healthwatch Surrey

# My Way, Every Day

A look at the activities available to residents in 25 Care Homes across Surrey

Care and support should put people in control of their care, with the support that they need to enhance their wellbeing and improve their connections to family, friends and community.



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# Executive Summary

**The experiences and stories collected by Healthwatch Surrey show that care home services in Surrey have a higher proportion of negative experiences than many other services and these services have been found to be comparatively worse than the rest of England[1].**

**During 2016, Healthwatch Surrey made it their priority to 'amplify the voice of the care home resident' and agreed that they could add value and support improvements by focusing on activity-based care.**

**A team of Authorised Representatives were trained and, using statutory Enter & View powers, they visited 25 care homes interviewing staff, residents and in some cases family and visitors. Together with this summary, their reports[2] provide valuable insights into the extent to which activity-based care has been tailored to the individual needs of Surrey care home residents.**

1. Source: Care Quality Commission
2. Individual provider reports are now published at .......

During this programme of Enter & View visits, **interviews with managers and staff demonstrated that they understood their responsibilities and could define what it meant to deliver meaningful activities in the context of person-centred care.**

Unlike other aspects of health and social care training, there has been no consistent approach to training and support for activities provision, for either care staff or specialist roles such as the Activity Co-ordinator. Even so, staff consistently focused on using good communication skills to support residents and recognised the importance of using the residents' life histories – that is the residents' interests, likes and dislikes – and could provide clear examples of where this approach was working. However, not all residents agreed that they received this level of personal differentiation. **Some residents had not been asked what they would like to do, offered alternatives or provided with an explanation if their needs could not be met.** There was also less evidence to show how staff were identifying or supporting residents' changing needs.

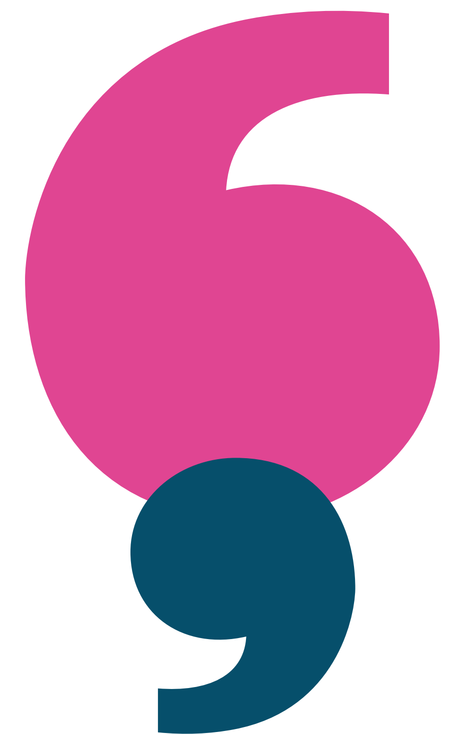
Across the care homes, **there was evidence of a rich mix of experiences and examples of the type of activities which were valued by residents** and, when asked, family consistently acknowledged that there was a real attempt to match the activities to what their relatives enjoyed.

There was less evidence of residents' involvement in tasks around the home and there were also examples of restricted access for wheelchair users (e.g. access to areas containing books) as well as more generic issues such as limited access to outside space and trips into the community. **Less than half the homes visited reported that they organised day trips for residents to go out for part or all of the day.**

Family, friends, volunteers and community organisations, such as churches and schools, as well as entertainers were providing residents with important connections to the outside world in all the homes visited. More creative ways of enabling residents to enjoy outside space, maintain regular contact with family, and friends, for example through social media, **Skype and access to the internet, was evident in some of the homes but not consistently made available across all the homes visited.**

Overall, the visits demonstrated that both managers and their staff had a sound understanding of what it means to deliver both one to one and group activities within person-centred care. In most cases, they recognised that all staff are responsible whether an Activity Co-ordinator is in post or not. However, **whilst there is a range of meaningful activities in care homes which support a high level of understanding, it is not yet standard practice and available for all residents, and particularly those living in smaller care homes** or in homes with a recent inadequate inspection.

Over the course of 25 visits, it has been possible to identify 16 key themes, some worthy of exploring further and others where it is possible to make more immediate recommendations. This summary report sets out these themes and 16 recommendations as the basis for informing future action planning.



# Introduction

> Care and support should put people in control of their care, with the support that they need to enhance their wellbeing and improve their connections to family, friends and community[3].

The Health and Social Care Reforms of 2012 and the subsequent Care Act 2014 set out an ambitious agenda to transform the way in which health and social care services are commissioned, designed and delivered, placing people at the centre of shaping those services. Within this context and with a priority to amplify the voice of care home residents, Healthwatch[4] Surrey sought to carry out a project that would help support service improvements across Surrey. In planning this work Healthwatch Surrey was mindful of the need to add value and not duplicate work and research carried out in the care sector.

There are several factors which have influenced both the selection and timing of this programme of Enter & View[5] visits.

1. The experiences and stories collected by Healthwatch Surrey show that care home services have a higher proportion of negative experiences than many other services. In 2016 around 2 in 8 people shared a positive experience with Healthwatch Surrey across all health and social care services; however, this compared with 1 in 8 for positive experiences in Nursing and Residential Care. Inspector ratings by the Care Quality Commission of these services in Surrey also compare less favourably with the rest of England[6].
2. Transforming the culture and improving the quality of care in residential care homes comes at a time when longer life expectancy for people with disabilities, dementia and long term health conditions will place greater demands on social care and require greater differentiation of services and support.
3. The increase in the number of paid adult social care jobs is set to rise by between 20-54% nationally by 2025[7], placing an increasing demand on providers to recruit, train and retain staff with the skill set to deliver person-centred care. Surrey is very much part of both the demographic and workforce trends. 18.1% of the population in Surrey is over 65 compared to 17.4% for England and this is projected to increase to over 20% of the population of Surrey by 2022. Lower levels of pay and training for care staff, combined with difficulties in recruiting care staff, presents a challenge for the quality of care.
4. In addition, Healthwatch Surrey looked at projects and reports by other local Healthwatch, which included the scoping carried out by Healthwatch Dorset for their prospective care home project. Healthwatch Dorset carried out an extensive scoping exercise looking at the national picture and talked with local agencies, including the CQC and their three local authorities. They concluded that ‘Looking at activity-based care would be very welcomed by the Local Authority (LA). This is an area that is not always monitored in-depth and is also an area that tends to be a “tick box” for many care homes’.

