healthwatch Stockton-on-Tees

What is it like to live in a care home for older people in Stockton-on-Tees?

August - December 2018

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Contents

1. INTRODUCTION

What is Healthwatch?

Healthwatch England is the national consumer champion in health and social care. It was set up by the government to ensure that people's views about health and social care services are listened to and fed back to service providers, commissioners and to local and national government with a view to improving services.

Each Local Authority in England has its own Local Healthwatch. Healthwatch Stockton-on-Tees aims to be a strong local consumer champion working with our partners to support:

- People to shape health and social care delivery.
- People to influence the services they receive personally.
- People to hold services to account.

We achieve this by:

- Listening to people, especially the most vulnerable, to help us understand their experiences and what matters most to them.
- Influencing those who have the power to change services so that they better meet people's needs now and into the future.
- Empowering and informing people to get the most from their health and social care services and encouraging other organisations to do the same.

What is Enter & View?

Under Healthwatch regulations there is a statutory duty on the providers of publically funded health and social care services to allow Healthwatch authorised representatives to enter their premises.

The role of the Healthwatch authorised representatives is to conduct visits to such services in order to capture the patient/customer experience and make recommendations where there are areas for improvement or to capture best practice which can then be shared.

Enter & View is the opportunity for Healthwatch Stockton-on-Tees to:

- Enter publicly funded health and social care premises to see and hear first-hand experiences about the service.
- Observe how the service is delivered, often by using a themed approach.
- Collect the views of service users at the point of service delivery.

- Collect the views of carers and relatives and those of staff members working in the service.

- Observe the nature and quality of services.
- Report to providers, the Care Quality Commission (CQC), the Local Authority, Commissioners, Healthwatch England and other relevant agencies.

Enter & View visits can happen if people tell us there is a problem with a service, but equally they can occur when services have a good reputation, so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.

It should be noted that Enter & View is not the only way in which information can be obtained. The use of questionnaires, surveys and themed focus groups are other examples of ways in which Healthwatch Stockton-on-Tees is able to gather relevant information.

The purpose of this report:

The purpose of this report is to look at the quality of life provided to older people living in residential and nursing care provisions across the Borough of Stockton-on-Tees. To look at what was working well, but also to consider those areas where it was felt improvements could be achieved with the overall aim of improving the quality of life for care home residents now and in the future.

Background:

Stockton-on-Tees Borough Council's Adult Services 'Market Position Statement' produced in 2015[1] shows that, in line with national trends, life expectancy across the Borough continues to increase. The document suggests that "between 2014 and 2020 the number of people aged 65 and over is forecast to increase by 6,000 people (19%), with those aged 85 and over increasing by 1,500 people (41%)".

Although the move both nationally and locally is towards providing support to enable people to live in their own homes for as long as it is safe for them to do so, inevitably this increase in numbers will have an effect upon the number of people requiring care home provision. In particular the Market Position Statement estimates that the number of people over the age of 85 living in non-Local Authority care homes with, or without, nursing will increase from 736 in 2014, to 976 by 2020.

In addition, and again in line with national trends, Stockton-on-Tees will experience a significant increase in the number of people aged over 65 living with dementia, "and particularly for those aged over 85, for whom carefully designed

services are critical in delivering the best quality of life and safety possible" (Stockton-on-Tees 'Market Position Statement' 2015).[1]

There is no sign of these demographics changing in the future. All the research suggests that the numbers of older people will continue to rise, and the numbers of people living with dementia are expected to continue to rise dramatically. Research produced for the Alzheimer's Association[2] puts the number of people in the UK currently living with dementia as 850,000. This is projected to rise to one million by 2025, and to a staggering two million by 2050.

Inevitably, with the aim being to maintain people living at home for as long as possible, the dependency levels of those moving into residential or nursing care provision continues to increase. This puts added pressure onto care providers, and particularly upon staff, many of whom have worked in care for several years, when dependency levels were not what they are today. In addition, the number of beds registered for residents living with dementia is increasing, and they are often faced with moving into provisions that were not specifically designed with their particular care needs in mind.

It is against this backdrop that we sought to establish what care provision was like at this moment in time across Stockton-on-Tees.

Acknowledgements:

We would like to thank staff and residents of those services that took part in this research (see Appendix 1), along with their relatives and friends who also contributed to this research.

We would also like to thank the hardworking volunteers of Healthwatch Stockton-on-Tees who freely gave up their valuable time to support us with our work.

EXECUTIVE SUMMARY

The purpose of this report is to look at the quality of life provided to older people living in residential and nursing care across the Borough of Stockton-on-Tees.

In order to gather information, Healthwatch Stockton-on-Tees sought to use its statutory power of 'Enter and View' seeking out the views of residents, relatives and friends of residents, and staff members working in the services we visited.

In total we received a response from 123 relatives/friends, 174 staff members and we spoke to 148 residents.

We sought information with regard to eight quality indicators, developed in 2016 by the organisation Independent Age[3], and tested in collaboration with Healthwatch Camden. These indicators aimed to cover those features that all good care homes should be able to evidence in their policies and through everyday activities.

High levels of satisfaction with the management of the services we visited were generally expressed by both staff members and by relatives. Managers were said to be supportive and approachable and relatives stated that they made themselves available to talk to if and when required.

Some managers were less visible around the home, particularly in larger services, and residents were not always aware of them, especially by name.

We did note that out of the 30 services visited as part of this research, over 50% had changed their manager in the previous 12 months. This was particularly noticeable in services that had received less than favourable CQC inspections. The Care Quality Commission 'State of Care' report 2017/18[4] also picked up on the high turnover of Care Home Managers nationally. The Manager's role is complex and demanding and they need to be supported by providers and not merely 'held to account' when something goes wrong. The CQC adds that, "considering the strong link between good leadership and high quality care this is an area that providers need to focus on".

Most staff spoken to believed they did have the skills necessary to do their job, but many commented that time pressures meant that they were not always fully able to meet the needs of residents.

The main reason given for this lack of time was the amount of paperwork staff are required to complete. Some staff commented that on occasions the direct care of residents could be compromised as a result of this.

This lack of time was picked up by relatives with one saying, "*staff seem inundated with paperwork*" whilst another said, "*staff care deeply but don't have the time*".

Residents said they found staff to be very kind, caring and compassionate but that they only managed to stop for a chat "*if they have the time*" and that very often this did not happen.

Staff described the process of how residents are admitted to the home and how they gathered information about health care needs, as well as gathering a personal history of each resident.

There was a lot of similarity about the process followed.

Again, however, time factors came into play, with one staff member telling us, "*all the information is in the care plans but you don't always get time to read them*".

However, some services were more proactive when undertaking care reviews. Some services had 'resident of the day' reviews and efforts were usually made to involve family members and residents themselves in the process. Others had a more ad hoc process, reviewing monthly, quarterly or six monthly depending upon need.

Family members generally felt they were kept well informed by the service.

Residents were less sure, with few actually referring to a care plan, but they generally felt that staff were aware of their particular needs and did their best to meet them.

A number of staff did not feel that a sufficiently stimulating activity programme was in place, and a third felt that residents were afforded little opportunity to engage in activity in the community. Some staff did not see it as their responsibility to undertake activity, it being the responsibility of an activity co-ordinator. Whilst most services had a co-ordinator, many services did not employ them every day of the week. In a majority of services the importance of residents being engaged in activity, including 1-1 activity, did not appear to be seen as a priority. Again, time pressures came to the fore, with staff saying they would join in with activities "if they got the time".

Many relatives also commented about a lack of stimulation and activity for their family member. In particular, many said that residents were only taken out of the home if a family member was able to take them.

Residents told us that there often was not a lot to do, and what was on offer was not always suitable to their needs. One resident said, "*there's not a lot for a bloke to do*" whilst another said, "*it's my body that's bad not my mind*".

It was noticeable that often those with the greatest need received the least stimulation. This was particularly evident in services that accommodated residents living with advanced dementia".

Generally high levels of satisfaction were received with regard to the choice and quality of meals served. All services offered a choice of main meal, with alternatives available if required.

Specific dietary requirements were seen to be met, and those residents on a soft or pureed diet received meals that were well presented. Contacts were made with the Speech and Language Teams (SALT) where necessary.

There was evidence of drinks and snacks being made available in between mealtimes.

At all services we visited, staff informed us that they accessed a full range of health care professionals as required. GP's across the Borough tend not to visit unless specifically asked to do so by the Community Matron, who would make the initial visit and who is able to write prescriptions. This was a source of concern to some nursing staff, and some relatives queried the process.

Other professional teams were sourced where necessary, these included the Tees Esk and Wear Valley Intensive Community Liaison Service (ICLS) who are contacted for advice in relation to residents with acute mental health difficulties or behaviour that may challenge.

Very few people from ethnic minority groups were resident in the homes we visited. Where they were, their dietary needs were met and staff told us that they respected their specific cultural practices such as prayer time.

Many staff felt that the religious needs of residents were being met and most care homes had visiting clergy, and a number also held occasional services on the premises. There was little evidence, however, of staff supporting residents to go to church. At one care home a lady told us she had been a nun for 15 years and would like to go to church, but although she had asked this had not been arranged.

Staff did not seem to be aware of any particular lifestyle choices that residents may have. For example, no staff raised any concerns, or awareness, of the needs of any residents who may be members of the LGBT community.

2. METHODOLOGY

Thirty four care homes across Stockton-on –Tees are commissioned by the Local Authority to provide care for older people. Most of these provide residential care, some have a mix of residential and nursing care provision, whilst a few only provide nursing beds.

All of these services were selected to be approached with regard to the work we wished to carry out.

An initial pre-visit was made to each service which enabled us not only to raise the profile and awareness of Healthwatch, but it helped to reassure care home managers about the purpose of our impending work and to gain their agreement for us to carry out our research with them.

After an initial pre visit, two of the 34 homes contacted (Reuben Manor and Ayresome Court) declined the opportunity to be involved in this research, whilst a further two services (Elton Hall and Church View) failed to engage with us.

Two services, (Briardene and Ashwood Lodge) received a pre-visit but no Enter and View was undertaken, primarily as a result of the relatively small scale nature of the services. Instead, a supply of questionnaires (and pre-paid envelopes) were left for staff, relatives and residents to complete. Responses were received back from Briardene, but not from Ashwood Lodge.

As a result of the above we carried out Enter and View visits at 28 care homes, agreeing the date and time of visits in advance, and arranging the timing of visits in order to cause the least disruption to the daily routine as possible.

A full list of the services involved are shown in Appendix 1. We were assisted in this work by our Healthwatch volunteers. These are authorised representatives who have been trained to support this type of engagement so that they can effectively capture the patient/resident experience. Each visit lasted between 1.5 hours to 4.5 hours dependent upon the size and nature of the service being visited.

Each care home was provided with posters and leaflets for display around the home in order to promote our visit. Additionally, a supply of questionnaires (and freepost envelopes) were made available for staff and relatives who may be unavailable at the time of our visit.

Relatives and staff were also able to complete questionnaires online, and information about this work was displayed on the posters which were also widely circulated to a range of professionals and community groups, across social media platforms and in the local Healthwatch newsletter.

Standard questionnaires (which can be found in Appendix 3) were used for:

- Residents
- Relatives
- Staff

The questionnaires we used were based predominantly upon **eight quality indicators,** first developed in 2016 by the organisation Independent Age[3] and tested out in collaboration with Healthwatch Camden. These indicators aimed to cover those features that all good care homes should be able to evidence in their policies and through everyday activities. We were clear that this was not an "inspection" and the scrutiny of recruitment records, training records, care plans, etc. was not part of our remit.

A good home should:

1. Have strong, visible management. The manager should be visible within the care home, provide good leadership and have the right experience for the job.	**5. Offer quality, choice and flexibility around food and mealtimes.** Homes should offer a good range of meal choices and adequate support to help residents who may struggle to eat and drink, including between mealtimes. The social nature of eating should be reflected in how homes organise their dining rooms, and accommodate different preferences around mealtimes.
2. Have staff with time and skills to do their job. Staff should be well trained, motivated and feel they have the resources to do the job properly.	**6. Ensure residents' can regularly see health professionals such as GP's, dentists, opticians and chiropodists.** Residents should have the same expectation to be able to promptly see a health professional as they would when living in their own home.
3. Have a good knowledge of each individual resident and how their needs may be changing. Staff should be familiar with residents' histories and preferences and have processes in place for how to monitor any changes in health and wellbeing.	**7. Accommodate residents' personal, cultural and lifestyle needs.** Care homes should be set up to meet residents' cultural, religious and lifestyle needs as well as their care needs, and shouldn't make people feel uncomfortable if they are different or do things differently to other residents.

4. Offer a varied programme of activities. Care homes should provide a wide range of activities (and ensure residents can access these) in the home and support residents to take part in activities outside of the home.	**8. Be an open environment where feedback is actively sought and used.** There should be mechanisms in place for residents and relatives to influence what happens in the home, such as Residents and Relatives Committee. The process for making comments or complaints should be clear and feedback should be welcomed and acted upon.

During this research we received a response from 123 relatives and 174 staff members.

We spoke to, and obtained feedback from, 148 residents. Other residents were spoken to but many lacked capacity to contribute. However we were able to observe their interactions with staff members and other residents, their engagement in meaningful activity, and their general demeanour within the care home environment.

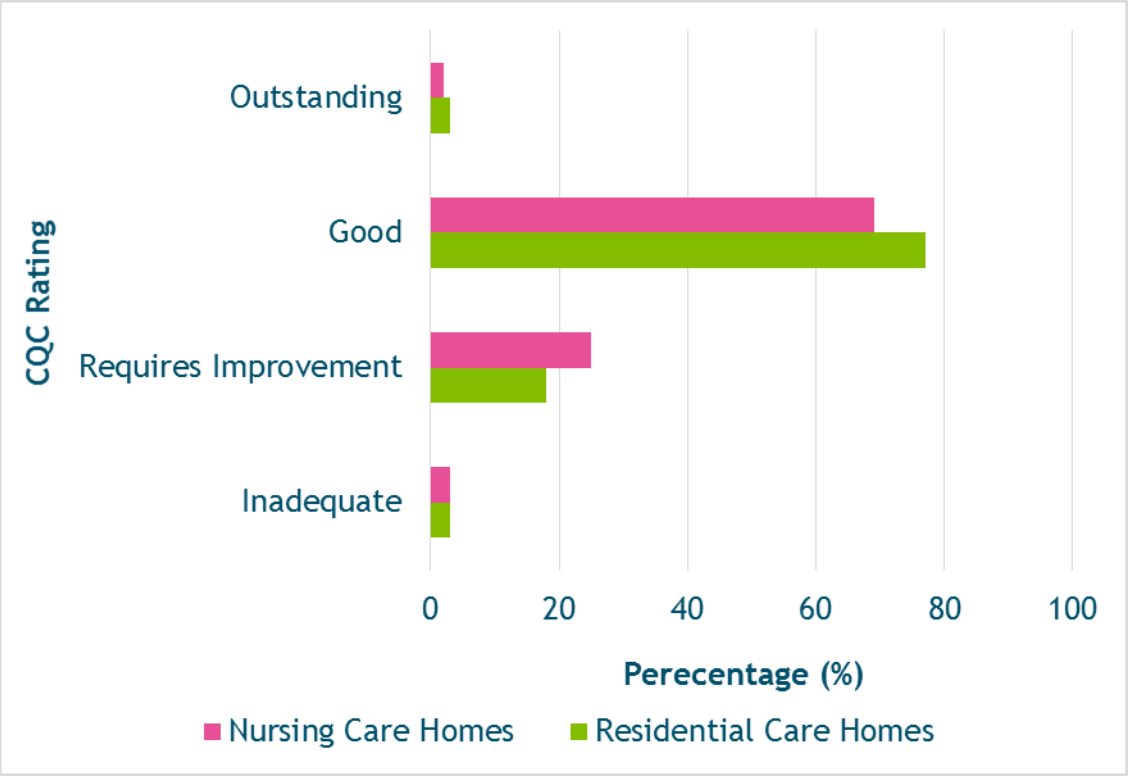
We also took the opportunity to be shown around each care home we visited, and were able to make a number of observations to help inform this report.

3. CARE HOME QUALITY INDICATORS

I. The service has strong and visible management.

A Care Home Manager should be visible within the care home, should provide good leadership and have the right experience for the job.

The 2017/18 'State of Care' report produced by the Care Quality Commission[4] shows that only a small percentage of care homes across England have achieved an overall rating of 'Outstanding'. In Stockton-on-Tees no homes included as part of this research had achieved this standard.



