after by the staff as if they were a client in the service.

8.5.3 Calm, empathic approach to care giving

As with previous reports on visits conducted, the staff in all homes were found to create a calm, caring atmosphere. All interactions reflect a high level of skill in applying sensitive approaches, especially with residents who show distress or confusion.

8.5.4 Attentiveness & pace of care giving

Staff were noted in their interactions to be focussed on the person being engaged with. They were also proactive in supporting individuals and as indicated under **8.5.1 & 8.5.2**, showed great awareness of the needs of people being supported and their capacities. There was no sense of people being rushed, and staff were observed to work with the resident at their own pace.

8.5.5 Effective communications – alternative/augmentative systems & accessible information

The personal communication strategies employed by staff were very good as outlined under **8.5.3** and **8.5.4.**

Alternative/augmentative systems of communication were not readily in evidence nor necessarily obviously required by residents except in some of the learning disability services. In one of these services, systems were recommended to be

reviewed and the service responded positively:

*"**Communication system similar to PECs** (Picture Exchange Communication System) **is now in place**."*

The application of the Accessible Information Standard in terms of having alternative forms of written communication according to the needs of clients, seems to have been managed effectively in the majority of homes visited. Pictorial material for example was used fairly consistently throughout homes for food menus and to discriminate bathroom and toilet areas. Further easy read materials were recommended in one learning disability service to which the response was:

"The notice board within the foyer area has been reviewed by the unit manager. Further, easy read versions of information have been put on display for client accessibility and understanding. However, safeguarding information and complaints information was already displayed in easy read format but dementia support, 'Changing Places' and dignity and respect information has been added in easy read versions."

8.6 Resident's physical welfare

8.6.1 Appearance, dress & hygiene

The vast majority of residents were observed to be clean with good personal hygiene, tidy in appearance and well dressed in clothing that was either chosen by them or selected appropriately on their behalf. ARs were informed that hairdressers and manicurists regularly visit services.

However, one resident referred to missing having a daily shower whilst no other negative comments were received about choice and availability of baths and/or showers as previously identified in the first Summary Report. Nevertheless, 2 services were only able to offer a weekly bath to their residents. The responses below to the report recommendations from these 2 visits suggested that Unit Mangers had or were due to review this situation;

"Senior care staff are now established in their new role, enabling them to spend more time on the floor. This has increased the amount of staff time to be spent with the residents, thereby promoting choice to receive more baths/showers as requested."

"The unit and service manager will be reviewing rota systems in June 2017. Bathing opportunities and link worker systems will be part of that review."

8.6.2 Nutrition/mealtimes & hydration

Meals were considered by residents to be of a very good standard and where ARs shared mealtimes with residents during one visit, they felt that the food they had was 'excellent'.

Menus had variety and choices each day; in some services the cook had introduced "themed" dinners which gave the menus even more interest and social enjoyment for residents. Mealtimes were (except for one service) flexible and residents commonly had options to eat in their rooms or join the majority in a more communal dining occasion. The dining experiences, when observed, were managed well to create a dignified and pleasantly social occasion.

Snacks and drinks were made available by staff throughout the day.

8.6.3 Support with general & specialist health needs

Homes visited indicated that they were well supported in meeting the health needs of the residents. It was apparent that, in many, district nurses or nurse practitioners visited regularly as did some GPs, or did so as and when required. Services stated that regular access to chiropody and physiotherapy services was available as needed and some homes mentioned regular vision and hearing tests being provided. However, there was no mention of, and no evidence was gathered, regarding the provision of dental care.

One service had a "community therapy facility" available designed to be used by multiple groups but the facility was under-used and the service in response to the resulting report recommendation stated:

"We are currently in negotiation with a consultant for the Frail Elderly to operate a clinic in these rooms but if this is not taken up we could explore whether podiatry/ dentistry/ ophthalmology professionals would be interested in regular usage of these rooms."

One or two residents specifically expressed their confidence in their health needs being supported well. Within learning disability short term/respite care services, health care support was readily available if and when it was needed. Two clients in one of these services, who both had epilepsy, expressed great confidence in the staff supporting and monitoring their needs which was supplemented by night time technology which would alert staff to any seizures that may occur.