3. Dept. of Health, 27 October 2016, ‘Care and Statutory Support Guidance’
4. For background: Healthwatch and information on Healthwatch Surrey see Appendix 1
5. For background: Enter and View see Appendix 1
6. Source: Care Quality Commission
7. See www.skillsforcare.org.uk/ for data and further information



# Background and aims of the project

Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care. Where it works well, it is coordinated and tailored to the needs of the individual, and ensures that people are always treated with dignity, compassion and respect.

Activities for residents in care homes are important as they offer emotional, creative, intellectual and spiritual stimulation and they help people to feel valued, providing a purpose and often a structure to life. As one relative noted:

> ‘At home, Mum sat and did nothing but since she’s come into the home, Mum has done painting, I couldn’t believe it. She’s done seated exercise. She really enjoys it.’

Tailored to the person’s needs and preferences, activities can range from daily living activities such as dressing, eating and washing, to leisure activities such as reading, gardening, arts and crafts, exercise, conversation and singing. They can be structured or spontaneous, for groups or for individuals, and may involve family, friends and carers, or the wider community. They should take place in an environment that is appropriate to the person’s needs and preferences, which may include using outdoor spaces or making adaptations to the person’s environment[8]. This might all seem a common-sense vision for any form of health care but it is not yet standard practice. Often, health care does things ‘to’ or ‘for’ people rather than ‘with’ them.

**Within this context, Healthwatch Surrey’s investigation set out to achieve seven aims:**

1. Are Surrey care homes relationship-centred?
2. Are care staff focusing on activity-based care supporting people to continue to be as active and independent as possible?
3. Do care homes learn about their residents, plan their care and daily activities around their preferences?
4. How is dignity being respected?
5. How effective is training and support for care staff?
6. What are considered to be the main barriers in providing activities?
7. Where is activity-based practice working well for the residents and their families?

8. Adapted from Social Care Institute for Excellence (SCIE) guide 15, Choice and Control, Living well through activity in care homes: the toolkit (College of Occupational Therapists) and expert consensus.

# Main Findings and Themes

Here follows the key evidence and main themes which emerged from the visits under each of the seven project aims, supported by illustrations and comments.

## Are Surrey care homes relationship-centred?

Person-centred approaches should be based on good communication skills which enable staff to develop an understanding of, and treat the person as, an individual. They need to act with dignity and respect, listening and helping the resident to make informed choices. During the observations and through talking with managers it was noted that, both managers and staff showed that they understood the importance of meaningful activities to the health and wellbeing of residents. As one manager noted:

**'It is around individual choices, every individual is different. Assessing an individual, looking at their likes and dislikes. Everyone should be treated equally to meet their needs whether it is nutritionally, psychologically, physically, emotionally or socially. Many times we hear…you have to listen to the individual. It's about the individual and meeting their needs'.**

1. **Managers in the homes visited showed an understanding of the concept and importance of person-centred care and knew what they expected of staff.** Managers were asked to define person-centred care and they consistently focused on features such as making sure they understood and met the needs of the individual, providing choice, tailoring what was on offer and treating people with respect. Care staff were often able to give examples of how person-centred care worked in practice. In most instances, they could define what person-centred care meant in the context of their day to day working practice and consistently emphasised the importance of building relationships.

'Providers must do everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be.'[9]

The types of approaches demonstrated by managers included ensuring that staff were made aware of the importance of activity-based care during their induction, encouraging staff to take time, not only to understand what is written in care plans and life histories, but to build on that knowledge through listening and building relationships. One manager noted that it is about;

**'Understanding an individuals' individuality and the home delivers care in line with that so that people are given choices. Staff are encouraged to listen to residents and be aware of their needs, so that individual support can be provided when necessary.'**

Several of the managers reported that in terms of training, staff had attended dementia awareness training and that this had not only raised their understanding of how to communicate with and support people with dementia but had provided a platform from which they could develop ideas for meaningful activities.

**'It is care tailored to meet the needs of the individual' …. 'we need to meet the individual needs of our residents.'**

**'Individualised Care, choice, dignity and respect'…. 'Including residents in discussions about their needs.'**

**'Putting the person at the heart of your work' …. 'tailoring activities towards a person and their needs.'**

**'Ensuring the individual is central to all aspects of their lifestyle, choices and care needs'….'facilitating and meeting their individual needs.'**

2. **There was a consistent focus on staff using good communication skills. During the visits, the Authorised Representatives observed care staff using a range of communication skills considered important in the social care setting[10].** Several staff noted that listening skills were particularly important. Staff showed that they were adapting their communication skills using touch, pitch of voice, speaking slowly, offering encouragement, using non-verbal signals. They were often aware of the need to use sensory stimulation when trying to engage effectively with people with dementia:

**'One resident who is almost blind…' you stay 'close to her, touch her, let her know you are there, explain everything.'**

**A resident who has 'hearing issues' … 'speak slowly, in a slightly higher voice and keep repeating.'**

**'You work around it, work around the individual. If they're hard of hearing you raise your voice.'**

**'We give big smiles and encouragement.'**

**A resident who is 'hard of hearing' when the care worker talks she does so in a 'higher pitched voice…' and uses 'body language'.**

**'It is fascinating, listening to their memories, their stories and how they lived their lives.'**

9. Source Care Quality Commission, Regulation Guidance, Regulation 9 (www.cqc.org.uk)

10. Further information at www.dementiauk.org

## Are care staff focusing on activity-based care - supporting people to continue to be as active and independent as possible?