State of Care Report – Care Quality Commission. 2017 – 2018

John Kennedy, an independent consultant and commentator in adult social care, writing an article entitled 'What makes a care home outstanding' published by The Guardian in 2016[5] stated that of those services rated outstanding, one common theme was that the Care Home Manager was well supported and valued. They have sufficient resources to do the job and these resources are invested in the service. Many of these outstanding services were run by private providers, with only one or two homes in their portfolio. Larger organisations, he added, often struggled to achieve consistency of ratings across their services. Evidence suggested that

managers were finding the role almost untenable given the complexities of the role and the external regulatory systems they face which were becoming increasingly adversarial and critical. They are faced with managing the finances for the provider organisation, balancing this with the requirements of a fairly stringent set of regulatory requirements and the safety and care needs of the workforce and meeting the ever increasing needs of the people they are providing a service to.

A 'Skills for Care' briefing on Registered Managers produced in 2016[6] found that one in four care homes lose their manager each year and the figure rose to one in three for nursing homes.

In Stockton-on-Tees we found that of the homes that took part in this research, over 50% had changed their manager in the previous 12 months. In many cases this was following a poor CQC inspection. This is in line with information contained in the recent Care Quality Commission 'State of Care'[4] report which states that, "in most of the services we looked at (which had a rating lower than 'good') a new manager had come in to deliver the improvements needed".

It is against this backdrop that we asked questions of staff, relatives and residents about the management of the service.

During our research we asked staff if they felt well supported by their manager, and if they found them to be approachable should they need to discuss anything.

Over 159 (93.5%) of the 171 respondents said that this was the case. Some of the comments we received included:

*"She is fantastic, very motivated with a lot of new/good ideas" (*staff member Roseville)

*"She is very much a people person. She is there for everyone and I feel really appreciated" (*staff member Chestnut Lodge)

"*There has been a massive difference since the new manager came. The difference is unbelievable and staff morale is so much better" (*staff member Woodside Grange)

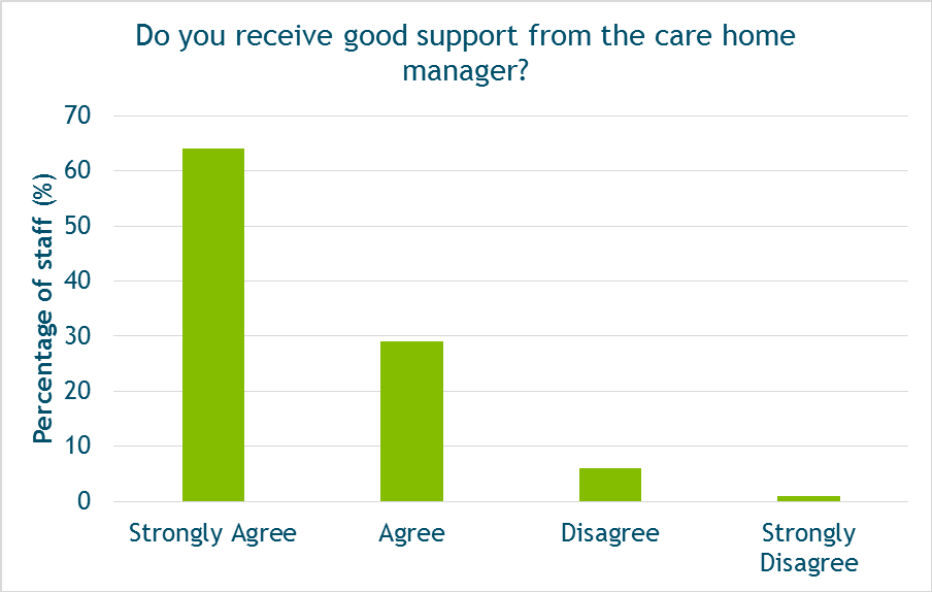
*"She is a really good manager, she actually listens to me and I can have a conversation with her" (*staff member Hadrian Park)

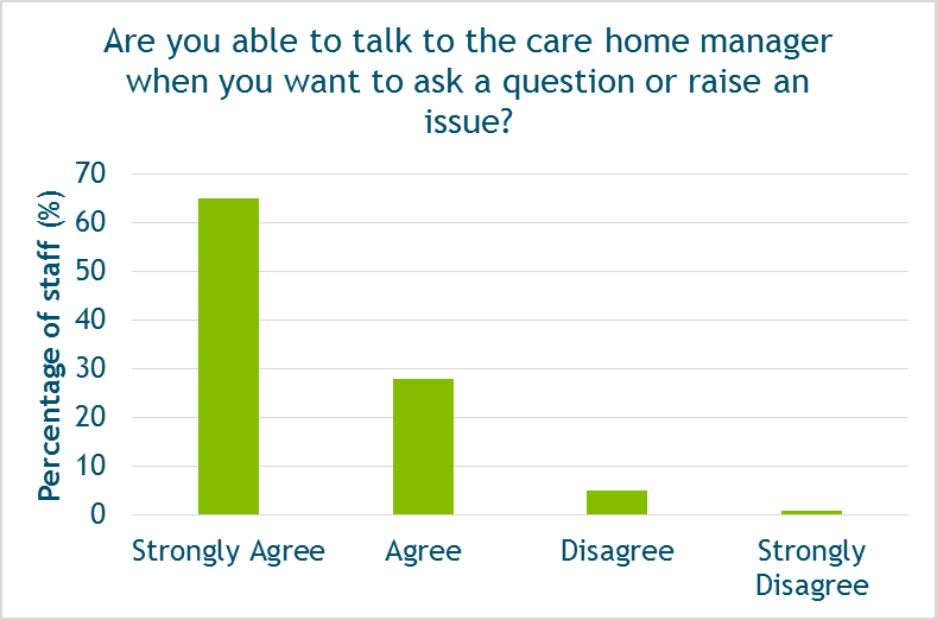
Only 12 staff (6.5%) of those who responded felt their manager was not supportive, and, perhaps unsurprisingly, these were from staff working primarily at homes that had received less than positive inspection outcomes.

"*I can approach her but I'm not always sure that she listens" (*staff member Teesdale Lodge)

At another service the Registered Manager had been absent for several months and the deputy was under pressure trying to run the service. As a result staff felt generally unsupported.

*"The deputy is quite stressed at present. Staff are not feeling that well supported" (*staff member Newland House)





Some managers spend much of their time in the office, and are not always visible around the home. However of the 118 relatives who responded, 107 (90%) felt that the care home was managed well and that the care home manager was available to talk to about any issues they may have. Further evaluation suggests that

relatives may not always go to the manager in the first instance, often directing any questions or queries to the senior carer on duty. Nonetheless high levels of satisfaction were reported.

Some managers held monthly surgeries, where relatives could book an appointment to speak to them, but, in addition to this, most seemed to have an 'open door' policy when they were available.

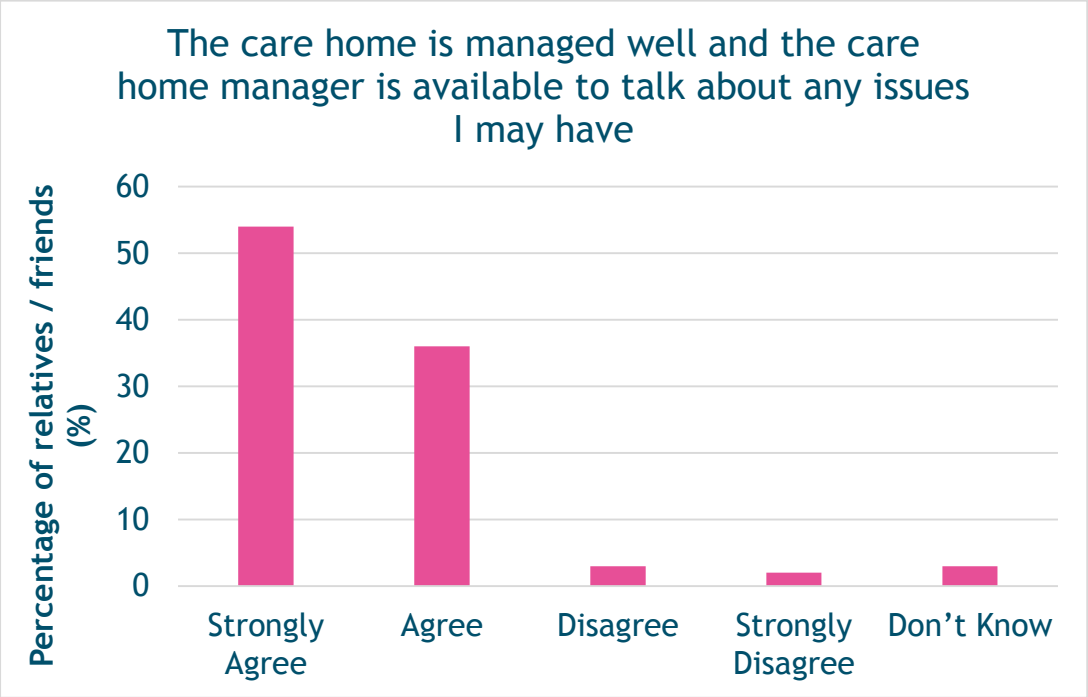
Relative responses included:

"My Mum gets on well with D (manager of the home), she has a joke with her which she likes" (relative Millbeck House)

"She is very pleasant, friendly and approachable. Has plans for the future. I hope she does well, it is no easy job" (relative Woodside Grange)

"If we have any problems regarding my Mum the manager is always there to see us" (relative Roseworth Lodge)

*"We have received far more support from J (manager of the home) than we have from the hospital or from social services" (*relative The Maple)



Discussions with residents were sometimes difficult, with some residents lacking capacity to really understand some of the questions they were asked. Some knew the name of the manager, whilst others said they would recognise them if they saw them. However it was evident that some managers made themselves more visible to residents than others. Of 135 responses, 73 residents (53%) said they knew, or would recognise the manager of the home.

Some managers made a point of getting to know residents, and their needs, whilst for others this was the role of more senior staff, or, in homes with nursing beds, the role of the nurses, particularly regarding clinical needs.

The lower the number of registered beds the more available the manager could become, and in some services such as The White House and Park House, both managers and their deputies had a very much 'hands on approach'. However, even in some homes with a large number of beds, we also found evidence of managers having a good knowledge of the needs of individual residents and maintaining a visible presence around the home.

*"She is very good. She visits me each day and always says good morning" (*resident Roseville)

*"She makes everyone feel at home. I think she's marvellous, one of my favourite people" (*resident Hadrian Park)

It was evident that there are many good, committed, care home managers working in services across the Borough. The manager is key to the successful running of the service and the quality of care being provided. According to John Kennedy in The Guardian (2016)[5] we have to recognise that care homes and the managers running them "need to be supported, not just held to account".

This is backed up by the Care Quality Commission's 'State of Care' report for 2017/18.[4] This states that, "though a Registered Manager is likely to have the greatest influence over the day to day running of a care service, it is important that they are supported by the provider or owner where possible. Poor relationships between provider and manager can have negative knock on effects for people working in and using the service". The CQC further state that, "considering the strong link between good leadership and high quality care this is an area that providers need to focus on".

II. Staff have the time and the skills to do their job

Staff should be well trained, motivated, and feel they have the resources to do the job properly.

Upon reflection, this question should have been split into two. Having the necessary skills to carry out their role does not necessarily mean they have the time to do it well.

Time

Generally, most staff who responded felt that they did have the skills, but some often found themselves to be rushed and this had an adverse effect on the quality of care they were able to provide to residents.

This was also noted by relatives, who often praised staff for their commitment and dedication, but who felt that staff simply did not have sufficient time to care for their relatives and to meet their needs appropriately.

Staff were asked, "Do you feel you have enough time to care for residents and meet their needs appropriately?"

Of 172 staff members who responded, 104 (60%) felt they did have sufficient time but several of these said that meeting residents' needs appropriately could be difficult. 68 staff members (40%) responded negatively to the question. One of the main reasons for this was the amount of paperwork they were expected to complete.

In 2014, the Joseph Rowntree Foundation commissioned a report 'Is excessive paperwork in care homes undermining care for older people'.[7] This report states that staff in care homes regularly have to complete more than 100 separate items of paperwork, often duplicating the same information for different audiences. Staff often said that they felt that the delivery of care was being lost under an ever increasing mountain of paperwork.

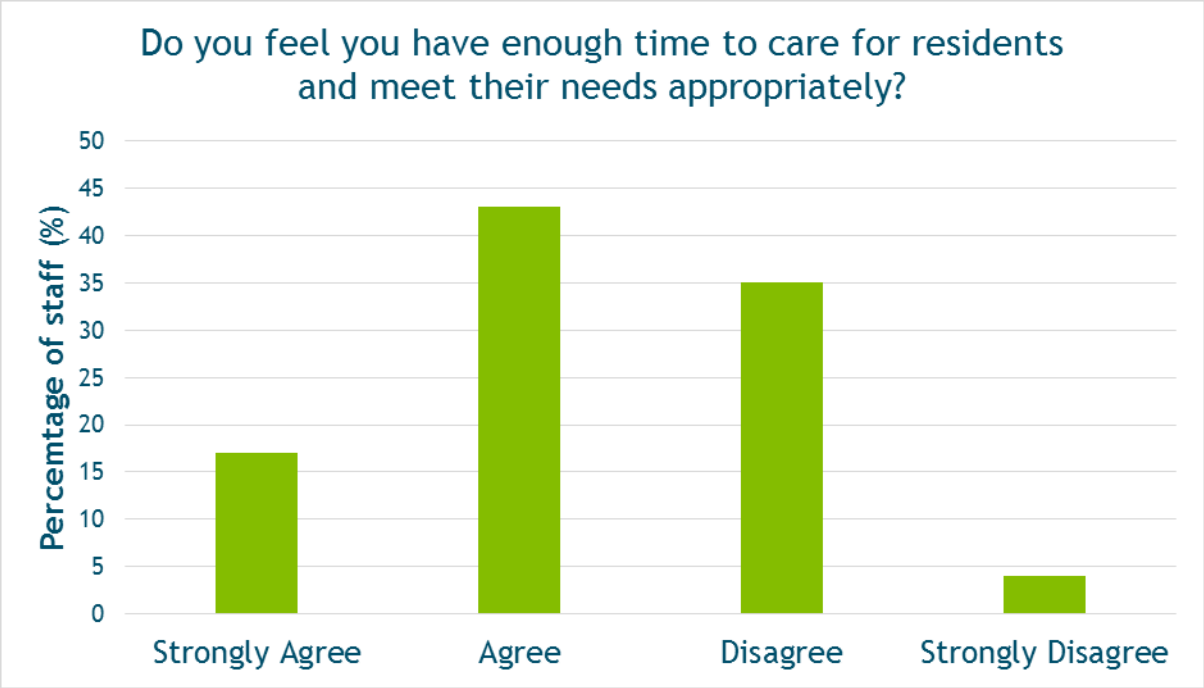
*"There is an awful lot of paperwork. Previously we are were able to sit and spend some time with residents" (*staff member Allington House)

"Less and less time to stop for a chat" (staff member Ingleby Care Home)

"*Paperwork has to be attended to before we can attend to residents*" (staff member Victoria House)

*"Would like to be able to spend 10 minutes or so to talk to and reminisce with them over a cup of tea" (*staff member Hadrian Park)

*"Meeting resident needs can be difficult - never enough staff - leading to who shouts the loudest" (*staff member Highfield)



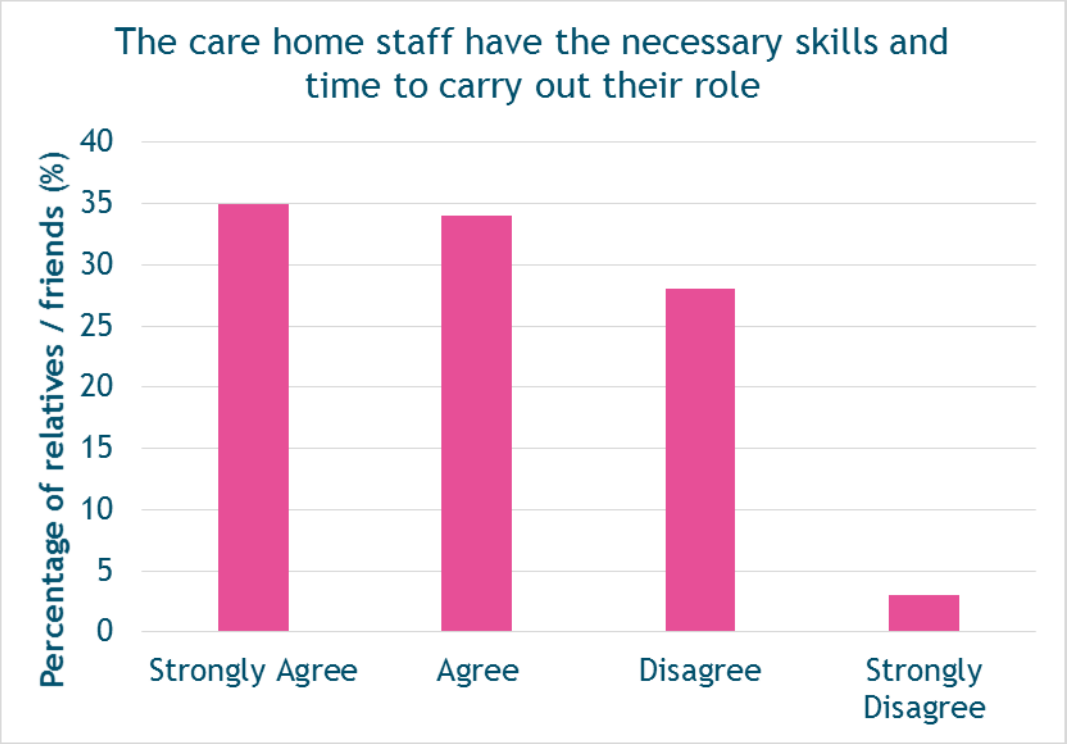
This doesn't go unnoticed by relatives who said that:

*"Staff seem inundated with paperwork completion. Would be interested to learn why this is necessary if it means that care is compromised (*relative Woodside Grange)

"*Staff care deeply but don't have the time". (*relative Green Lodge)

Relatives were asked "Do the care home staff have the necessary skills and time to carry out their role?''