8.6.4 Balance of activity & rest

Homes reflected a stimulating, unpressurised atmosphere for residents to choose to be active or more restful during each day. In the older persons' services, communal areas incorporated comfortable seating and foot stools to aid relaxation. In all services music facilities and television was available for entertainment. In all services there were areas where, for example, books or board games were located with one or two homes also having computers available although ARs did not observe these facilities being used during their visits to the older persons' services. Gardens were also available to access during good weather **(see 8.7.6).**

8.6.5 Ensuring comfort

ARAs identified a clear sense of both physical and emotional comfort experienced by residents/clients in all of the homes visited. However, in one service it was noted that the heating was very high and staff reported that this was often unbearable. The report recommendation from this visit led to this response:

"Whilst thermostatic valves on each radiator are not an option due to budget constraints, the unit manager arranged for a visit by the heating engineer, who visited on 13th March, and has ordered a 'panel' which will be fixed within the boiler room and enable the service to regulate the temperature."

In one home the roof lights were noted not to have any protective system from strong sunlight and the recommendation resulted in the following action by the service:

"The roof lights in both dining areas have been measured for blinds to be in situ to protect residents from sunlight."

8.6.6 **Maximising mobility & sensory capacities**

Across all visits it was noted that residents were encouraged to maintain their mobility. There appeared to be a more than adequate range of adaptations and mobility aids available across the homes visited.

As referred to previously under 8.1, the corridors, in a few homes visited, were thought by ARs to be somewhat narrow to easily navigate with a wheelchair or adequately assist clients who had mobility difficulties. In each case the services confirmed that the width of corridors was adequate and did not restrict wheelchair mobility or other types of mobility assistance. These are exemplified by the following responses to recommendations made:

"Wheelchair users and people using Zimmer frames can navigate successfully around the corridors."

"Unit manager to continuously assess if difficulties occur."

"The corridors are small but we manage wheelchair access and equipment."

The needs of any residents who had hearing impairments seemed to have been met satisfactorily. The last summary report (published February 2017) asked DCC to confirm that hearing loop systems were installed in all homes to which the response was:

"Currently a review of the hearing systems in our care homes is taking place. This will highlight where improvements need to be made and action plans can be agreed in order to update the equipment where required."

In one service a concern was raised by a resident which led to a recommendation being made to review the adequacy of the public telephone used by residents to ensure those who are hard of hearing may use it without difficulty. The response stated:

"The current payphone has a speaker system installed but further discussion between the unit and service manager (is) ***due in April 2017."***

In addition the service referred to the previous response received (cited above) that:

"DCC are currently reviewing loop systems in the care homes."

8.7 Resident's social, emotional & cultural welfare

8.7.1 **Personalisation & personal possessions**

All homes demonstrated that they had in place approaches which recognised and respected each resident as an individual.

Bedroom doors in some homes were personalised with pictures and the person's name, and residents were able to keep personal possessions in their rooms.

In one learning disability service which provides short term care, a client who uses the service regularly, said that they are always able to use the same room on each stay with which they were very happy.

8.7.2 Choice, control & identity

As indicated through preceding sections of this report, there appeared to be a good level of choice and control afforded to residents/clients acknowledging their general life-style preferences. The evidence from ARs indicated that the unique identities of residents/clients was being satisfactorily promoted and respected.

Where capacity allowed, residents/clients maintained control of their own money and held their own bedroom keys. Where possible residents had freedom of movement outside of the home following appropriate risk assessment.

In some homes supporting older persons, those residents who were able, and enjoyed being more active were often supported to do small chores for themselves like dusting, cleaning their own rooms, folding laundry or hand washing of items such as their own under-clothing and in two cases some cooking. The nature of the learning disability services meant that these types of life-skill activities were more commonly the norm across all users of the services.

8.7.3 Feeling safe & able to raise concerns/complaints

All residents/clients encountered by ARs expressed their confidence in raising any concerns, as did relatives that were met. The close, open relationships between staff and residents/clients in all homes was fundamental to this being the case.

Residents' meetings are held in homes with some evidence obtained from an older persons' service about the effectiveness of these e.g. contributions to suggested furnishing for a newly decorated lounge.

Entry/exit security was evident in homes and call systems appeared adequate. In one service, staff carried 'pagers' to which call systems connected and ensured that staff attention was offered in a timely manner.

In one home garden security was raised within a recommendation which was referred to by the home to the relevant DCC department. In another home the intended restriction of clients to kitchen access (for safety reasons) was noted to not being adhered to and this was addressed by the unit manager.

8.7.4 Structured & unstructured activities/stimulation

Since the last summary report the reconfiguration of staffing within homes has introduced senior care workers who, as part of their role, provide the lead on coordinating the staff team to deliver social/therapeutic activities within services.

In one service, ARs were informed of how the activities programmes were coordinated to optimise the planning and their therapeutic outcome by maintaining client activity profiles, photographic logs and linking these to individualised memory boxes.