‘It is important that older people in care homes have the opportunity to take part in activity…. They should be encouraged to take an active role in choosing and defining activities that are meaningful to them. Whenever possible, and if the person wishes, family, friends and carers should be involved in these activities. This will help to ensure that activity is meaningful and that relationships are developed and maintained.’ [11]

NICE Quality Statement (Q550)

Engaging residents in meaningful activities should be based on discussion; understanding the preferences of the resident and providing information in a way that residents can understand what is involved and how they might benefit. Providers should give choice and encourage participation through persuasion, using friends and family for support. Both resident and family feedback was largely positive with the focus for residents being on choice, variety, enjoyment and the opportunity to continue their own interests and hobbies. Family also acknowledged that there was a real attempt to match the activities to what residents had enjoyed doing previously.

3. **Across the care homes, there is a rich mix of experiences and examples of the type of activities which are made available and valued by residents and their family**[12]. In the homes visited, the volunteers saw a range of group activities on offer and examples of interaction with residents. The full range of activities they observed or heard about is extensive and it would be impossible to list all those that had either been undertaken prior to the visit, were underway during or were planned for the following week. They were often based on action (for example dance and seated exercise), music (singing and/or visitors playing the piano), one to one (for example knitting), games (quizzes and bingo) and several homes were proactive in arranging outside trips and supporting residents in the garden either with games, to attend a barbecue or to do light gardening.

   It is clear from the sample that different approaches work in what might appear to be similar settings, for example one home encouraged residents to come down for breakfast to ensure that they had an opportunity to socialise. In another, residents were given the choice to have breakfast in their own time and in their own room. Both approaches were focused on the individual, provided choice and worked in their own setting. Appendix 3 gives an illustration of the range of activities on offer.

4. **There was less evidence of residents being involved in tasks around the care home.** Family members who completed the questionnaire often commented that they did not consider it appropriate to involve their relative due to health issues or dementia. However, residents in the early stages of dementia often benefit from structure and routine and involvement in simple tasks such as folding clothes or laying tables. One resident had been placed on the catering rota to ensure that it was part of her routine. She had wanted to be involved and was added to the catering rota to help her participate. There were other instances of residents helping with light gardening. In one home residents were growing produce to help raise funds for a mini-bus. So, whilst there are challenges and risks when it comes to supporting residents to help around the home, there are also opportunities and evidence that it can be beneficial for the resident.

11. NICE, Dec 2013, Mental Wellbeing of Older People in Care Homes, Quality Statement (Q550)
12. Source: Friends and Family Questionnaire

5. **The role of the Activity Co-ordinator is key to the planning and organisation of activities.** Many care homes employ Activities Co-ordinators to help plan, co-ordinate and deliver activities and several noted that they needed to work closely with care workers to secure resident participation. Many of the activities were planned to take place when the Activities Co-ordinator was available and, therefore, limited to the hours that he or she was working. This was more of an issue for smaller homes who employed part-time Activity Co-ordinators and even more so for smaller homes with no dedicated Activity Co-ordinator in post. One had tried to overcome this problem by enabling the Senior Carer to work part-time to co-ordinate group activities and involve the rest of the team. Many homes were also using the additional services of people such as dancers, musicians and pet therapists. In the larger homes (i.e. those with over 50 residents), there is often more flexibility with the potential to employ more than one Activity Co-ordinator and/or supporting staff, and therefore a broader range of activities available over a longer period.

   It was also recognised that whilst the Activity Co-ordinator is a key role, care workers integrating activities within the daily routine, and alongside the role of the Activity Co-ordinator, was also an important feature of activity-based care. As one manager noted;

   **‘We have an Activities Co-ordinator but it’s a team effort……the Co-ordinator organises and facilitates, but helping a resident to make their bed, tidy up or make a drink, all staff do this.’**

   During one visit, the manager made it clear that everyone had a responsibility and role in delivering activities including the management team. In this case the Activity Co-ordinator’s role was ‘making the plans, but for basic activities every one of us is responsible’.

## Do care homes learn about their residents, plan their care and daily activities around their preferences?

Managers and their staff reported that they use care plans consistently to capture residents' life histories and ensure that their interests and views and those of their family are documented and the information updated on a regular basis. All the homes visited recognised the importance of capturing the residents' life history, interests, likes and dislikes when they entered the home as well as involving family in the development of the information. Most of the homes record this in the care plan with a number choosing to provide additional information through specially designed templates, for example the use of the 'This is Me'[13] template. Care managers and staff refer to the care plans and life histories when choosing how to differentiate activities, encourage residents to participate and support activity on a one to one basis. Managers referred to the care plan and life histories as vital in differentiating activities for the resident, taking into account likes, dislikes as well as factors which would either enable or constrain their participation.

**'We know their likes and dislikes, we then set activities for the resident that matches what's in the care plan. This is how we make sure activities link into individual care plans that are person-centred.'**

**'We look at each resident's specific needs and shape activities around them.'**

However, not all residents interviewed confirmed that this level of differentiation was offered. There was evidence during some of the conversations with residents that they had not been asked what they would like to do or offered alternatives based on their interests before entering the home.

13. 'This is Me' toolkit is available at www.altzeimers.org.uk

All the homes visited recognised the importance of capturing the residents' life history, interests, likes and dislikes when they entered the home as well as involving family in the development of the information.

There was evidence during some of the conversations with residents that they had not been asked what they would like to do or offered alternatives based on their interests before entering the home.

6. **Whilst engaging residents in meaningful activity is recognised as a priority, the approaches which staff considered important were not always consistently applied across the home,** either by care staff engaged as part of different teams in delivering/supporting activities or when looking at how activities were delivered between different parts of the home or through the resources provided.