Whilst 83 (69%) of the 120 relatives who responded felt that staff did have the time and skills required, many added that whist they had the skills they did not always have the time. Had the question been split into two a different response might have emerged. Nonetheless, a significant number of relatives, 37, (31%) responded negatively to the question.



Residents themselves were often very positive about the staff who supported them in the home. Lots of residents spoke about staff being "kind", "caring" and "compassionate", one resident saying "*they are like angels, I can't praise them highly enough*". However they too felt they were too rushed and were only able to stop and have a chat "if they have the time".

The Joseph Rowntree report of 2014[7] states that, "there seems to be very little co-operation between different regulators and commissioners, and some duplication arises when they ask for much the same information but with a twist to suit their own individual needs". This can have a significant impact upon the home.

Too often staff felt that they had to complete the paperwork, not so they could provide better care for residents, but so that they could ensure legal compliance and prevent litigation.

Managers too are affected by this burden of paperwork. The Joseph Rowntree report suggests that, "paperwork can take managers …. away from precisely the leadership activities they should be engaged in to ensure high quality care for their residents". Managers and staff felt that they should be judged on their ability to deliver good quality care or the effectiveness of their leadership and management, and less on their ability to fill in or check paperwork.

Other factors adding to the timescale pressures include the fact that virtually all services are operating on minimum staffing levels. These fail to take account of the fact that the care needs of some residents often fluctuate on a daily basis. Many staff who agreed that they had sufficient time added the word "usually" or "sometimes" and that, "it depended upon what was happening that day".

We observed several instances of staff being absent from work and shifts not always being covered. This was evident at Victoria House where the nurse rostered on shift on the first floor was absent from work. This left a nursing unit with more than 20 residents, without a nurse on duty. The nursing assistant on duty was so busy in the office dealing with paperwork that she said she did not have time to talk to us during our visit. One staff member commented that, *"I used to enjoy the whole care side. Now it is all a rush to get daily tasks complete"*.

Of course this lack of time can manifest itself in a variety of ways. As we shall see later on in this report, the ability of care staff to provide valuable activities and stimulation to residents also depends upon staff having the time to do so. Similarly, enabling residents to access services in the community is also dependent upon staff having the time, and resources, to support them.

Whilst we found evidence of assessments being undertaken and care plans being formulated, it was important that staff had sufficient time to familiarise themselves with these and to meet the required care needs of each individual resident appropriately.

"It's in the care plan, but you don't always get time to read them" (staff member Green Lodge)

Senior staff, and clinical staff in homes providing nursing care, are often the first port of call for relatives seeking information or wishing to discuss issues regarding their loved one. Whilst this is perfectly understandable, it can seriously impact their ability to 'work the floor'. In addition these staff have to deal with a significant amount of paperwork, medication administration, arranging and chairing review meetings, communicating with and arranging visiting professionals as well as often delivering staff supervision and appraisals. It was difficult to know whether they were included in minimum staffing level requirements or whether they were supernumerary (additional staff above minimum requirements). If it is the former then this further reduces the number of staff available to provide direct, 'hands on', resident care.

Skills

Although training records were not looked at as part of this research, the vast majority of staff felt that they had been appropriately trained to carry out their role.

Some services have a programme of e-learning that staff are expected to complete. Others provide more in the way of 'in-house' training, whilst some use a combination of both. Some staff also said that they got behind with on-line training because they did not have regular access to a computer.

A majority of staff indicated a preference for 'in house' training, feeling that this was more beneficial to them. Some care homes used their provider's own internal trainers and a number of services also brought in external trainers to cover specific areas.

One of the issues identified was the fact that staff in some services are paid for coming in to undertake training, whilst in other services they are not, and have to come in on their days off. This would seem to be offering little incentive to staff and clearly was a source of discontent to many. Similarly, those who had completed e-learning were not always paid whilst others received a payment for each module completed. There was no evidence of staff being given 'time off in lieu'.

Some services closely monitored staff to ensure training was completed in a timely manner, whilst other services did not seem to provide timescales.

Staff had differing views on the best approach to take:

"We mainly do training in house - you learn more that way" (staff member Stockton Lodge)

Whilst at Roseworth Lodge a staff member said *"it's now mostly done on-line and this means we no longer have to come in on our day off"*.

Some services ensured all staff were well trained and had opportunities to develop their careers. This was particularly evident at Park House where all staff members had been trained to at least NVQ Level 3 in Health and Social Care, and several had received training to a higher level. A chart in the staff room provided dates for staff to show when they were expected to have completed their training, and when it was next due for review.

One staff member at Park House told us, *"the owner pushes staff to complete their training and will support this. I said I would be interested in doing a sign language course and this was arranged for me"*.

Staff here felt valued and respected, and, perhaps unsurprisingly, staff turnover was very low, with several staff having worked at the service for more than ten years.

Although most staff who responded said that all mandatory training was done, this was not always the case.

"I *have been here two months now and haven't done any moving and handling* training *so I can't use the hoist" (staff* member Victoria House)

With dependency levels of residents increasing, some staff will require more specialist training in order to be able to meet the individual needs of all residents in the most appropriate way.

A staff member at Victoria House, working on the 'dementia' floor with some nursing patients living with advanced dementia said, *"I have had no dementia care training"*.

Locally, a great deal of support and training is available to care staff. Although staff in some services said they received specialist training, sometimes from NHS services, this did not always seem to be the case.

III. Staff have a good knowledge of each individual resident and how their needs may be changing.

Staff should be familiar with residents' histories and preferences and have processes in place for how to monitor any changes in health and wellbeing.

Staff were asked two questions:

1. How do you ensure that staff get to know a resident's life history, personality and health care needs when the resident first arrives?

2. How is information about a resident's likes/dislikes and their health care needs updated as these change?

In many services we were told that a pre-assessment was undertaken prior to admission to the home. This was usually undertaken by the care home manager and/or a senior member of staff. This resulted in an assessment of healthcare needs, and helped to determine whether the service would be able to meet these needs in the most appropriate way.

Not all admissions to care homes could be planned in this way, and in these cases as much information as possible was taken from social worker assessments, hospital discharge notes, and from potential residents and their family members as soon after admission as possible.

Upon admission this information is built upon, again usually by senior staff, and a care plan is put together to determine how the resident's individual needs should best be met. At the same time discussions take place with regard to a resident's likes and dislikes, their preferences, and a general 'life history' is put together.

The care plan should be used to introduce the person to everyone who will work with them. It must cover not just health needs, but aspects of their life history, their culture and religion, etc. in order to help staff to understand the 'whole' person. It should set out the objectives the staff, and often family members, will have planned with the person for the future.

Staff who responded to the questionnaires said they were then told to read the plan of care and familiarise themselves with the residents and how their needs should be met.

Some services allocated a 'key worker' to individual residents. The 'key worker' role is to ensure the manager or senior staff are kept up to date in regard to the service user's needs and with any family concerns or issues. They are responsible for liaising with their manager to ensure changing needs are being recorded in care plans. They are also a key link between the resident and any family or friends. Whilst this system has many merits, the 'key worker' cannot be on duty all the time and therefore other staff also have to have a good knowledge of the individual health and social care needs of residents.

We were told by staff that they were required to familiarise themselves with the care plans of residents. However, one of the main issues here is staff having the time to read, understand, and remember the plan of care.

*"All the information is in the care plans but you don't always get the time to read them" (*staff member Green Lodge)

This was not untypical of the responses we received.

Additionally, the needs of residents will change over time. Some may find their health improves and they become less dependent once they are receiving good care and treatment and are eating a nutritious diet. However, others will see a deterioration and as a consequence of this their care needs will increase. These changes in need have also got to be recorded in the care plan, and staff have to be made aware of them.

All services said that they carried out staff handovers when shifts changed. At this point any changes in a resident's need were fed back verbally to the new staff coming on duty. In some services a communications book was provided where updated information could be recorded and was easily available. Again, however, this required staff time, and it was unclear how staff who may be off shift for a few days kept up to date with this information.

One relative said:

*"Care plans are not followed consistently, or at all. The job seems haphazard and in the past falls have not been reported accurately or attacks by other residents" (*relative at Woodside Grange)

Some services, including Allington House, Cherry Tree Care Centre and Hadrian Park, had 'resident of the day' reviews. These included a full review of the care plan which usually included attempts to engage in discussion with family members, and where possible, the resident themselves.

At Hadrian Park one relative told us *"I have a discussion about once a month about the needs of my wife"*

In other services reviews were undertaken monthly and in some cases six monthly, although we were told they were reviewed more frequently should the need arise.

The care plan is a vitally important document. It is a working document so will always be subject to review by staff, by family members, and by the resident concerned. For some staff however, recording in care plans and keeping them up to date added to the paperwork overload and detracted from what they saw as their key role, the provision of direct care to residents. We saw a lot of examples of care staff completing care plans at a table in resident lounges. This meant that staff were able to observe residents but had little opportunity to interact or engage with them.

Some services such as Green Lodge have started to introduce technology in an effort to reduce time spent on updating care plans. This is a relatively new concept and some staff felt it took them time to get to grips with the complexities of it.

However, one staff member added, *"we have a new system in place which is better and it gives us more time to spend with residents. We are not always filling in forms"*

Other technology is being used to carry out and record checks on residents, such as when the resident is awake/asleep, turns in bed, fluid intake, toileting, etc. which can also cut down on paperwork.

IV. The care home offers a varied programme of activities?

Care homes should provide a wide range of activities (and ensure residents can access these) in the home and support residents to take part in activities outside of the home.

Sylvie Silver is the Director of the National Association for the Providers of Activities for Older People. They offer support to care homes to enable residents to live life in the way they choose with meaning and purpose.

She suggests that meaningful activity is invaluable as "it affects the wellbeing of residents and research has shown that if your wellbeing is good you will cope better with the challenges of ageing. People become depressed more if their wellbeing is low. It makes sense for care homes to have residents who are motivated".[8]

She is of the belief that delivering activities should not simply be the remit of an activities co-ordinator, but that care staff should not only be seen as pure care deliverers but should also be involved in supporting people rather than meeting

personal care needs. She suggests that “activities are integral to person-centred care which is what residents should be receiving”.

There is also a perception that activities are simply a group event. This is by no means the case, and many residents fail to receive suitable stimulation or interaction with people as a result of a reluctance, or an inability, to join in with group activity. For these residents 1-1 interaction and stimulation is essential and the benefits can be far-reaching.

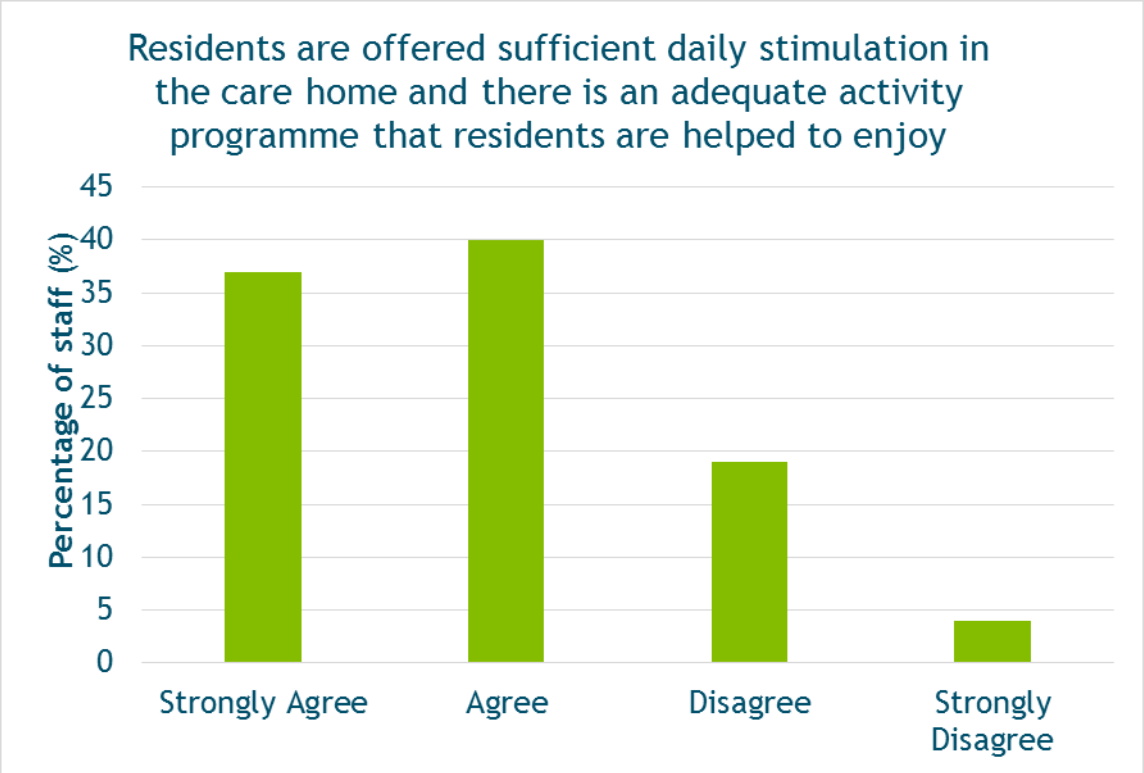
Further research presented at a recent Alzheimer’s Association International Conference (AAIC) in 2018 [9] found that 10 minutes of social interaction a day helps to improve wellbeing for people with dementia in care homes. With figures suggesting as many as 80% of people currently residing in a care home may be living with dementia this would be invaluable to many residents.