In all services visited there seemed to be general satisfaction from residents/clients and relatives with the opportunities that were available. However, in three of the older persons' services staff expressed some concern that

they were unable to spend more time in social and therapeutic interaction with residents. All responses from unit mangers to recommendations for review of this were positive:

"Unit manager to discuss with service manager and the staff team at next staff meeting by April 2017."

"In the next few weeks a new three rota will be implemented which will allow three staff on shift morning and afternoon, with a contingency for extra staff if client's needs increase. In addition we are planning the shifts in order to have protected time for staff to undertake activities and interact with clients in a social setting."

In one home the staff felt that their opportunities to interact with residents was reduced particularly as a consequence of the time they needed to spend undertaking laundry duties to which the following response was received from the unit manager:

"We have enquired as to whether senior management can consider that the home has specific dedicated staff hours for laundry work as opposed to general hours currently. With the new shift system and more precise delegation of tasks during the shift the impact on care staff of time taken doing laundry duties will be reduced."

In another home, where a good range of activities seemed to be available, such activities were not communicated to residents very clearly, particularly to those accessing the short term/respite care provision. The resultant report recommendation was acted upon as follows:

"Staff are in the process of producing a newsletter, outlining daily activities which will be displayed in the main entrance and copies will be readily available" and, ***"After discussion with staff it was decided that a calendar of activities would be displayed in client's rooms who would be staying for respite."***

In the one home where less organised activities appeared to occur, the unit manager expressed their concern and intention to address the issue. The report recommendation that resulted from the visit, led to the Unit Manager stating that:

"Lifestyle plans currently being updated for resident's interests/ hobbies/ skills" and, ***"New activity programme arranged after consultation with residents."***

8.7.5 **Cultural, religious/spiritual needs**

Within the older persons' services, there was no evidence that the cultural needs of residents either in terms of religious/spiritual needs, lifestyle, customs, practices or dietary preferences were not being satisfactorily met.

Most homes have made satisfactory links with local churches of different denominations who either visited the home or could be contacted if needed. Two of the newer homes had multi-faith room facilities. Two other services seemed to have no regular contact with local religious clergy but indicated that they would respond to this if wanted by residents.

8.7.6 Gardens – maintenance & design/suitability for use/enjoyment

Within this range of visits five of the 10 homes required further attention, to varying degrees, of the gardens/outside spaces. Generally the state of such areas has been raised in many previous visits and featured in the first summary report published in October 2016; the response from DCC at the time stated:

"The garden maintenance contract for care homes is currently being reviewed. This will lead to ensuring a consistent ongoing garden maintenance plan is in Place."

Some visits took place over the winter period where one does not expect gardens to look their best. Nevertheless, there was a contrast at the time between homes which appeared to have the resources to maintain reasonable up-keep and presentation and others where clearly this was not the case.

Where the above issues were raised within report recommendations, the responses received were:

"It is accepted that the gardens are in poor condition and that DCC do not provide frequent, ongoing maintenance. It is my understanding that DCC are reviewing the general state of all garden areas of their establishments, as this recommendation has been raised by Healthwatch at several other establishments. The garden areas at the … are in need of attention but I am unable to comment on the Senior Management Team progress in resolving this issue countywide."

"Contacted local college for assistance with garden area."

"Bedframe moved the following day when the skip arrived. Garden furniture and maintenance will begin again shortly."

9. Additional issues

9.1 Healthwatch visits at the request of the CQC, monitor the display of the CQC rating certificate at each residence visited. In the main these were displayed satisfactorily and were only missing where in one instance redecoration was taking place, and in another where items which were hung on the walls were at the time being pulled off by a client. The DCC website is also regularly checked and this has always been up-to-date with the CQC information clearly evident.

9.2 In addition to the above, the Healthwatch Enter and View Officer has introduced a comparative analysis of the most recent CQC report with the Healthwatch draft report following its production for each home. It is important to note that the Healthwatch visit does not cover exactly the same range of issues which CQC address but there are commonalities of overlap particularly with respect to observable care delivery and resident/relative feedback.

In the main the Healthwatch reports have concurred with those areas that the CQC have identified as either being *'good'* or *'requiring improvement'*.

In two visits however, Healthwatch did not find evidence of the same concerns that CQC had raised. These were with regard to one setting with respect to the staffing level and capacity of staff to attend to needs in a timely manner and in another

service in relation to the attitude of staff and quality of resident interaction. In both of these instances Healthwatch ARs found no evidence of concern in either service from their own perspective.