   Whilst care staff recognised the importance of meaningful activities, an Activity Co-ordinator noted that she was not able to rely on residents being brought to the activity by care staff.

   On a number of occasions, the Authorised Representatives also noticed that even though resources were available, they were incomplete or inaccessible. For example, provision of books which were not accessible to residents in wheelchairs or when using walking frames and other issues such as knitting wool without needles, jigsaws with puzzle parts missing.

   During one of the visits, the Authorised Representatives observed that there was less available for those in nursing care than for those in other parts of the home which may indicate that practice can vary within homes as well as between them.

7. **There was less evidence to show how care staff were identifying or supporting the changing needs of their residents.** Within the resident feedback, there were examples where a resident could no longer participate due to a change in health and no alternative had been offered or provided, for example following a stroke, a resident had been unable to attend a 'knit and natter' club at the local church and when asked, had not been offered alternatives.

The processes that are designed to pick up these changes may not be ensuring that residents' individual needs are always considered, alternatives offered or solutions pursued in conjunction with the residents family. In several cases, care homes noted that individual needs and changes were incorporated into personal activity plans or daily schedules. However, this was not reported as standard practice.

**'Once you understand the resident and their likes and dislikes you can do activities (group or one to one) that fits their needs and incorporate this into the daily work schedule.'**

The processes that are designed to pick up [changing needs] may not be ensuring that residents' individual needs are always considered, alternatives offered or solutions pursued in conjunction with the residents family.

8. **The environment, that is the home and garden, plays a key role in providing opportunities for activities and there were several examples of where this was working well.**

   Many of the homes made a concerted effort to provide stimulating displays and a safe environment and made use of communal areas and corridors to have thematic displays relevant to times gone by. Aimed at helping residents reminisce these were linked to photos of people from that period.

   Where residents had produced paintings, these were seen on display on two occasions and evidence of activity was seen through arts and craft work. Residents' rooms were customised on one occasion enabling a resident with a strong interest in fishing to feel at home and another had a mural of a dolphin. On other occasions, they could bring their own pictures and personalise the space.

   Two provided a sweet shop, one with a 50s theme, others provided facilities such as a library, reading area, activities room and/or space for a computer. One home provided open kitchen/dining space so that residents could be supported to prepare their own food but in terms of facilities, smaller homes faced more of a challenge. They often needed use of rooms for a dual function which limited the scope and the timing and availability of group activities.

   The extent to which the care home provides access to outside space, a range of activities (such as ball games) or used the garden for events to attract visitors and provide residents with social events varied. On a few occasions, use of the garden was limited to summer time only. There were examples of residents with an interest in gardening being given access to and supported to plant flowers and, on one occasion, raised beds had been introduced to enable those with mobility issues to participate.

   'We were shown around the garden where the manager informed us that residents had been instrumental in planting flowers for display. The flower beds were raised making them easily accessible for wheelchair users.'

9. **All the homes ensured that, apart from family, there were a range of visitors coming to the home connecting residents to the outside world, giving opportunities for conversation and entertainment for residents.**

   Care homes made efforts to involve the community through links with local organisations such as churches, schools and colleges and through service providers such as chiropodists; where friends and family were encouraged to visit regularly this was with the consent of the resident. More creative ways of enabling residents to maintain contact with family, friends and the outside world through social media, Skype and access to the internet was evident in some of the homes but not consistently made available across all the homes visited.

   The most common regular contact was through churches who were providing pastoral support and services, and on occasions volunteers to help and support. The second most common group of visitors was schools/colleges whose students were providing entertainment in the form of singing or plays, talking with the residents or making gifts. Staff commented that the links with schools/colleges, and to a lesser extent Brownies/Guides and Duke of Edinburgh volunteers, was beneficial as it provided residents with inter-generational contact.

More creative ways of enabling residents to maintain contact with family, friends and the outside world through social media, Skype and access to the internet was evident in some of the homes but not consistently made available across all the homes visited.



Less than half the homes visited reported that they organised day trips for residents to go out for part or all of the day.

10. **Residents enjoy being able to take trips outside the home but several homes quoted transport as one of the main barriers.** Several able residents were either supported to go shopping or allowed to go by themselves.

    Less than half the homes visited reported that they organised day trips for residents to go out for part of all the day. Where buses or taxis were provided, they gave access to day centres, provided opportunities to attend events, visit cafes, museums and use leisure activities. Residents also welcomed days out to the coast.

    One home had been able to secure a bus but had no driver, others used taxis and one stated that whilst they would like to, the cost of taxis was prohibitive. A number commented that family members would also support, take residents out or contribute to the cost. Resident feedback in this area either acknowledged that this was something they had liked to do but were no longer able to and others expressed the wish to do more. One owner noted that one of the biggest barriers is 'not having a bus and that plans were in place' but 'regulation change regarding disabled seating capacity prevented purchase'.

    **The visits also provided some insights into potential solutions.** These included family members providing practical support, the Activity Co-ordinator taking on the role of driver and the residents in one home growing garden produce to sell and raise funds for a minibus.

## How is dignity being respected?

11. **Care staff respected the residents' right to choose and considered that it was important to listen to their reasons where they did not want to participate.** Several care staff noted that they would encourage residents to participate or provide one to one support while the activity was taking place. Another noted that she would encourage the resident to watch hoping that they would change their mind, others would wait and ask again and in several examples the care staff combined participation with a treat such as a biscuit or cup of tea.

    'If someone does not want to, you cannot tell them to do it.'

    'I try to get everyone involved. I explain the activity, make it fun. I offer a reward like sweets or biscuits, but give everyone involved a sweet or biscuit.'

    'I really try to encourage any resident who is not involved in an activity. It's important to do that because no resident should ever be left isolated or feeling they're on their own, or that no one cares. I have a duty to the residents to not let that happen.'