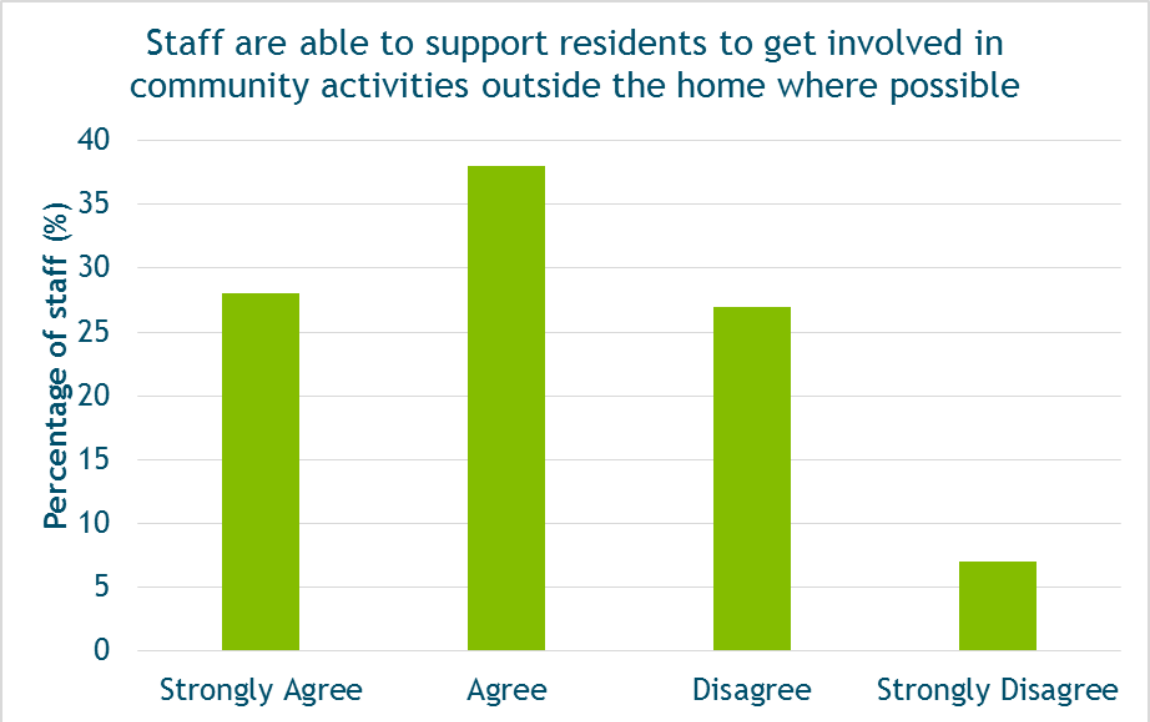
Professor Martin Green of the English Community Care Association said that, “activity co-ordinators play a central role in delivering purposeful activities that stimulate residents and improve their wellbeing”.[10] Activities must be tailored to individual needs and must be within a person’s achievable capabilities, but not too simple. Activities must be quite varied and discussions with residents themselves and their family members will help staff to familiarise themselves with any particular interests individuals may have had prior to their care home admission.

As part of our research, staff were asked two different questions.

1. Do residents receive adequate daily stimulation and is there a varied programme of social activities for residents to enjoy?

2. Are staff able to support residents to get involved in community activities outside of the care home environment where possible?





Staff members spoken to generally felt that residents did receive adequate daily stimulation. However after further discussion with them the overall picture was not so positive. Staff undertaking a range of roles were spoken to, and those who provided direct resident care tended to have very mixed opinions. When telling us

about the range of activities available to residents there was a very strong emphasis upon group activity. Staff often made comments such as "*there's loads of activities but they don't always join in*" (staff member Piper Court) and "*some residents don't seem interested*" (staff member The Beeches). Other activities that were found to be common across most services included hairdressing, listening to music, movie days (sometimes consisting of a DVD being played). Some services listed a monthly visit by the visiting "sweet trolley" as an activity. On some days the only activity scheduled on the noticeboard included 'pamper days' 'nails' and 'beauty sessions', activities that were not particularly relevant to most male residents.

Some staff failed to see the importance of trying to provide something for everyone, the need to tailor activities to individual needs and preferences, and the benefits of providing 1-1 engagement and stimulation was often overlooked.

Even allowing for this over emphasis on group activity, results show that 39 (23%) staff who responded, either disagreed or strongly disagreed with question 1 and even more, 57 (33.6%) disagreed with question 2.

Although some services put a lot of emphasis on activity, others only employed an activities co-ordinator 2 or 3 days a week, whist a small number employed no activities co-ordinator at all.

Hadrian Park employs three "lifestyle co-ordinators" whose role is to get to know each resident and to tailor activities specifically to their needs. During our visit we saw some good examples of activity taking place.

The Maple also employs three co-ordinators, one per floor, although they worked as a team. Mornings tended to be spent offering 1-1 support to residents, whilst group activity took place mainly on an afternoon.

Similarly we saw good evidence of residents joining in with a range of positive activities at Stockton Lodge, Park House, and a few other services.

Some services, including Highfield, Ingleby Care Home, Mandale House and Roseville had booked monthly virtual reality sessions which residents thoroughly enjoyed. One resident was able to visualise being back at Norton duck pond, where he had spent many happy moments in the past. Roseville had also purchased a Tovertafel which could project images and provide a range of sensory activities. Some homes had Wi-Fi available for residents, and at Chestnut Lodge one resident had access to a lap-top computer and was being assisted by staff to pursue his interest in photography. At Briardene a resident who had been a musician was being supported to regain his skills and was thoroughly enjoying this.

We found examples of some innovative activities taking place during our visits. These included in-house cinemas (with popcorn) at Hadrian Park and Willow View, and baby yoga at Ingleby Care Home. At Park House a couple of residents had been interested in knitting, and staff had helped to set up a regular "knit and natter"

group where residents were now making items for the premature baby unit at the hospital. Some residents at Teesdale Lodge and The White House had been taken for a 'wheelyboat' ride on the River Tees. At Cherry Tree, amongst others it was good to see that all religious festivals were being celebrated and at Park House, Burns night had been recognised with a serving of haggis, neeps and tatties.

At many services however, we found little evidence of activities taking place, despite seeing activity programmes on notice boards. A number of staff didn't see it as their role to provide activities, and where they did, they didn't have the necessary time to arrange and deliver them. Too often residents were left sitting in a lounge, often with the TV tuned in to programmes such as Jeremy Kyle. No on appeared to be watching it, and we observed little interaction or discussion between residents.

"*A lot of people need 1-1 and we struggle to do this. They would benefit from it, it would relax them" (*staff member Cherry Tree*)*

*"There is a good activity plan in place but it is difficult to free up staff time to carry out activities" (*staff member St Mark's*)*

*"We have an activities co-ordinator 4 days a week but on other days care staff try to do their best if we have the time" (*staff member The Poplars*)*

*"There is only one activity co-ordinator. There is very little happening. One unit might be chosen to do an activity but the others are left. There is very little time to do 1-1" (*staff member Victoria House)

"*It's the activities member of staff's responsibility*" (staff member Allington House)

"*Staff might get an opportunity - when jobs are done - to sit and chat to a resident*" (staff member Woodside Grange)

*"staff feel frustrated by the fact that they have not got the time just to sit and talk to the residents, which they feel is just as important as the physical care they give" (*relative Highfield*)*

In general we observed that those residents with greatest needs often received the least stimulation. This was particularly evident in services that accommodated residents living with advanced dementia.

On the first floor at Victoria House, which accommodates people living with dementia, including some requiring nursing care, we saw no attempts to engage residents in activities. Indeed for long periods during our visit residents were left sitting by themselves in the two lounge areas. One resident had been assessed as requiring 1-1 support. This consisted of the resident standing in the corridor throughout our visit with the allocated member of staff standing one step away from him. At no time did we see any attempt to make any sort of communication or other form of interaction with the resident. Another resident was observed lying

curled up on the floor outside the lift – again with no attempt being made at engagement. At Highfield we observed one resident "wandering" up and down the corridors throughout the time of our visit. Again we did not observe any staff interaction and it was later on that we discovered that the resident could be quite challenging, but no attempts were made to try and alleviate this behaviour.

Staff comments included:

*"People on the ground floor tend to get the majority (of activities).People in the dementia unit need more time to engage in activities" (*staff member Woodside Grange*)*

*"Not enough activities done to include all residents" (*staff member Highfield*)*

*"There could be more done for people in the dementia unit" (*staff member Willow View*)*

There was also a perception amongst some staff that residents did not want to engage in activity.

"*Some residents don't like activities" (*staff member Allington House*)*

*"There are loads of activities but some won't join in" (*staff member Piper Court*)*

This may be more to do with the activities on offer rather than a reluctance to participate. Whilst true that not everyone would wish to join in group activities there is much more that could be done on an individual 1-1 basis.

Comments from two residents were particularly relevant.

"There's nothing much for a bloke to do" said one resident at Highhfield, where the activities noticeboard highlighted things for that week such as baking, nail care, hairdressing, and bingo.

"*I don't join in much - it's my body that's bad, not my mind"* said a resident at Piper Court, suggesting that the activities on offer were not meeting his needs.

When it came to activities outside of the home over a third of staff were of the belief that residents did not get sufficient opportunities to engage in activities in the community. Almost universally, though not exclusively, this was down to staffing levels, with staff not being able to come off shift in order to accompany residents out of the home. Where residents did go out they tended to be taken by the activity co-ordinator, who clearly was limited with regard to how many residents could be taken at any one time. Although some residents were taken out, staff members regularly came in on their days off to support this, which although very admirable, should not be the norm.

*"Staff come in on days off to help with days out" (*staff member St Mark's*)*

*"Occasionally the co-ordinator will take people out to the shops etc. Staff haven't really got time to do this" (*staff member Willow View*)*

*"Sometimes staff will come in during their time off to help out. Staff usually haven't the time to take residents out but the co-ordinator can, sometimes helped by a family member" (*staff member Mandale House*)*

*"Took some residents out last week to see the war memorial and the parade. Staff volunteered their own time to do this" (*staff member Teesdale Lodge*)*

*"Some staff come in on days off to take residents to the duck pond or pub for lunch" (*staff member Millbeck House*)*

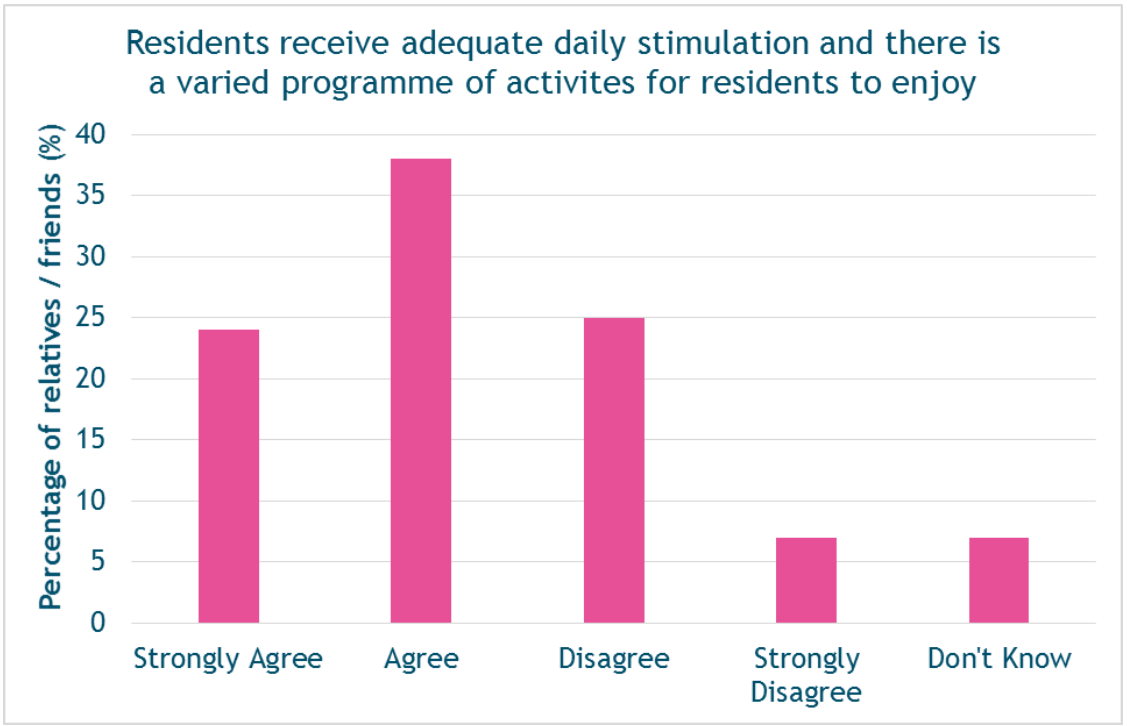
It was also noted during our visits that many services, even those with a significant number of residents, did not have their own accessible transport. This further limited opportunities to take residents out of the home, on outings, etc. At The Beeches we were told that the cost of hiring accessible vehicles was quite high, and in any event they were only available at specific times such as in between school runs, etc.

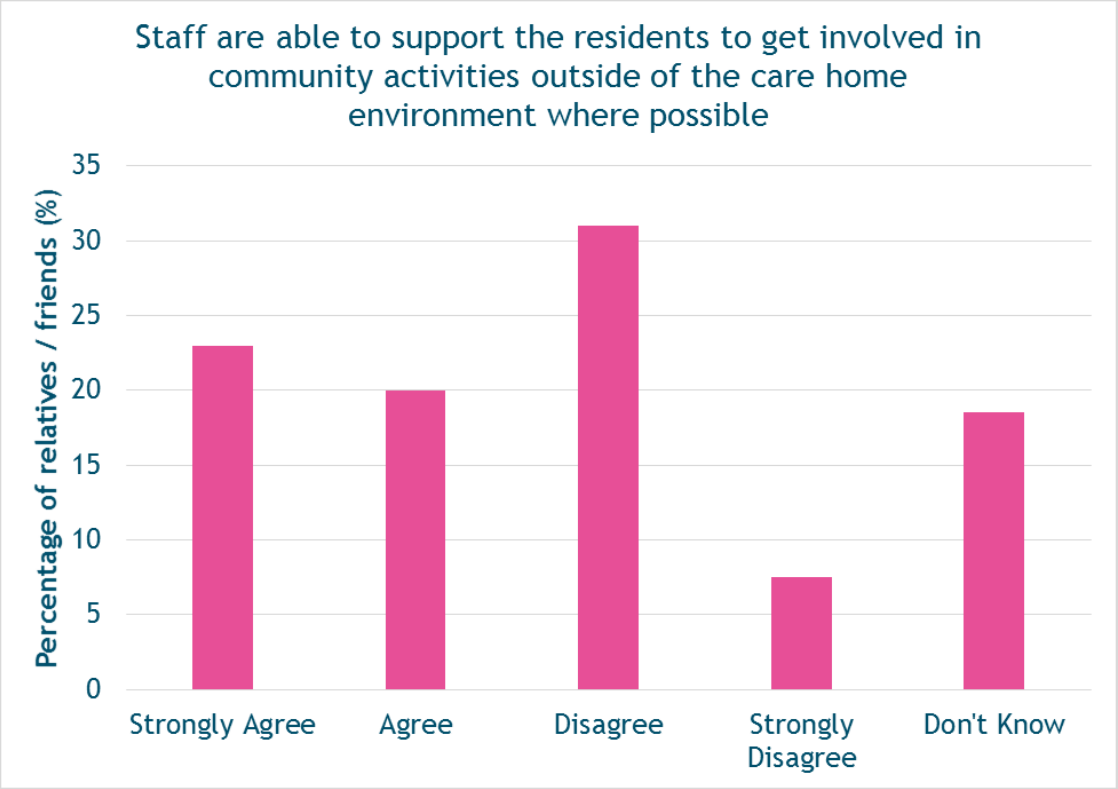
Those relatives who completed questionnaires also had similar views to staff in relation to the level of activities provided.

They were also asked two questions.

1. Do residents receive adequate daily stimulation and there is a varied programme of activities for residents to enjoy?

2. Are staff are able to support the residents to get involved in community activities outside of the care home environment where possible?





Whilst relatives themselves generally felt that the overall level of activity available within services to be adequate, they again focussed heavily upon group activity and some occasional entertainment by a visiting professional. Typical comments included:

"*some of the residents are not interested. They won't join in anything*" (relative Victoria House)

"*my partner isn't well enough or interested enough in doing activities*" (relative Roseville)

"*this opinion is formed from watching. On a personal level my husband is unaware of what is going on*" (relative Willow View)

Of 121 relatives who responded, 38 (31.5%) did not feel enough was being done to stimulate residents in the home. This figure increased to 46 (38.5%) who felt there were not enough opportunities for residents to engage in community activities. A further 19% responded that they 'did not know', indicating that their own relative was not supported to engage in activity outside of the home but that they were unaware in respect of other residents.

The "Home from Home" report by the Alzheimer's Society in 2007 stated that, "54% of carers reported that their relative did not have enough to do" and that this was particularly acute for people with severe dementia "with many carers reporting that their relative was left alone in their room for hours with no attempt from staff to engage with them".[11]

This was backed up during our visits with relatives commenting:

*"I see no evidence of activities for the residents who have dementia or mobility problems" (*relative Woodside Grange*)*

*"Mum has severe dementia and to my knowledge no one has taken her out of the home" (*relative Woodside Grange*)*

*"A few years ago a carer took mum out for a walk" (*relative The Poplars*)*

*"Although there is an events person on shift, I feel there is not enough entertainment in the care home" (*relative Willow View*)*

*"There is little stimulation. He wanders from room to room taking chocolates. There are no activities at all. Staff have never taken him out" (*relative Victoria House)

*"My husband can't join in (group activities) but it would be nice if staff could just sit for a chat or read sometimes" (*relative Allington House*)*

The design and location of some services also has an impact upon staff availability to take residents outside. Whist many services had spacious, often well cared for garden areas, access to them for more dependent residents, often located on the first floor, was problematic.