In another service visited the Healhwatch report considered that there may be staffing issues which impacted on time available to spend with residents, which the CQC had not considered as an issue within their own visit report.

10. Elements of good practice/standards of care

- The use of 'reference sheets of information' for staff outlining key likes/dislikes, needs and preferences of individual residents/clients (Older Persons' Service).
- Staff engaging in experiential learning activities to see what it might feel like to be a client in the service (Learning Disability Service).
- "Themed" dinners which gave menus even more interest and social enjoyment for residents (Learning Disability Service).
- Clients who had epilepsy, expressed great confidence in the staff and service support they received (Learning Disability Service).
- A client being enabled to use the same bedroom in each of their short term care visit stays (Learning Disability Service).
- Residents being enabled to maintain their independence, self-help and social skills (Older Persons' Service).
- The management of activities programmes as a therapeutic contribution to individualised memory boxes (Older Persons' Service).

11. Recommendations

Individual reports for each home/service included recommendations that have already been responded to satisfactorily. This summary report therefore is not intending to repeat these but place them into a broader context where DCC may lead in supporting recommendations for application across all relevant services.

12. Considerations for DCC from this summary report

12.1 To advise of any service standards supporting the personal hygiene needs and preferences of residents with particular reference to the choice and frequency of taking baths or showers. (8.6.1).

12.2 To confirm that all services have effective systems of enabling residents to access regular professional dental care/oral hygiene. (8.6.3).

12.3 To advise of progress and outcomes of the DCC review of hearing loop and other auditory support systems within services. (8.6.6).

12.4 To state how effective the introduction of the Senior Care Worker role has been to date in enabling each service deliver a rich, varied programme of activities for residents. (8.7.4).

12.5 To advise how each staff group has been enabled to be allocated adequate

time to support and implement social/therapeutic activities for residents (8.7.4).

12.6 To provide an up-date on the review, commenced last year, of the garden maintenance contract for care homes. (8.7.6).

13. Service Provider response

Derbyshire County Council are invited here to provide a summary of their perspective on the work and impact of the visits undertaken and reports generated by Healthwatch Derbyshire over this final part of the commissioned period in conducting unannounced Enter & View visits to their residential service provision.

Recommendation	Response
12.1 To advise of any service standards supporting the personal hygiene needs and preferences of residents with particular reference to the choice and frequency of taking baths or showers (8.6.1)	The commitment to providing individual support and choice with personal care is laid out in the 'Service User Guide' which is issued on admission and discussed when reviewing their plan of care. The offer of this choice is at times compromised due to staffing constraints and available facilities within the establishment, but these are addressed and contingency plans put into practice.
12.2 To confirm that all services have effective systems of enabling residents to access regular professional dental care/oral hygiene. (8.6.3)	Professional dental care for individuals is discussed, planned and documented when agreeing their plan of care. This is either arranged by the manager or family members by means of home visits or escorted trips to the practice. The staff provide ongoing monitoring of individual needs and report to the manager any concerns so that issues can be dealt with swiftly.
12.3 To advise of progress and outcomes of the DCC review of 'hearing loop' and other auditory support systems within services. (8.6.6)	DCC have reviewed what is currently in place within establishments as a standard and a development plan is being drawn together. Residents have their sensory needs addressed on an individual basis and recorded on their plan of care and where needed are able to access different forms of assistive technology.
12.4 To state how effective the introduction of the Senior Care Worker role has been to date in enabling each service deliver a rich and varied programme of activities for residents. (8.7.4)	At present it is too early to offer a broad overview in the development of this role. There is however signs that in some areas the Senior Care Workers are embracing and developing a leadership role within their service. They are supported through a well-planned and coordinated training programme alongside a framework of professional development to assist them in new skills and to develop confidence. Information with regards to residents' interests and hobbies is being used to develop meaningful activities.

Recommendation	Response
12.5 To advise how each staff group has been enabled to be allocated adequate time to support and implement social/ therapeutic activities for residents (8.7.4).	The introduction of the role of Senior Care Worker enables the staff team to have greater opportunities for a variety of direct work with residents. An additional flexible pot of staff hours has been allocated, which the manager can deploy at their discretion to organise different activities throughout the week.
12.6 To provide an up-date on the review, commenced last year, of the garden maintenance contract for care homes (8.7.6)	Areas of responsibility and a maintenance program has been outlined and agreed. The council's property services will provide a low maintenance landscape which they will maintain through a regular service program. There will be designated garden areas where the manager can involve residents, families and staff to become involved and which will also assist in the development of activities.