    An Activities Coordinator expanded by saying that some residents are reluctant to leave their rooms. He encouraged them to engage in activities and;

    'routinely goes to see them - coordinates with care workers to find out if they may be interested, or whether they are in suitable health.' He may take small props with him, such as a 'small suitcase with copies of old programmes, posters and tickets'.

    'If they don't want to we find something the resident will want to engage in. If they say 'No' I respect that, I say 'Can I ask you again next time?' and when that time comes around I remind them and speak with them about it.'

**12. Staff often commented on the importance of providing residents with one to one time, either in private or in their room, to discuss their preferences, respecting their right to privacy and choice.** A number of homes reported that they had a dedicated room for when friends and family visited though this did not appear to be standard practice.

On one visit, it was noted that residents were offered a quiet area so that they could discuss any concerns or personal issues in private.

When asked how residents were encouraged to take part in activities, most staff recognised that it was important to respect a resident's wishes, talk one to one and try to find alternatives. As one care worker noted;

'If it's one resident in their room, or anywhere, I stroke their hand and ask what's wrong and how they are feeling. I hold their hand and ask them to talk to me… I'd give them quiet time…'

There was a consistent message from care staff that choice was important. Several care staff noted that residents were given the option to engage in social/group activities and, if not, they were encouraged but not pressurised. This view was also echoed by the residents and their families.

During the visits, Authorised Representatives saw many examples of staff talking with residents in a way which showed respect, understanding and consideration and in a language and tone which was appropriate.

**13. Staff commented that they would try to encourage a resident to engage in activities or social events to limit the possibility of isolation and loneliness.**

'Those who don't want to do it, we try to encourage even if it's only for a short time… encourage everyone to come out their rooms.'

'If they want to withdraw from activities there should be a reason, we don't want residents to be isolated. If they want to stay in their room, we will talk with the resident…explain the activity…. ask what they want to do in their room.'

However, this was not reported as standard practice and it was not always clear how residents were monitored to ensure that they did not spend prolonged periods on their own.

Residents were encouraged to be independent but also supported where they needed help. The Authorised Representatives observed as well as talked with staff and noted that on many occasions staff were providing support when it was needed or when the resident requested.

However, [encouraging residents to participate in activities] was not reported as standard practice and it was not always clear how residents were monitored to ensure that they did not spend prolonged periods on their own.



## How effective is training and support for care staff?

'Relationships should be at the heart of training and development, and care staff who feel listened to and valued and who have positive and productive working relationships with their trainers, will…learn how to relate well to their residents…We all learn these qualities through our own experience of being cared for and cared about'.[14]

(Skills for Care)

Conversations with managers, senior care workers, care staff and Activity Co-ordinators provided insights into the way in which staff are supported, both through formal training and by their managers, to acquire and develop the skills they need to integrate meaningful activities into the daily routine. These insights reveal that:

**14. Unlike other aspects of health and social care training, there is no consistent approach to ensuring that staff develop the knowledge and skills for activity-based care.** Three Activity Co-ordinators had taken part in formal training delivered through NAPA and one reported that they were involved in providing informal training to support care staff. One Activity Co-ordinator reported that they networked with others to share expertise and in several cases, the Activity Co-ordinator had been recruited with skills which enabled them to undertake the role such as a background in working with dementia, teaching or drama. One Activity Co-ordinator noted that:

14. Source: www.skillsforcare.org.uk

[She had completed] 'a course in pottery and a Diploma in art. I love my job, I love to see people do things they think they couldn't do'.

Twelve care homes noted that their staff had completed dementia training as part of their formal training and this helped improve their awareness of people's needs and the importance of meaningful activities. As one manager noted:

'There is no specific formal training for activities. But when you think that specific training in dementia and neurological disorders training identifies meaningful activities and the importance of it you can work from that and formulate activities that meet the individual needs of the resident.'

**15. Managers play a key role in how they encourage, support and arrange training** to support staff to integrate meaningful activity into the daily lives of the people they care for. In some cases, managers were co-ordinating a range of training;

'All staff do the Care Certificate, a small unit on Mental Health, E Learning of seven dementia modules, Advanced Dementia Training (two Day Course), all staff will do this course within six months, this includes person-centred care, staff also do Challenging Behaviour and Breakaway Techniques, this helps with activities.'

In other cases, training over and above the mandatory training was not perceived as a need or priority. A senior carer noted that there was;

'None with meaningful activity.' 'All staff have individual learnings, it's an ongoing process NVQ's at different levels to suit each member of staff - some staff are doing dementia training.'

## What are considered to be the main barriers?

16. **The most cited barrier was the health limitations of residents, particularly those with physical disabilities or dementia.** This might highlight a continuing professional development need in terms of support and ideas for engaging residents, particularly those with physical disabilities and/or dementia. However, whilst it was the most common barrier, there were also managers who considered that nothing would act as a barrier.

**'We look at the risk, reduce it, make sure people are safe, whether they go out on a trip or a barbecue in the garden, even using different type of paints for arts and crafts activities. We would meet the needs of any resident and not allow any barrier to prevent an activity taking place.'**

Managers quoted the capacity of staff on six occasions and on two occasions where managers were unable to provide the capacity and support staff effectively, it was reported that the impact of CQC inspections had led to restrictions in accepting new residents at the home which in turn had led to a decrease in staff and restrictions on resources.

**'The main problems creating barriers to carrying out meaningful activities are staffing and finance'. On this occasion, the manager went on to say that she 'had problems getting staff for activities…' that '…staff had limited time…' because the home was '…down on capacity'. She stressed that lack of finances contributed to problems in this area.**

There were several other barriers which featured to a lesser extent in the feedback. They were either funding constraints for the organisation, a lack of space to run activities and transport/transport costs for outside trips. Several staff noted that funding for activities was not a barrier, both in small and larger homes with one smaller home noting 'we have no financial issues, the owners are very supportive.'