"We don't really get a chance to go to the garden - as staff would need to come off the floor to go with them. A couple of smokers do occasionally get the chance".

Figure 1 - Enclosed garden at Hadrian Park

The Alzheimer's Society report "Home from Home" published in 2007,[11] stated that access to outside areas is something carers hugely value, providing opportunities for their relative to continue to enjoy some gardening or just to take some exercise and benefit from the fresh air. Some services did have enclosed sensory gardens where residents could safely spend time tending to raised beds or just enjoy being outside. These included Allison House and Hadrian Park which had recently involved relatives and residents in the design and development of particularly good dementia friendly gardens. At Ingleby Care Home we were also informed by one resident that he loved to look after a part of the garden in memory of his late wife, and he spent time out there feeding the birds.

It was evident that some homes are working hard to put activities at the centre of their care, recognising the importance of this to residents. Some actively promoted activities by ensuring that residents received an individual copy of the activity programme. Many residents we found were unaware of what was happening as they were not able to get access to notice-boards, and at some services, such as Piper Court the activities were displayed on a sheet of A4 paper which many residents would have difficulty reading. At The Maple however we found evidence that the activity co-ordinators visited each resident daily to remind them what was taking place that day and to encourage their involvement.

Figure 2 - Activity Board at Green Lodge

Others had some more innovative ideas. These included "today let's chat" at Roseville, where at a certain time each day all staff stopped for 15 minutes to think about ideas for things they could do with residents. At Woodside Grange staff had devised a '2 o'clock stop' where all staff were supposed to stop what they were doing for 15 to 20 minutes and to spend time just engaging with residents. At The White House we saw a video of the "Summer Olympics" which had taken place in the garden. This had been added to the homes Facebook page so that family members could keep up to date with what had been taking place.

Figure 3 - Activity Board at Ingleby Care Home

The National Institute for Clinical Excellence in an article entitled 'Mental Wellbeing of Older People in Care Homes' published in December 2013[12] calls upon care homes "to provide spontaneous and planned opportunities by trained staff during the day allowing residents to engage in meaningful activities of their choice, involving family and friends if the resident wishes, helping residents to express themselves and maintain their personal identity".

The article goes on to suggest that care homes must provide a suitable budget for activity provision, those that spend the least rely upon

Figure 4 - Activity poster at Millbeck

producing crafts, cakes and events to raise funds rather than activities being specifically planned and chosen by the residents. Even homes with an activities co-ordinator can fall short when it comes to personalisation if they are not given a realistic budget to work with.

Heather Manktelow, an Occupational Therapy Specialist in Dementia and Elderly Care, writing in 2014,[13] suggests that activities are just as important as personal cleanliness, comfort and safety of residents. She goes on to add that activities don't necessarily mean a lot of extra expense …"just a change in attitude and culture within the home". It doesn't cost anything for staff to be regularly communicating with every resident. However it is "priceless" in terms of benefit to wellbeing.

V. Offer quality, choice and flexibility around food and mealtimes.

Homes should offer a good range of meal choices and adequate support to help residents who may struggle to eat and drink. The social nature of eating should be reflected in how homes organise their dining rooms, and accommodate different preferences around mealtimes.

Discussions took place with residents, relatives and staff members in relation to the quality, quantity and choice of food provided to residents. Overall the results were very positive.

We asked staff if "there is always a choice of meals available for the residents and the food is of an acceptable quality". As can be seen from the graph below, of 170 respondents, 167 (92%) agreed or strongly agreed with the question.

Some homes tended to have the main meal of the day at lunchtime, others provided this later in the day. We could not determine whether this made a significant difference to residents, although good practice would suggest that the views of residents should be sought in relation to this.

The main meal tended to consist of two courses – a main course and a dessert. A few homes provided a three course main meal. Typically meals included two choices for residents to choose from. All staff who responded said that should a resident not wish either of the choices then an alternative would be offered. Alternatives were generally something that could be easily and quickly prepared such as a jacket potato, an omelette or a sandwich.

Figure 5 - Menu Board at Woodside Grange

Although menus were displayed, these varied tremendously. Some services simply wrote the daily menu on a white board, whist others had pictorial displays,

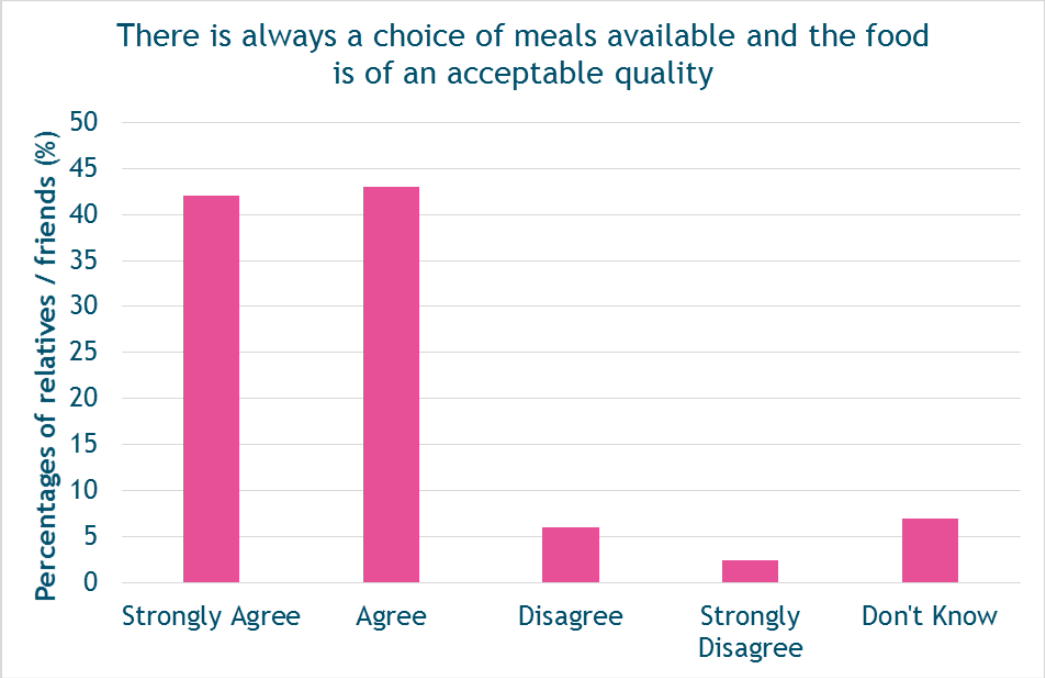
depicting a picture of the day's food choice. Some services had a menu on the table, from which residents could make their choice. For those residents living with dementia, a pictorial menu can be very beneficial to them in making an informed decision.

Some services, such as Hadrian Park, Wellburn House, Highfield and St Mark's provided "show plates" from which residents were able to actually see the meals being offered and to choose accordingly.

In other services the cook made a point of going to see residents each morning to talk to them about what was being offered that day. This was the case at 16, and a few other services.

There was evidence that particular dietary requirements were being met and the cooks were kept informed of "likes and dislikes" of residents. It was pleasing to note that for those residents requiring a soft or pureed diet that these were being well presented with several homes using moulds to make the meal look more appetizing. Specialist advice was usually being sought as required. The involvement of staff from the NHS Speech and Language Therapy (SALT) team, or from community nurses was sought for residents with particular nutritional requirements.

Relatives also spoke positively about the food provided with 103 out of 122 (84.5%) stating that food served was either good or very good. A further nine relatives stated that they did not know.



One relative at Millbeck House said *"food is smashing, a choice of different things. They know what she likes and dislikes"*, whilst another at Piper Court said that *"the food is lovely, amazing. Good choice and well presented"*

Another relative of a resident at Piper Court said *"he is 'PEG' fed – but the cook did a couple of chips and some brown sauce especially for him as a treat one day"*

At Kirkdale a relative said *"the chef comes and talks to me about my husband's likes and dislikes – he has a soft diet I give some advice on recipes"*

Residents were also generally happy with the quality and quantity of food they received.

"*Meals are gorgeous – they make lovely broth*" (resident Cherry Tree)

"It's very good, they bring us a choice to choose from" (resident Hadrian Park)

"*It's magic, usually hot and well presented*" (resident The Poplars)

At Stockton Lodge we were informed by a relative that *"with supervision she is allowed to do some of her own meals, which is very good"* thereby enabling the resident to retain her skills and decide for herself what she would like to eat.

We were told that other dietary requirements and choices were also met. Vegetarian diets were prepared for some residents as well as coeliac diets for people who were gluten intolerant.

However, there were some people we spoke to who felt that more could be done to improve the mealtime experience.

One resident spoken to said that *"there are choices but the alternative to fish and chips is fish pie or scampi – and I don't like fish".*

At Victoria House, a staff member commented that *"there is no choice for those on a soft of pureed diet"*

Figure 6 - Hydration station at Hadrian Park

All services appeared to ensure that snacks and drinks were offered to residents throughout the day. At some these were contained on the trolley that went around at certain times of the day. However many services provided "hydration stations" throughout the home from which residents could help themselves to a range of cold drinks, snacks and fresh fruit". Whist this is good practice, care should be made to ensure that all residents are offered drinks and snacks, including those who may not be able to access the hydration station.

At Park House the cook made a "cake of the week". This was a cake that was chosen on a weekly basis by residents and which changed from week to week.

Figure 7 - Cake of the Week at Park House Rest Home

Although all services had dedicated dining rooms, residents could also choose to take meals in their own room. Some said that they enjoyed the dining experience and that it gave them an opportunity to meet and chat to other residents. At Ingleby Care Home we were informed that staff took their meals with residents so that they could initiate discussions with them.

Some simply preferred being in the privacy of their own room – or were unable to access the dining room. However for some they chose to do this as they did not enjoy the dining room experience.

"*So many residents need help to be fed - it's not very nice*" (resident Piper Court)

"*I won't go in the dining room. I didn't get on with the person I was sat next to*" (resident Allington House)

"*I have meals in my room. I couldn't cope with the behaviour of some of the other residents*" (resident Allington House)

"*I prefer to take meals in my room as residents often argue/fight and I don't like it*" (resident Highfield)


Figure 9 - Dining Room at Wellburn House

Whist most dining areas were well presented, some were lacking in 'homely' features. This was particularly noticeable in the dining areas of some homes catering for residents living with dementia. At Willow View for example the dining rooms on the ground floor were smartly furnished, bright and airy. Tablecloths were provided and tables were set out in an attractive manner. On the first floor dementia care unit this was not the case. Tables were bare, with no tablecloth or nice 'touches' being provided. This was raised with the home manager who advised us that residents on this floor would just "*pull the cloths off*".


Figure 8 - Dining room at Hadrian Park

This was not the case in other services we visited, such as Hadrian Park and Wellburn House where

tablecloths were provided and place mats, cruet sets and napkins made the environment look homely.

An article by Luisa Stone published in the End of Life Journal 2014[14] states that people with dementia can have problems eating/feeding, which can put them at risk of malnutrition. At least in part, this can be minimised by the provision of more welcoming and relaxing dining room provision. She states that "a dining environment that is welcoming and comfortable has the potential to increase food intake, social interaction and stimulate the senses, which can make the eating experience more enjoyable and minimise eating/feeding difficulties."

Figure 10 - Clock at Wellburn House

Some good examples were seen such as having a large, clearly visible clock on the wall showing times for breakfast, lunch and dinner. Other services had coloured tablecloths with contrasting coloured place mats and crockery making it easier for residents to see and use them. Some services played relaxing, familiar, music in the background which could help reduce agitation.

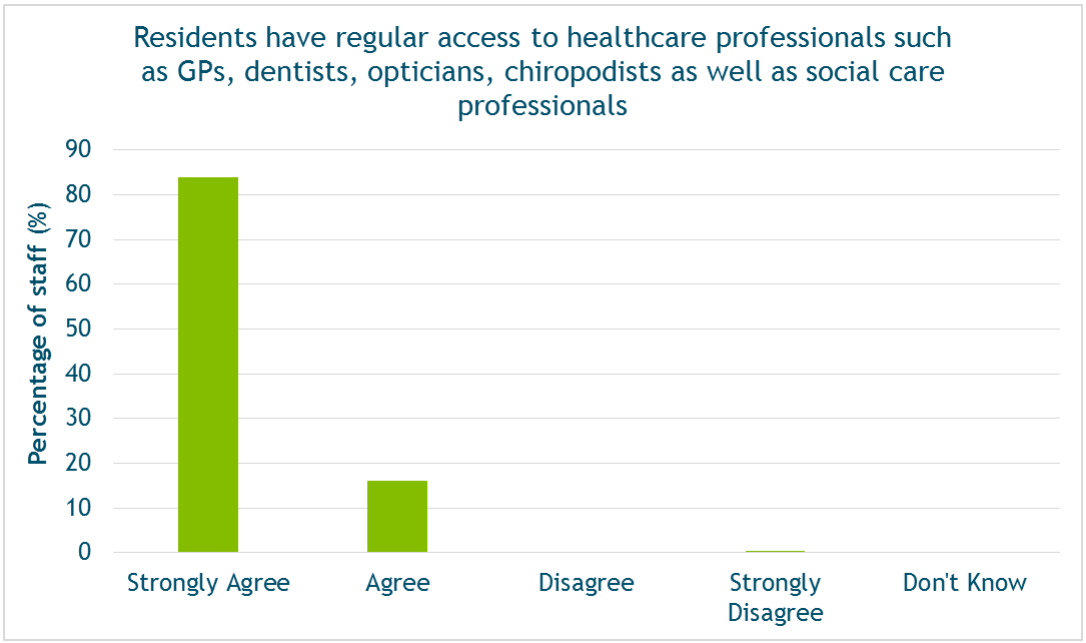
A particularly good example was seen in the Chester's Unit at Hadrian Park. The dining room was comfortable and homely. Staff were seen supporting residents appropriately and there was a general feel of calm. No one was agitated, no one appeared distressed. Staffing levels allowed for staff to attend to the needs of those who required more support which was undertaken in a calm and professional manner.

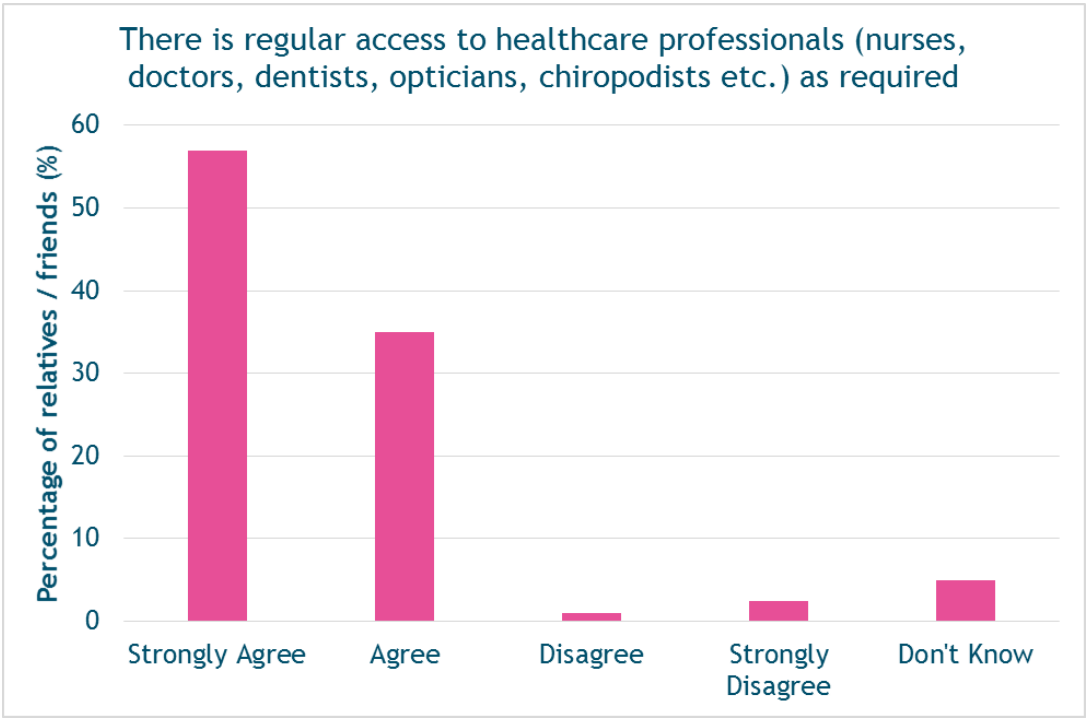
VI. Ensure residents can regularly see health care professionals such as GP's, dentists, opticians and chiropodists.