One manager noted that perception was an issue and when asked further went on to say;

**'It's a barrier because Authoritative Bodies don't accept we are providing meaningful activities because of their perception and potentially it's a barrier to our success…. it can be as simple as having your nails done.'**

## Where is activity-based practice working well for the residents and their families?

There is evidence of practice working well, from when a person enters the home through to the types of activities which are delivered and the way in which residents are supported to stay in touch with family and friends.

Some homes support the initial care planning process with useful tools to ensure they fully understand the resident and capture the information. 'This is Me' was used on at least three occasions and one used a file called 'Key to Me' which uses two admission forms. This may seem like additional paperwork, but it enabled the staff to capture personal relationships, habits, likes, dislikes, hobbies, routines and preferences. The information is then embedded in a care plan.

To ensure that no change or preference of a resident is missed and staff are updated, one care home noted that they are expected to ask the residents daily, then log anything daily and all staff are aware that they must read this. This might seem common sense but does not appear to be standard. In another home, care staff were allowed to use a case load approach and develop a closer supporting relationship with three residents.

When observing two activity group sessions the Authorised Representatives reported that the Activity Co-ordinator clearly knew the residents and engaged with them by referring to their past and using names to maintain their focus and engagement. A memory box activities session covered topics like washing and ironing, linking the past to the present. When a staff member came in he was also drawn into the discussion. On this occasion the activity co-ordinator used visuals, a £5 note, to help link from past to present.

There were examples of staff and volunteers making a valued contribution. A Senior Care Worker who works three days a week volunteered to attend on two extra mornings to organize activities. She compiled a substantial folder of possible activities and is preparing individual folders for residents showing where they have been involved. Another volunteer had helped a resident to use Skype and email and that resident is supporting other residents to keep in touch with family and friends via this method.

Some homes use email to keep families updated and one family member noted that she is emailed the weekly activity calendar with her mother's activities highlighted. She is now able to plan her time so she can attend and join in.

Finally, there were some small but nevertheless important illustrations such as:

a) one care home produces two calendars, 'one for Reminiscence Neighborhood (for residents living with advanced Dementia) and one for Assisted Living';

b) photo boards to help with communication and menu choice, and

c) a range of tools to help improve communication during an activity such as coloured card and large bingo cards.

**Some homes use email to keep families updated and one family member noted that she is emailed the weekly activity calendar with her mother's activities highlighted. She is now able to plan her time so she can attend and join in.**

# Recommendations

Local Healthwatch have a statutory power to make recommendations, and have these responded to, which supports its ability to amplify the voice of local people.

Healthwatch Surrey makes the following recommendations which are linked to the key themes and findings identified in the report.

**For the service commissioners:**

1. Consider conducting research into how person-centred care has become known and understood amongst managers of the Care Homes, in order to inform future work to embed other concepts e.g. meaningful activities or volunteering in Care Homes (links to theme 1);
2. Make sure that its Market Position Statement and other commissioning arrangements support and secure the rich mix of activities and on-going involvement of communities in Care Homes into the future (3 & 9);
3. Consider conducting research into the views of residents – particularly those with Dementia and physical disabilities - on their participation in tasks around the Care Home including any perceived barriers to participation (4);
4. Consider conducting research into the extent and nature of residents' participation – particularly those with Dementia and physical disabilities – in tasks around the Care Home and draw comparisons with views on participation (4);
5. Should investigate (or share existing evidence with Healthwatch Surrey) about the extent to which residents, families, Carers and Service Providers experience transport as a barrier to taking trips outside the home (10);
6. Should investigate (or share existing evidence with Healthwatch Surrey) share evidence about the extent to which residents in smaller homes (less than 20 residents), without Activities Coordinators, participate in activities
7. Should investigate (or share existing evidence with Healthwatch Surrey) about the extent to which front-line staff encourage residents to participate in activities (13);
8. Consider conducting research into the extent to which care staff identify and support the changing needs of their residents, in relation to participation in activities, and the contribution this makes to health and wellbeing (7);
9. Consider exploring how they can support providers in the development and training of volunteers as a means of increasing provider capacity for one to one and/or group activities (9).

**For service providers:**

10. Should review their activity provision to make sure that people can participate in activities:
    a. in a flexible way that overcomes health limitations (e.g. physical disabilities or dementia) particularly as needs fluctuate or change (5 & 16);
    b. throughout the whole week, including weekends, and; (5);
    c. consistently across different times, days and teams of people delivering care (6);
11. Should review recruitment processes, induction planning and job specifications to ensure that 'meaningful activities' is an integrated part of the care worker's job role (1 & 6);
12. Should explore ways in which family, friends and volunteers can take a greater role in supporting meaningful activities, building on current practice (9).

**For others:**

13. Skills for Care should review how qualifications can be improved to ensure that staff are fully supported to acquire the skills needed to plan and deliver meaningful activities as part of person-centred care - to make sure activities provision and the skills to support it is an explicit part of the health and social care qualifications framework (14);
14. The Care Quality Commission and the Quality Assurance Team at Surrey County Council should explore the extent to which there is a shared understanding between their teams and service providers about what constitutes 'meaningful activities' (16);
15. The Care Quality Commission and the Quality Assurance Team at Surrey County Council should explore the extent to which they could support providers through the publication and sharing of effective practice (3) in the main areas for improvement.

Responses to these recommendations will be collated, made available on the Healthwatch Surrey website in spring 2017 and added as an appendix to this report.

Next steps will be considered once these responses are received.

# Acknowledgements

Healthwatch Surrey would like to acknowledge the contribution that the care home managers and their staff[15] provided and would like to thank the residents and families for their contribution. They would also like to thank the Healthwatch Surrey volunteers for their time, commitment and contribution to the individual reports and this summary report.

**Led by Alan Walsh, the visits were supported by the following volunteers:**

- Milly Bizimana
- Jill Bowman
- Gareth Jones
- Jane Owens
- Angus Paton
- Mary Probert
- Jason Vaughan
- Janice Turner

The volunteer team has been well supported by the Healthwatch Surrey staff team amongst which significant contributions were made by Julie Dallison, Katherine Leach and Erika Lorimer, thank you.

Healthwatch Surrey would also like to acknowledge and thank Surrey County Council and the Care Quality Commission for their assistance in identifying providers within scope and in working with Healthwatch Surrey when issues were identified during the visits.

Finally, the assistance of the local Healthwatch network was instrumental to the scoping and development of the questionnaire and we would like to thank Annie Dimmick at Healthwatch Dorset, as well as Healthwatch Isle of Wight and Healthwatch Sunderland for their support and guidance.

The final report has been produced with the help and assistance of a local consultant Jackie Parry who has also made a generous commitment of her own time on a pro-bono basis.

15. A detailed breakdown of the homes visited is provided at Appendix 2

# Appendix 1: Background to Healthwatch

**What are local Healthwatch organisations required to do?**

Local Healthwatch are corporate bodies and within the contractual arrangements made with their local authority must carry out activities. Many of the legislative requirements are based on:

- promoting and supporting the involvement of local people in the commissioning, the provision and scrutiny of local care services;
- enabling local people to monitor the standard of provision of local care services and whether and how local care services could and ought to be improved;
- obtaining the views of local people regarding their needs for, and experiences of, local care services and importantly to make these views known;
- making reports and recommendations about how local care services could or ought to be improved. These should be directed to commissioners and providers of care services, and people responsible for managing or scrutinising local care services and shared with Healthwatch England. 1 Section 221(2) of The Local Government and Public Involvement in Health Act 2007;
- providing advice and information about access to local care services so choices can be made about local care services;
- formulating views on the standard of provision and whether and how the local care services could and ought to be improved; and sharing these views with Healthwatch England;
- making recommendations to Healthwatch England to advise the Care Quality Commission to conduct special reviews or investigations (or, where the circumstances justify doing so, making such recommendations direct to the CQC); and to make recommendations to Healthwatch England to publish reports about issues;
- providing Healthwatch England with the intelligence and insight it needs to enable it to perform effectively.

## Healthwatch Surrey

**Our mission**

Healthwatch Surrey is an independent consumer champion that gives the people of Surrey a voice to improve, shape and get the best from health and social care services by empowering people and communities.

**Our vision**

Healthwatch Surrey is the respected, trusted and credible champion of the consumer for health and social care in Surrey.

**Our Goals**

- To have the relationships, people and organisational structure in place that enable us to be trusted by all our stakeholders, collect the consumer voice and feed it back to the relevant parts of the system. We will be persistent in seeking outcomes and measuring our impact;
- To have a simple, widely understood identity and mission and ensure that at the time when people may benefit from contacting (or have stories to tell) Healthwatch Surrey, they know who we are and what we do, can find and interact with us easily and, where appropriate, do share their need and/or stories with us;
- To acquire evidence, knowledge and insight that much more fully reflects consumer and local experience of services in Surrey and usage by different user groups, whilst ensuring that we actively seek out insight from seldom heard or hard to reach groups;
- To secure additional sources of income by offering services that are complementary to those of our main Healthwatch contract.

**The role of Enter and View**

Enter and View is one of the ways Healthwatch Surrey gathers information about services. It involves members of our Enter and View team visiting a service provider such as a hospital or care home to observe what is happening and to speak to people using the service and the staff working there.

The Health and Social Care Act 2012 grants all local Healthwatch the statutory power to 'Enter and View' all publically funded health and social care premises. Enter and View is not an inspection, but instead offers a lay person's perspective on service provision and quality.

Enter and View visits can be carried out as part of a wider project by Healthwatch Surrey, where there is evidence to suggest a visit would be needed to gather more feedback, or by invitation of the provider of the service.

After the visit, the Enter and View team produce a report on what they have seen and heard during the visit. The report is shared with the service provider, the CQC and appropriate commissioners. More information about Enter and View can be found on the Healthwatch Surrey website.

# Appendix 2: Care Homes visited

Breakdown of care homes visited, size and where Activity Co-ordinators are in post.

| Name of Care Home | Location in Surrey | Number of Residents | One (or more) Activity Coordinators |
|---|---|---|---|
| Abbey Chase | Bridge Road, Chertsey | 61 | ✔ |
| Albury House | Albury Road, Guildford | 20 | ✘ |
| Alvington House | Wray Park Road, Reigate | 12 | ✘ |
| Arbrook House | Copsem Lane, Esher | 37 | ✔ |
| Ashton Manor | Beales Lane, Farnham | 35 | ✔ |
| Brownscombe House | Hindhead Road, Haslemere | 26 | ✔ |
| Cherrydale | Springfield Road, Camberley | 20 | ✘ |
| Elizabeth Court | Grenadier Place, Caterham | 50 | ✔ |
| The Epsom Beaumont | Church Street, Epsom | 48 | ✔ |
| Glebe House | The Broadway, Staines | 23 | ✔ |
| Holly Lodge | St Catherine's Road, Camberley | 56 | ✔ |
| Keswick | Eastwick Park Ave, Great Bookham | 48 | ✔ |
| La Luz | High Street, Tadworth | 16 | ✘ |
| Limegrove | St Martin's Close, East Horsely | 54 | ✔ |
| Malmesbury House | Beauchamp Road, East Molesey | 13 | ✘ |
| Moorlands | Portsmouth Road, Hindhead | 97 | ✔ |
| The Pantiles Care Home | Harriotts Lane, Ashtead | 13 | ✔ |
| Princess Christian Care Centre | Stafford Lake, Knaphill | 30 | ✔ |
| Sheerwater House | Sheerwater Road, Woodham | 17 | ✘ |
| Smallbrook | Suffolk Close, Horley | 30 | ✔ |
| Southlands | Linkfield Lane, Redhill | 26 | ✔ |
| Sunrise of Bagshot | London Road, Bagshot | 96 | ✔ |
| Surrey Heights | Brook Road, Godalming | 26 | ✔ |
| Wey Valley House | Mike Hawthorn Drive, Farnham | 25 | ✔ |
| Whiteley Village | Whiteley Village, Walton-on-Thames | 65 | ✔ |