Residents should have the same expectation to be able to see a health professional as they would when living in their own home.

Services have a responsibility for meeting the health care needs of residents living in their care homes. Residents, relatives and staff all felt that this was arranged for residents in a timely manner and as required.

A Department of Health document 'Voice, Choice and Control' published in 2015[15] states that having good access to a range of visiting healthcare professionals "can make a huge contribution to keeping people active and mobile, which is better for their health and wellbeing as well as their morale and ability to retain some control over their lives".





A range of visiting professionals including GP's, community matrons, district nursing staff, chiropodists and opticians were observed during the course of our visits.

Comments received included:

"*The optician was called out and Dad got some new glasses*" (relative The White House)

"*My Father was able to see the optician today. Staff identified there was a problem and organised it. Very helpful*" (relative Woodside Grange)

"*They are in the process of getting new dentures at present*" (relative St Mark's)

"*There is a lot of liaison with the mental health teams and the multidisciplinary teams*", (staff member Roseville)

There was also evidence of other healthcare professionals being used for a variety of different reasons.

Staff confirmed that the local NHS Speech and Language Therapy Team (SALT) team are contacted in relation to residents who may have eating or swallowing difficulties.

The Tees, Esk and Wear Valleys NHS Intensive Community Liaison Service (ICLS) team are contacted for advice concerning prompt assessment and intervention to residents with acute mental health difficulties or behaviour that challenged.

At St Mark's a relative said, "*I suggested a collar for my wife. They got the physiotherapist involved and this was arranged*" whilst at Chestnut Lodge a resident said, "*I hadn't seen a physio for a long time but I have started to see one now that I am here*".

There was some discussion around the fact that GP's often will not visit care homes when they are called out. This seemed to be common practice across the Borough. Instead, the community matron, who is able to prescribe medication, would be the first person to call, only contacting the GP is it was felt necessary.

Some nurses working in the care settings were unhappy about this, believing that having had clinical training they felt they could decide if a GP was needed.

One relative of a resident at The White House also commented "*I'm not sure why the GP won't call and everything has to go through the matron service or the district nurses. District nurses are a law unto themselves and I would like more direct feedback*"

VII. Accommodate residents' personal, cultural, religious and lifestyle needs.

Care homes should be set up to meet residents' cultural, religious and lifestyle needs as well as their care needs, and shouldn't make people feel uncomfortable if they are different or do things differently to other residents.

Many people we spoke to focused primarily upon whether the service was meeting the religious needs of residents and demonstrated a lack of awareness with regard to other aspects of this question.

Staff members were asked "can you give an example of how the home caters for the different religious, cultural and lifestyle needs"?

It was evident that the majority of care homes arranged either occasional church services in the care home or arranged for visiting clergy to see residents individually. Only in rare instances were residents supported to go out of the home to church, and then it was usually arranged by family or friends.

One resident at Cherry Tree said "*I was a nun for 15 years - I would go to church if I could get a lift - I asked staff but nothing has happened yet*.

The number of residents from ethnic minority groups residing in care homes across the Borough is very low. Indeed we were only made aware of about 10 such residents during the course of our visits. Staff commented that as far as possible they would try to respect their different cultural needs should any residents require it. Where residents from an ethnic minority were residing staff said:

"*We are mindful of respecting times for prayer"* (staff member at Woodside Grange)

"We have two residents who are Muslims and we prepare halal food for them and respect their prayer times" (staff member Teesdale Lodge)

It was interesting to note that in one care home, although there were no residents from ethnic minority groups, this was not the case with regard to staff members. It was reported that although meals were provided for staff, the home did not provide food in accordance with their religious beliefs.

The needs of other religious groups were acknowledged. At Ingleby Care Home we were told of a resident, a Jehovah's Witness, who did not receive an egg at Easter but who received a chocolate bar instead.

Most services tried to meet specific requests made by residents and relatives.

"I don't like tea or coffee so they bring me cups of hot water, which I like" said one resident at Cherry Tree.

At Piper Court, as well as some other services, married couples were being accommodated and were provided with two rooms, one used as a bedroom and the other as a sitting room for the couple.

Another resident at Piper Court said "*I like a glass of wine on a night and staff let me have this. I have a mini fridge in my room"*

At Mandale House relatives of a resident asked if they could bring in a budgerigar for their family member and this was arranged.

Some residents said they enjoyed being able to help out around the home, giving them a sense of achievement as well as the satisfaction of doing something useful. *"Staff let me help out cleaning up the dining room after breakfast. I like helping"* (resident Woodside Grange). This should be welcomed and encouraged.

It was noticeable that no staff member (or relative) raised any concern about the needs of residents who may be members of the LGBT community.

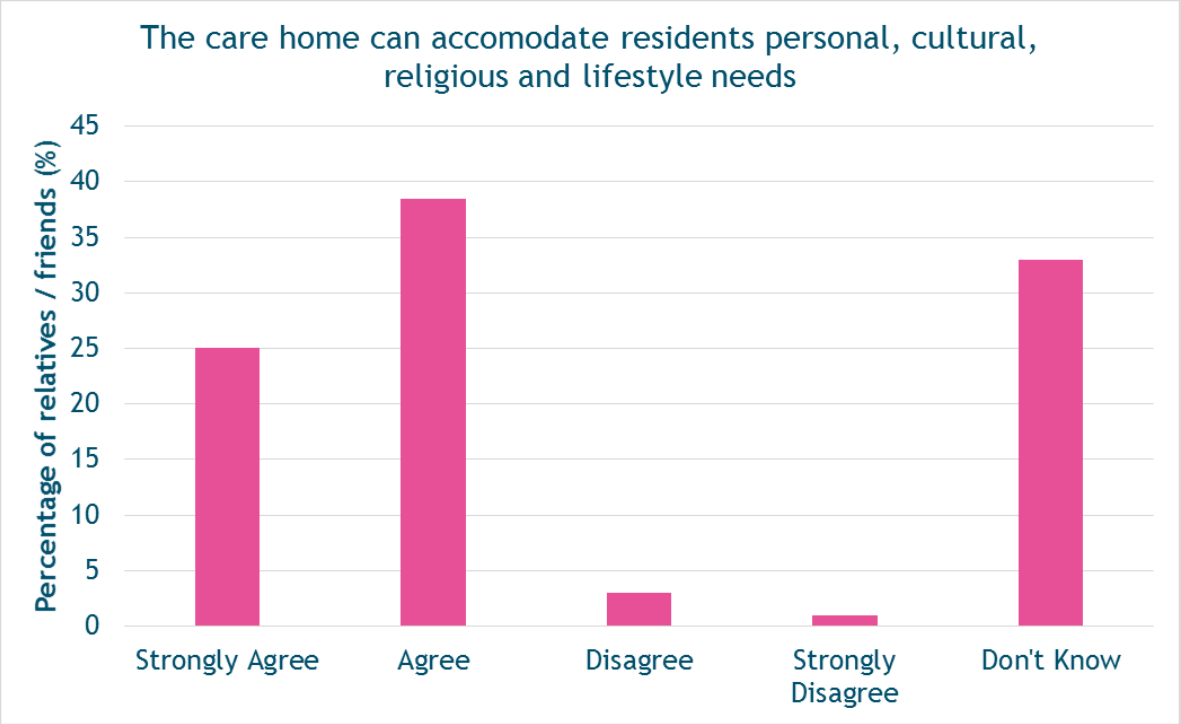
Homosexuality was decriminalised in 1967 and many of those who have lived their whole adult lives since then are now reaching their later years. Following research, Age UK have produced a resource pack entitled 'Safe to be Me'[16] which states that "whether you know it or not, there will be LGBT people using your service either now or in the future. Because you cannot immediately see someone as lesbian, gay, bisexual or trans, many older LGBT people remain 'invisible' as far as statistics are concerned. But this doesn't mean they don't exist". More locally, an article published in the Evening Gazette in July 2018[17] highlighted research by Stockton based LGBT charity, Hart Gables. The report concluded that LGBT people living in care homes have become a "forgotten community" and that many staff "think non-binary identity is a modern fad, being gay is a lifestyle choice and homophobia could not exist within their care home".

As part of the care planning process, staff need to ensure they gather as much information as possible about the likes, preferences, needs, and wishes of all residents in order to ensure that care, personalised to the needs of every resident, can be achieved.

Relatives were asked whether the care home could accommodate residents' personal, cultural, religious and lifestyle needs.

Many who responded agreed that the home could meet these needs. However, these comments tended to be in relation to their own relative, and many focused purely on meeting their religious needs.

A significant number of people told us that they 'did not know' which is perhaps not surprising given their lack of awareness of the specific needs of other residents in the home.



VIII. Be an open environment where feedback is actively sought and used.

There should be mechanisms in place for residents' and relatives to influence what happens in the home, such as a Residents and Relatives Committee. The process for making comments or complaints should be clear and feedback should be welcomed and acted upon.

Staff members were asked whether residents and their family members, had opportunities to have a say in how the care home was run.

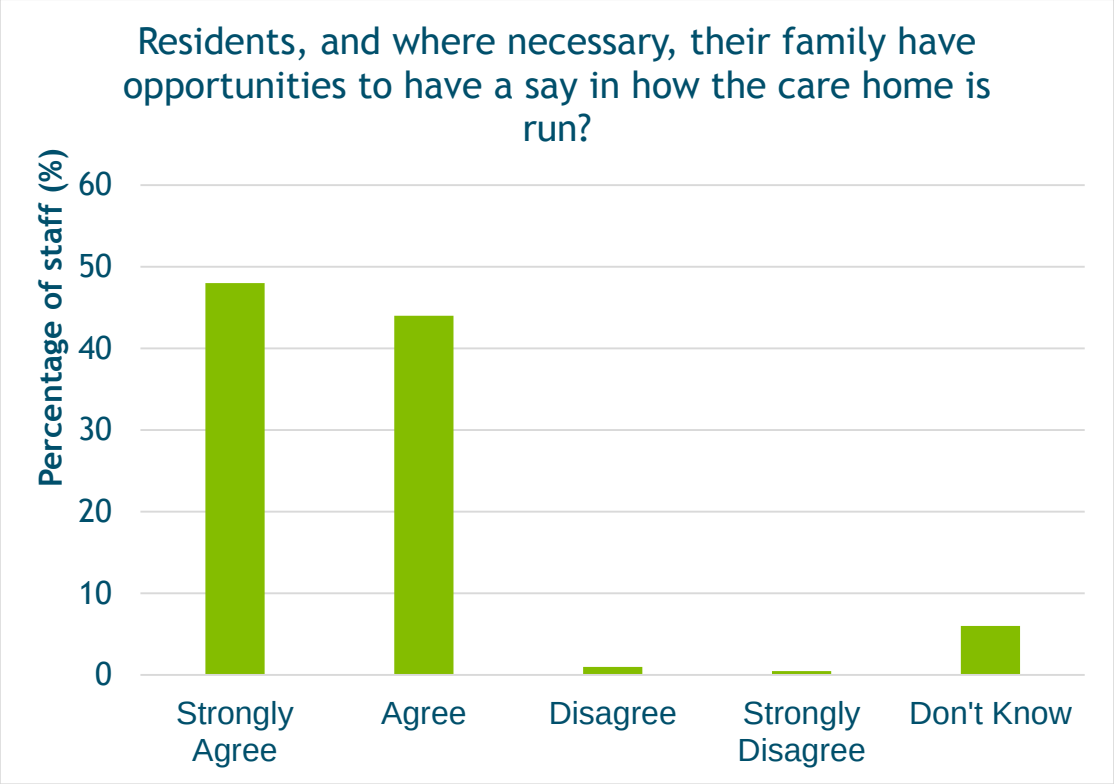
Generally, staff at the care homes visited confirmed that the views of residents and relatives were taken into account.

Most services held resident and relative meetings although their value could not always be determined. Some staff indicated that meetings were often poorly attended. Some care homes had recorded minutes of such meetings and there was evidence of "You Said – We Did" posters on notice boards.

Other methods for seeking peoples' views included having suggestion boxes and carrying out their own surveys. We were shown examples of both food and activity surveys that had been undertaken at Stockton Lodge and 'Voice of the Customer' surveys at Hadrian Park.

Some manager's held "surgeries" where relatives could book an appointment to talk to them, but we were told that in addition to this many managers also had an

'open door' policy and would always try to make themselves available to discuss the care of a resident.



Staff were also asked if they could give any specific examples of how a resident or family member had influenced how the home was run. Most staff spoken to had difficulty in providing such examples.

However, some good examples were given. These included:

"At a recent resident meeting one resident stated how she would like to have a bath every morning at 7am. An extra member of staff was placed on duty at this time to accommodate this request" (staff member The White House)

"*The tea room is new - families asked us to provide this*" (staff member Teesdale Lodge)

"*We developed a garden room and discussed this with residents and relatives*" (staff member The Beeches)

"*Relatives and residents helped with the painting and planting out of the new garden area*" (staff member Hadrian Park)

At Allison House relatives had been closely involved in the redecoration of the home, gathering ideas for wall murals and helping to make the home more dementia friendly. They were also actively involved in running a weekly coffee morning"

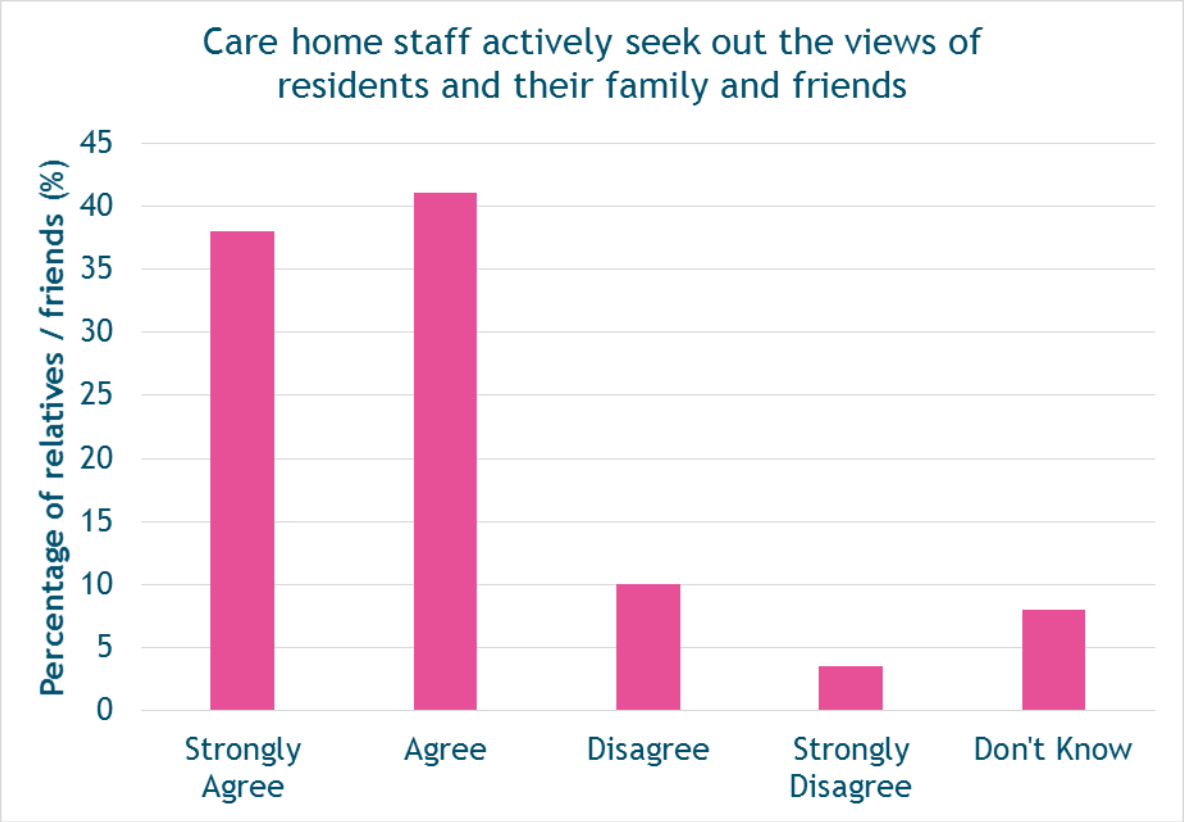
One member of staff here said "*families are very important and we get them involved in plans of care and ideas for engaging with residents*"

At Hadrian Park a "decision tree" was positioned by the main door, where residents and relatives could post their views on various aspects of life in the home. At the time of the visit the question being asked was in relation to the type of entertainment that should be arranged for Christmas.