# Appendix 3: Methodology and Approach

Healthwatch Surrey's aim was to use Enter & View powers and small teams of volunteers, all of whom had undergone training and DBS clearance. Their remit was to visit 25 homes, observe the environment as well as speak to staff, residents and their relatives to find out how residents' preferences were being considered when providing care and activities that are relationship-centred. Questionnaires were developed using the learning from Healthwatch Dorset's scoping work, with input from those also developed by Healthwatch Isle of Wight and Healthwatch Sunderland and by piloting the questionnaires with two local care homes. These provided a consistent format for gathering information.

A full list of the Surrey care homes was provided to Healthwatch Surrey by the Care Quality Commission (CQC). These services were grouped by Clinical Commissioning Group (CCG) and then divided into a list of large services (greater than 40 residents) and small services (40 residents or less). From these lists a smaller selection of 30 were chosen in order to reflect some of the diversity in size and location of services across Surrey. Enter & View powers only apply to services where there is a resident accessing a publicly funded service and so this list of 30 was then shared with Surrey County Council (SCC) to determine which homes had Local Authority funded services. From that information, the final 25 care homes were identified which included 13 homes with less than 30 residents, 2 homes with between 30 to 45 and 10 homes with more than 45[16].

A schedule of visits was arranged giving the managers of the care homes 7 days' notice and providing a letter for display. During each visit, the Authorised Representatives aimed to interview the manager, care staff, Activity Co-ordinators, residents and, if possible, a relative.

During the visits, the Authorised Representatives were given access to the communal areas to observe care staff supporting residents, see the environment and resources available and check accessibility to outside space, seating areas and the garden. Where possible, they also observed group activities taking place. The volunteers noted where the CQC report and/or letter notifying their visit was on display and, in addition to the scope of the visit, they made a note of any serious concerns needing to be raised with Surrey County Council and the CQC. In several instances, they also raised important issues direct with management and/or made recommendations in the individual reports, such as improving restricted access to resources and books.

In almost all cases, the manager was interviewed except for one where it was noted they had a prior appointment and another case where there was currently no manager in post. On these occasions either the owner, deputy manager or senior care worker was interviewed instead. During all visits, care staff were interviewed and frequently observed supporting residents on a one to one basis.

Though it wasn't possible on every visit, there was a priority to speak with residents and, where possible relatives. In total, 32 residents offered their opinion and 6 family members also expressed their view or spoke on behalf of their relative, in addition to those completing the friends and family questionnaires. Although the Authorised Representatives sought to explain the purpose of the visit and gather a diversity of residents' views, it was only possible to interview one resident in 17 of the care homes and the opinions offered were often informative but not always relevant to the questions asked. This may be due to a number of factors but given that only 9 of the care homes displayed the letter advising the visit, it may be that the residents hadn't received notice of the visit or understood its purpose.

Following each visit, a care home report was compiled and sent to each care home. Managers were given 10 days to respond to the findings which if provided, were then captured in the report. The individual reports were forwarded to CQC and SCC for information and in one case CQC took action following concerns that were raised. These reports are now published on Healthwatch Surrey's website. It is important to note that both the individual reports and this summary report relate to findings observed on the date of the visit. They are not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time. Together with the family and friends' questionnaires they form the basis of this summary report.

16. See Appendix 2 for a breakdown of the homes involved

# Appendix 4: Sample of Activities

## Selection of the activities on offer in the homes visited

- Activities schedule showing reflexology, music therapy, floor games, hairdressing, arts & craft, puzzle time, ladies club, pamper time, bingo, fruity Friday, 1-2-1 sessions, afternoon sports and afternoon at the movies;
- Activities prompts that include telephone boxes with 'old style phones on each floor.';
- An activities room that had residents' pictures and paintings on the wall;
- Dementia Shop on the first floor adorned with cans and boxes covering the period from the 1930's to the 1950's;
- Activities noticeboard showing: Nail Care, Movement in Music, Coffee Morning, Sing-a-long, Camberley Alzheimers Café, Film Day, Gardening and a Halloween Photo Display of relatives, family members and staff at a recent activity;
- Weekly group activities supported by an activities room with Bingo, Scrabble, Jenga, Call to Mind, Nought & Crosses, along with Arts & Crafts, Darts, Knitting and Skittles;
- Social activities, such as during summer, bar nights to include families, summer fairs to invite family and the community into the home;
- Stimulation through group singing and poetry groups;
- Group activities structured within a weekly programme that includes: Mental Aerobics, Gentle Exercise, Thai Chi, Pamper Nails, Gentlemen's Club and a Ladies Group, Singing 4 Fun and bus trips to Holy Communion events, events at Farnham Maltings and trips to Haslemere Theatre;
- A giant (communal) scrabble board for which the activities team organise scrabble challenges that which brings out the competitive side to residents;
- Happy Memories Garden depicting a poppy field that was made by residents;
- An activities calendar showing Art Therapy, Baking, Our favourite memories, Beauty Session, Board Games, Bath Bombs, Exercises, Singing, Holy Communion and Hairdressing;
- Creative use of communal areas to enable residents to have access to books and access to a computer;
- Creative use of grounds and gardens to enable residents to engage in light gardening with raised garden beds and provision for outdoor seating, events and outdoor activities;
- Seated exercise and dance, ball games in the garden and carpet bowls indoors.

## Tell us about your experience of:

### Health services
e.g. GP, dentist, hospital, district nurse

### Social care
e.g. home care, day centre, care assessment

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