"*We have meetings, the home will try to accommodate people's wishes. All rooms are personalised -it is their home at the end of the day*" (staff member Green Lodge)

Relatives were asked whether care home staff actively sought out their views.

Again, the majority of those who responded felt that this was the case although there were some people who disagreed, feeling that they did not have a great deal of input.



More positive feedback included:

"*Instant action from the floor manager when requested and I received a phone call to say it had been done. Impressive.*" said a relative of a resident at The Maple.

"*I have been to resident/relative meetings and anything could be discussed. Anything that would make lives more fulfilling*" (relative at Allison House)

At Piper Court one relative said that "*we work together to look after my husband. If you ask them to do something they will do it almost immediately*"

"*They normally do it on a 1-1 to talk to us about Dad's care*" (relative Teesdale Lodge)

"The manager is always asking relatives for views/opinions" (relative Roseworth Lodge)

"We came in and asked for the room to be decorated – it was done within a week" (relative Roseworth Lodge)

"We have had a few surveys" (relative Woodside Grange)

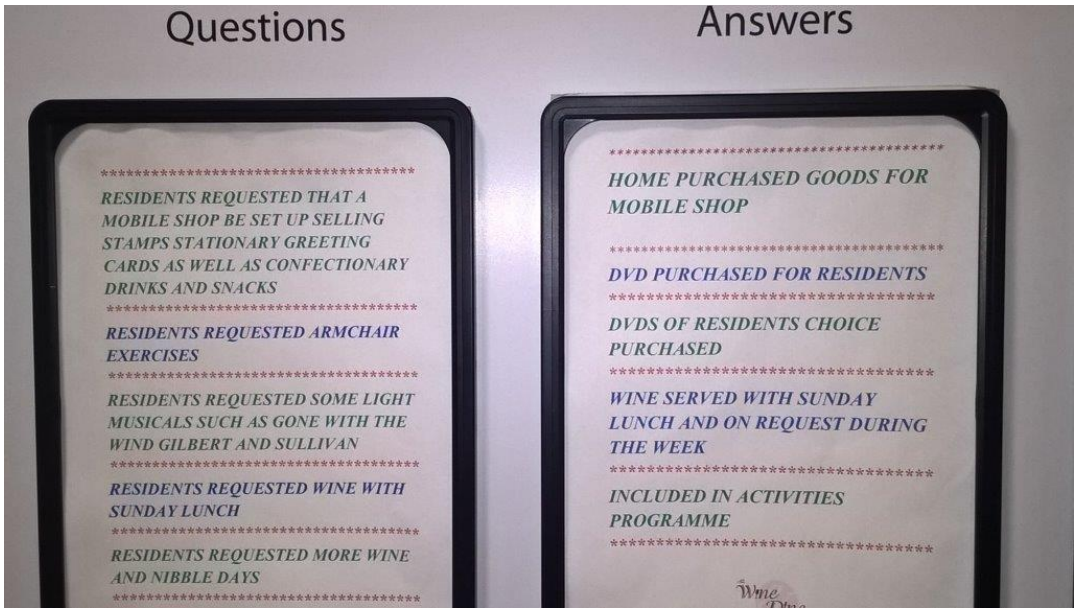


Figure 11 - You Said We Did at Highfield Care Home

However other feedback was much less positive:

"*Seek out views – not at all*" (relative Wellburn House)

"*The last three meetings did not go ahead despite us turning up on each occasion*" (relative Woodside Grange).

"*They do sometimes ask but not all the time*" (relative Victoria House).

"*We have experienced poor toileting and personal hygiene routines despite bringing it to the attention of nurses on duty on many occasions* (relative Woodside Grange).

Residents themselves often lacked capacity to respond to questions about how much they were involved in discussions about their care or the service in general. Others said that their relatives saw to these things. Responses from those who did comment were mixed.

"*They know what we like and we can say. If we need help they are here for us*" (resident Park House)

"*Staff ask but don't appear to listen*" (resident Willow View)

"*No they don't ask us*" (resident The Beeches)

One staff member at St Mark's said that "*I would like to involve residents more, and some just need to be given more time*"

Whilst many staff did feel that they could make suggestions and that their input was valued and respected, this was not universally the case. In some services staff told us that they could raise matters but that they were not always listened to, or that they were not encouraged to voice their opinions. In a small number of homes, newly recruited members of staff told us that "*it is not our place*" to have a say in how the home was being run.

Other observations

During the course of our research, we also took opportunities to consider other issues relating to the care homes we visited.

These included:

1. The use, where required, of dementia friendly features.
2. Whether the home was kept clean and tidy and hygiene issues were properly addressed.
3. An understanding of procedures to be followed should a resident or relative wish to make a complaint.

1. Use of dementia friendly features.

Figures produced by the Alzheimer's Society in their 2007 report, 'Home From Home'[11] suggested that 700,000 people in the UK have dementia. Over a third of people living with dementia (240,000) live in care homes. From this it was concluded that two thirds of care home residents in the UK have dementia. Ten years have now passed since this report was published.

The report in 2007 states that the total number of people with dementia in the UK is forecast to increase to over one million by 2025 and over two million by 2050 if age-specific prevalence remains stable.

A more recent report, published by the Alzheimer's Society in 2013[18] estimates that more than 320,000 of the 400,000 people living in care homes in England,

Wales and Northern Ireland now have dementia or severe memory problems. It stated that the figure was more than 30% higher than previous estimates because of the rise in the ageing population and improvements in data collection.

We are aware that it is now Government policy to maintain people in their own home as long as possible providing they are safe and their needs can be appropriately met. Given this, it is evident that the needs of those entering the care home sector are increasing. In particular, those residents living with dementia in care homes are now requiring more specialised care in an environment suited to their particular needs.

Against this background we looked to see whether care homes were incorporating more dementia friendly features to aid and assist the increasing numbers of residents living with dementia who are being admitted.

The Dementia Services Development Centre at Stirling University has developed best practice guides,[19] including those for care homes, suggesting that "getting the design right can make a fundamental difference to the lives of people with dementia". They further state that "it can improve the life experiences and increase the life expectancy of those affected by dementia".

We saw some excellent examples of good practice in this respect. At Allison House, a full internal redecoration has taken place incorporating a host of dementia friendly features as can be seen in the photographs below. Many of these ideas were the result of discussion with relatives who were involved in the decoration programme.

Figure 12 - Internal Redecoration at Allison House

Figure 13 - Internal Redecoration at Allison House

Similarly, the Chester's Unit at Hadrian Park has been upgraded to make it a very welcoming dementia friendly environment, with a sensory room and secure enclosed garden area, again with many dementia friendly features. The home has a resident dog, something that many residents, especially those with dementia, found beneficial, helping to reduce anxiety, depression and agitation. A number of other services have also introduced 'pet therapy' sessions which have included bringing a pony and even sheep into the home.

Figure 14 - Coloured room doors at Woodside Grange

Several other homes have also taken steps to incorporate more dementia friendly facilities where possible. However, in some services, even those with units catering specifically for residents living with dementia, there was little evidence of this. Some corridors had a lack of landmarks, inadequate lighting and doors which all looked the same. Signage was limited which can make it difficult for residents to find their way around causing them anxiety and distress.

2. Was the home kept clean and tidy

It was evident that efforts were being made in every home we visited to maintain a good standard of cleanliness.

Out of 120 relatives who commented, 116 (96.6%) agreed, or strongly agreed, that the home was kept clean and tidy.

Comments received included:

"It's spotless, and always smells lovely" (relative Piper Court)

It is also evident that domestic staff support the smooth running of the homes in other ways.

A relative of a resident at Woodside Grange told us "*the cleaners are kind, caring and take a pride in their jobs. They interact with the residents and help us out in difficult situations*"

Whilst it is difficult to eradicate unpleasant smells easily, only a handful of homes visited were found to be malodorous in certain areas. Steps were being taken to deal with these issues.

In some homes, including Park House, we saw good examples of infection control, with supplies of aprons, gloves, wipes, etc. easily accessible at various points around the home. At some other services these were less in evidence although may still be provided.

3. A clear and understandable complaints procedure.

One of the requirements of the Care Home Regulations is that each service must have a clear and understandable complaints procedure and that this must be made available to all residents.

Many staff said they were aware of a procedure, but could not recall what it said. In most instances staff said that if they received any complaints they would be directed either to the care home manager or to the senior member of staff on duty.

Relatives too were unsure about this. Some said they were not aware, whilst others said they may have received something about it when their family member was first admitted to the home.

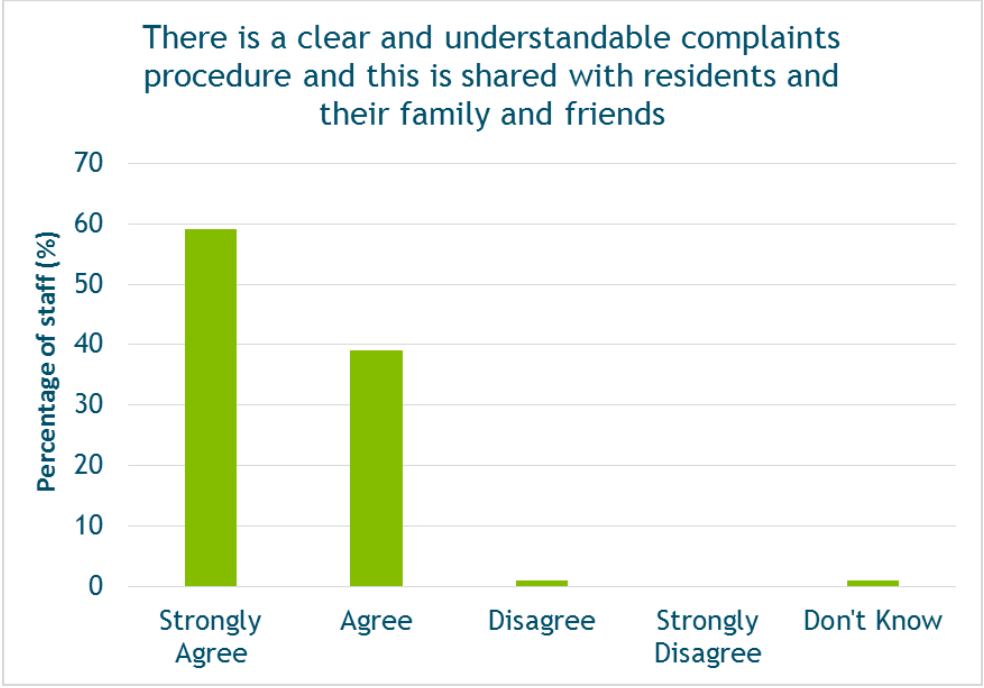
The majority however said that if they had any issue they would raise this with either the manager or the senior on duty.

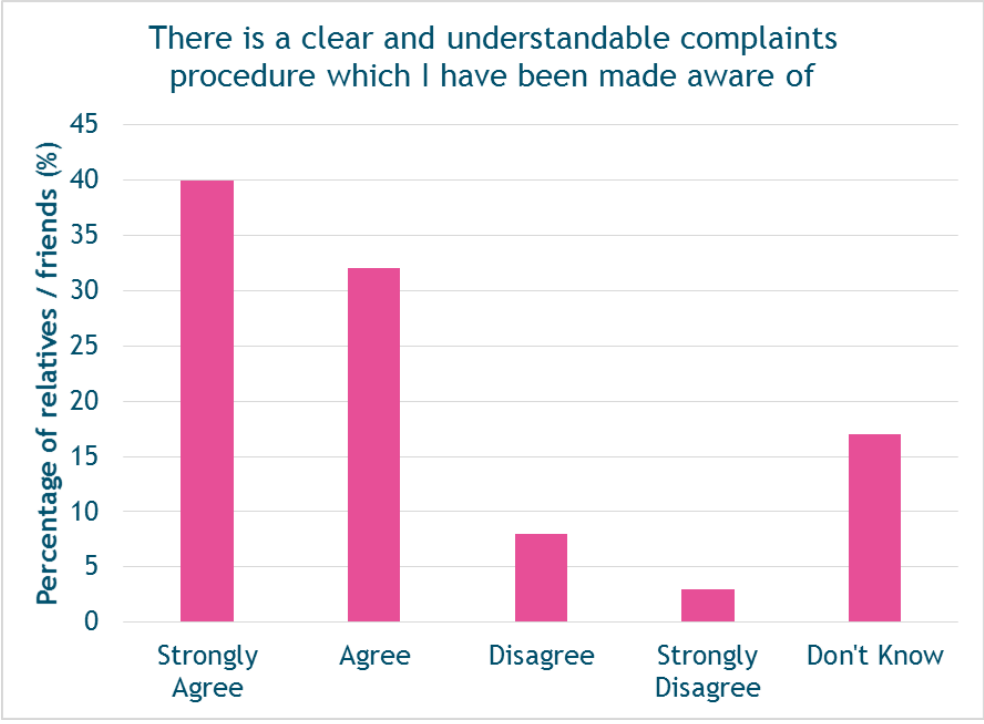
One relative at The White House said, *"the care home has an attitude of come to us if there are any problems and we will try to sort it out"*

A relative of a resident at Roseworth Lodge told us "*there was a safeguarding incident involving another resident. The home dealt with this appropriately. I have used the complaints procedure twice and it has been followed both times"*

One relative however was quite unhappy at the way his complaint had been handled. Although the procedure had been followed he said that "*a company*

investigating themselves is like turkeys voting for Christmas" (relative Wellburn House)





Most residents told us that they would know what to do in the event that they felt they needed to raise a complaint; however, not all of these were aware of there being a specific procedure in place. Some said they were probably given a copy when they were admitted but could not remember much about it. Most of those

we spoke to said they would just raise any issue with the staff and it would be dealt with.

Comments included:

"I would talk to the management of the home through the senior staff on this unit" (resident Woodside Grange)

"*I would find someone to speak to*" (resident Highfield)

*"I would just go and tell them" (*resident Allington House)

A few residents, however, were less sure and perhaps showed a reluctance to make a complaint.

"I would be very reluctant to make a complaint but I will talk about any problems" (resident The Maple)

"I would keep it to myself - but I don't have anything to complain about" (resident Roseville)

We did observe information about the complaints procedure prominently on display in many services. We also saw copies included in brochures and other information handed to new residents and their families

4. CONCLUSION

Generally, across the care homes we visited there were high levels of satisfaction expressed by both residents themselves and by their relatives and friends with regard to the standards of care being provided.

Overall the quality, quantity and choice of meals available was said to be of a good standard. Residents and relatives were happy at the speed at which staff sought to arrange the services of medical professionals as and when the need arose.

Managers and senior staff were said to be approachable and were on hand to discuss any issues that might arise and relatives in particular felt that they were kept up to date with the care of their loved one and that their opinions were taken into account.

We spoke to many residents, and their family members and friends, who often spoke very positively about the staff working within their particular service. Staff were said to be kind, caring, compassionate, friendly, supportive and approachable. However many of those spoken to also said that staff were extremely busy, rushed, and didn't always have the time they needed in order to be able to meet all the care needs of their residents.

Residents were asked, "would you like to change anything about the home"? and out of 108 who responded 19, (18.5%), said that there were things they would like to change.

These included:

- Meal times being too close together
- Sunday lunch at night not lunchtime
- The food in general x3 people
- More entertainment x2
- More activities x2 people
- More trips x2 people
- To be able to get out a bit more
- More carers x3 people
- Lift not being big enough for a stretcher, and it broke down
- Noisy at night – even the staff slam the doors
- Staff attitude

A lack of time was something we heard from staff members themselves on many occasions. The vast majority of those spoken to "loved their job" and gained pleasure and high levels of job satisfaction from being able to support the

residents in their care. However, their ability to do this was, on occasions, being compromised.

This manifested itself in so many ways. Several staff we spoke to felt they did not have enough time to really engage in activities with residents (and a few didn't see it as their responsibility to do so), let alone have the time to be able to support them on activities outside of the home. At some services getting the time for a chat over a cup of tea was something that could only be done once all other tasks, including the completion of paperwork, had been completed.

Although all staff were encouraged to read care plans, and to keep up to date with any changes in residents' needs, getting the time to do this was becoming increasingly difficult, with at least one member of staff admitting, *"we don't have the time to do it"*.

As a result of this, three of the key quality indicators were in danger of being severely compromised.

- Staff with **time** and skills to do their job
- Staff having a good knowledge of individual residents and how their needs may be changing
- Offering a varied programme of activities

In many services we visited, staffing levels were often only at the minimum required levels to meet the residents' assessed needs. This allows for no spare capacity in the system to cover for staff absence, staff taking residents to hospital and especially the changing demands placed upon them each day. Statistics show increasing numbers of residents living with dementia being admitted to care homes, alongside an increase in dependency levels. We were told that staff have to face different challenges on an almost daily basis, some of which could not always be predicted. Those residents with physical needs are also becoming more dependent, many requiring two members of staff at a time to support them with their personal care needs, thereby reducing the number of staff available to meet the needs of the other residents.

It is acknowledged that care home fees being paid by Local Authorities across the country have not kept pace with the introduction of the minimum wage, and other demands placed upon care home providers. In 2017, the Competition and Markets Authority published its final report following its market study into care homes for older people.[20] This shows that the average fees paid by Local Authorities are below the full costs required to meet the care needs of residents. The report states that "many care homes, particularly those that are most reliant on LA-funded residents, are not currently in a sustainable position. Our analysis shows that while many can cover their day-to-day operating costs, they are not able to cover any additional investment costs." It further states that while they may be able to 'get by' in the short term, they will be unable to maintain and improve their facilities, and "in the long term will find themselves having to close, or move away from the LA-funded segment of the market".

This is a national problem, outside the scope of this report, but there is no doubt this has a huge bearing upon the ability of providers to maintain staffing levels much above minimum legal requirements.

Additionally, we saw that many services are seeking to register increasing numbers of beds for residents living with dementia. Previously many such residents would be integrated into the general residential areas and could benefit from being amongst people who were not affected by the disease. Now however these residents are living with much more advanced forms of dementia. Studies put the number of residents living with dementia in a care home at between 70% and 80% of the total population. In some services we visited this was seen to be having a detrimental effect on the other 20% to 30% of residents. Some said they no longer wanted to take meals in the dining room, some said they could not sleep at night due to "*screaming and shouting*". Some said that they did not like it when they saw or heard other residents fighting or arguing.

Similarly, the environment in many homes does not meet the needs of many residents. Newer homes are able to incorporate a more dementia friendly environment, and we saw many good examples of this. For other services however this is not always possible and even access to garden areas is limited by staff availability to accompany residents living with dementia.

In an article written by Emma Forde and published on the BBC News web page in 2017[21] highlighted high numbers of assaults between care home residents. The article states that "police recorded 1,200 assaults between residents living at care homes between 2014 and 2016". It is the responsibility of those in charge of running services to ensure all residents are kept safe and are protected from harm, but clearly this does not always happen. In the same article, Professor Martin Green, Chief Executive of Care England is quoted as saying, "as we see more people with different types of dementias and exhibiting more challenging behaviours, we have to have a system that's ready to respond to that".

Locally, the Teeswide Safeguarding Adults Board - End of Year report for 2017/18[22] shows a year on year increase in the number of safeguarding referrals being received with 46% of reported abuse taking place in care homes. This goes against the national trend where the most frequent risk is in the person's own home. Minimum staffing levels, alongside, in some cases, a less favourable environment, puts great strain on staff being able to ensure all residents' safety.

Our research showed that many services are doing their best to provide a person-centred approach to the care of their residents. Relatives, and those residents able to give an informed view generally commented that they were kept involved and had the opportunity to raise issues with managers and senior staff. However, once again, this was often hampered by the pressures of time. Some staff told us that residents often needed time to be able to do things and join in things and

sometimes the ‘time and task’ approach of staff members did not allow for this to happen.

It should also be pointed out, that we did see many good examples of care being provided, many of which have been highlighted in this report. Often this was down to the hard work and dedication of the work force who were clearly trying to do their best but who were all too often let down a lack of resources and perceived bureaucracy.

5. RECOMMENDATIONS

This is a list of the **key** recommendations coming out of this piece of work. They are generic in nature and do not apply to every service that we visited. However they should be taken into consideration by all service providers.

1. Care homes should ensure activities are provided for residents 7 days a week. These activities should be personalised to meet the needs of all residents. Care homes should have adequate resources and staff/activities co-ordinators should be trained appropriately.

2. All **care staff** should understand the importance of engaging with residents. Care staff should look at opportunities to incorporate this into their day to day work e.g. read a newspaper/book with a resident.

3. All **care home staff** should make time to chat with residents on a daily basis.

4. All services should provide – or have regular access to – accessible transport for the benefit of residents in order that they are able to enjoy a greater range of activities within their local community.

5. All staff should receive Equality and Diversity training to ensure they take fully into account residents cultural, religious and lifestyle needs.

6. All care homes should ensure that greater priority is given to the implementation of resident and relative meetings and that residents and relatives are encouraged and, where necessary, supported to attend.

7. Care homes should ensure that all areas of the service accommodating residents living with dementia make the best possible use of dementia friendly features, and are maintained and decorated to the same standard as other areas of the home.

8. Care homes should ensure that all residents are well supported to enjoy their dining room experience. If necessary staggered mealtimes could be given some consideration, as well as greater use of adapted cutlery, plate guards etc.

9. With increasing numbers of beds being registered for people living with dementia, care homes should recognise the impact this may have on other residents in the home. Support and safeguards should be in place to ensure the well-being and safety of all residents.

10. Staff should be encouraged to take up training opportunities and should not be expected to do this in their own time.

11. Care home Managers should be fully supported by the provider and should have the necessary resources to carry out their role.

12. Care homes should explore the use of technology to help reduce high levels of paperwork and improve service delivery.

13. Wi-Fi throughout the home would bring benefits for residents in terms of being able to remain in contact with the world outside of their immediate environment.

14. Although all homes had a formal procedure for dealing with complaints, further efforts should be made to ensure that everyone, including residents, relatives and staff are aware of this.

Additionally there are recommendations coming out of this work for regulators and commissioners of care services.

1. Regulators and commissioners of services should work more collaboratively with care providers in order to determine what they require in terms of information as part of a more joined up process of assessing care. This would help to minimise duplication of information in different formats for different audiences and free up staff time.

Some short term recommendations in this respect were highlighted in the Joseph Rowntree Report of 2014 is excessive paperwork in care homes undermining care for older people.

These included:

a) An agreement between regulator (CQC) and safeguarding boards on the acceptance of one form for incident reporting.
b) An alignment between CQC, the NHS and local commissioners about which areas are currently inspected and the paperwork generated by care homes against these areas.
c) Closer working between regulators, commissioners and care providers to identify some “quick wins” at local levels to reduce unnecessary paperwork.

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8. Sylvie Silver – reproduced in an article published on www.carehome.co.uk in 2013
9. University of Exeter Medical School and Kings College London in partnership with the Social Care Institute for Excellence (SCIE) and presented to AAIC in 2018
10. Professor Martin Green –reproduced in an article on www.carehome.co.uk 2013
11. Alzheimer's Society – 'Home From Home' (2007)
12. National Institute for Clinical Excellence (NICE) – Mental wellbeing of older people in care homes. 2013
13. Helen Mantkelow 'Activities In Care Homes Don't Need To Be Costly –But are Priceless.
14. Louisa Stone – Eating/Feeding Issues in dementia – Improving the Dining Experience' published in the End of Life Journal Vol 4 No 1 2014
15. Department of Health – 'Voice, Choice and Control' 2015
16. Alzheimer's Society – 'Safe to be Me' resource pack
17. James Cain – Evening Gazette "Profoundly upsetting" report reveals elderly LGBT people in care homes are a "forgotten community" July 2018
18. Alzheimer's Society – 'Home From Home' 2007
19. Alzheimer's Society – Low Expectations –Attitudes on choice, care and community for people with dementia in care homes' Feb 2013
20. Dementia Service Development Centre – Stirling University. Article by Sue Learner and reproduced in an article on the website www.carehome.co.uk 2015
21. Emma Forde – BBC News 'Assaults between care home residents reported daily' 2017
22. Teeswide Safeguarding Adults Board – End of Year 2017/18 Performance Report.

RESPONSES RECEIVED IN RELATION T0 RECOMMENDATIONS MADE IN THIS REPORT

The following responses were received.

Service	Response
Victoria House	I have taken some time to read through the final report that has been produced and feel that since Healthwatch visited the home last year there has been considerable change to the home. The points that were mentioned in the report about the home from the inspectors, staff or relatives would no longer been applicable to where the home is today. I wanted to take this opportunity to inform you of the changes that the home has worked hard to achieve over the past few months. 1. At the time the visit took place the home was going through a change in management and had a newly appointed manager, she is a very experienced and competent manager .This has allowed the home to make many improvements to the satisfaction of the Stockton & Tees and the Care Quality Commission. 2. The new manager has enabled staff to further develop in their roles and as a result improved their performance and the quality of both care and interactions with all stakeholders, including families. 3. All newly appointed staff undertake an induction into the home this includes all of their mandatory training. We have an onsite trainer who delivers manual handling training to all staff as soon as they start. This trainer also spends time observing staff to ensure they are competent in this area. All staff who work in Victoria House undertake Open hearts and Minds training this covers supporting people living with dementia. 4. We have improved communication with relatives we have an open door policy for relatives to come and see us and talk about any issues or concerns they may have. We also invite them to be part of the process

	when we are updating care plans and take their views on board so that they feel involved in the process. 5. We have introduced monthly resident and relative meetings and also staff meetings this allows us to have open honest transparent communication between all parties. These meeting allows us to keep people up to date of any changes that may be taking place in the home. 6. At a company level there is increased oversight of key clinical information, such as weight loss, wounds and falls. This data is entered monthly by the home manager and a report is produced which highlights any issues in the home and also individual residents who may be at risk and need an increased level of support or intervention. The Area Quality Director role is a newly created post and part of their role is to monitor clinical risk and check that appropriate actions have been taken. If this is not the case then they will prompt the home to make necessary referrals and any relevant changes to care. 7. We have recruited a new catering manager and increased the staffing in our kitchen. All staff working in the kitchen have spent time with the hospitality team to develop their skills. They have also had additional training in different choices of pureed meals. The chef spends time with the SALT team when they come into the home to ensure they are kept up to date with any changes to the resident's diets. 8. We have recruited two new well-being officers who provide stimulating activities throughout the home over 7 days. They are have regular trips out of the home to local areas of interest. 9. We have improved the environment of the units supporting people living with dementia. HC-One have developed a harmony project to support people living with dementia and Victoria House has been a pilot home to introduce life stations. At Victoria house we

	have garden, music, around the home and Middleborough football life station. We have also introduced a virtual wall to involve residents in a game of domino. We are also working closing with Stockton's dementia service development manager to introduce HenPower into the home and look at the opportunities of our residents being part of the allotment scheme. Over the coming months we will continue to develop this area to ensure the home offers suitable stimulating activities that our residents enjoy to participate in.
Teesdale Lodge	Teesdale Lodge welcomed the opportunity to take part in Healthwatch and has accepted the findings of the report. Our manager has recently relocated from the upstairs administration office, to the downstairs reception office, giving increased access and visibility to staff, visitors and residents. Staff have been reminded that if they have any concerns then they are encouraged to approach the manager to resolve them. Our manager is also attending a Stockton Borough Council leadership course which will enhance their interpersonal skills. Already this course has confirmed our managers belief that person centred activities are imperative in the improvement of the wellbeing of our residents. As identified in the Healthcare report. We have now recruited a new Activities Organiser who is innovative and refreshing current ideas such as 'Resident of the day' and is actively encouraging members of all departments in the home to become involved and have shared ownership in the implementation of the activities. The Activities organiser is discussing with residents and care staff how best to develop an activities plan to cover the whole of the week. The activities programme has 'out and about' time listed which is implemented by the Activities Organiser and a member of the care staff that are on shift. Also the home is continuing to work with the local College and Nursery to involve residents with the local community. In addition the home has developed 'Teesdale Team – What are we doing well' feedback form which have been distributed throughout the home in each residents room to seek views of the resident,

	relatives, and visitors to run alongside 'Comments, Compliments or suggestions' forms. Also an Employee of the Month scheme has been initiated voted for by residents, relatives, visitors and staff. The Manager discusses the feedback individually with staff at the end of the month to promote their good practice. There is a post box in the foyer at the entrance of the home for the feedback forms so they are visible and accessible. Teesdale Lodge welcomes opportunities to use and develop good practice for the benefit of the residents in our care. We believe that the Healthwatch visit has provided stimulus towards these changes.
Willow Lodge	Thank you for your email, We think that report is factual and concise
Roseville Care Centre	I can confirm I have read the report , feel our homes did really well
Hartlepool and Stockton CCG	Thank you for sharing the Healthwatch report in relation to the Care Home Enter & View work undertaken. The report provides a helpful insight into the quality of life of older people living in long term residential and nursing care homes across Stockton-on-Tees. The CCG is committed to working with care home providers and residents to continually improve the way in which healthcare and support is delivered for residents and their carers. We note your recommendations for improvements in the services and will discuss these colleagues and partner agencies. I will also bring to the attention of the CCG Governing Body.

APPENDIX 1

Services where Enter and View was carried out;

Allington House Marsh House Avenue Billingham	**Park House** 2 Richmond Road Stockton
Allison House Fudan Way Thornaby	**Piper Court** Sycamore Way Stockton
The Beeches Green Lane Stockton	**The Poplars** 375 Thornaby Road Thornaby
Cherry Tree Care Centre + South Road Norton	**Roseworth Lodge** Redhill Road Stockton
Chestnut Lodge 302 Norton Road Stockton	**Roseville Care Centre** Blair Avenue Ingleby Barwick
Green Lodge The Green Billingham	**St Marks Care Home** 1 Hartburn Lane Stockton
Hadrian Park Marsh House Avenue Billingham	**Stockton Lodge** Harrowgate Lane Stockton
Highfield The Meadowings Yarm	**Teesdale Lodge** Radcliffe Crescent Thornaby
Ingleby Care Home Lamb Lane Ingleby Barwick	**Victoria House** Bath Lane Stockton
Kirkdale Radcliffe Crescent Thornaby	**Wellburn House** Wellburn Road Stockton
Mandale House 136 Acklam Road Thornaby	**The White House** 76a Darlington Road Stockton
The Maple Dover Road Stockton	**Willow View** 201 Norton Road Stockton
Millbeck House High Street Norton	**Windsor Court** 44-50 Windsor Road Stockton

Newland House * 304-308 Norton Road Stockton	**Woodside Grange** Tedder Avenue Thornaby

+Since our visit the provider of this care home has changed

*Since our visit this care home has closed

Services where a pre visit was made and questionnaires (and freepost envelopes) were left for distribution.

Briardene West Avenue Billingham	**Ashwood Lodge** Bedale Avenue Billingham

Services where a pre visit was undertaken but the service did not allow and Enter and View to be carried out.

Ayresome Court Green Lane Yarm	**Reuben Manor** 654 York Road Eaglescliffe

Services that failed to communicate with Healthwatch regarding either a pre visit or an Enter and View.

1. **Church View** Thompson Street Stockton	2. **Elton Hall** Elton Village

APPENDIX 2 – Poster

What is it like to live in a care home?

Healthwatch Stockton-on-Tees is a strong independent consumer champion. We are here to make sure your views on local health and social care services are heard.

We want to hear the views of residents, staff and those who have friends or relatives who live in care homes in Stockton-on-Tees.

We have an online survey which you can access to give us your views:

https://www.surveymonkey.co.uk/r/QSTRLRL

The online survey for **staff** can be found at:

https://www.surveymonkey.co.uk/r/GZ5DKZB

All responses will be completely anonymous

it starts with YOU

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healthwatch Stockton-on-Tees

APPENDIX 3 - Questionnaire for relatives

Care Home Family & Friends Survey

Healthwatch Stockton-on-Tees works with local people, patients, services users, carers, community groups, organisations, service providers and commissioners to help improve local health and social care services to ensure they are meeting the needs of the local community.

As part of our 2018/19 work plan, we would like to hear the views of residents, staff and those who have friends or relatives who live in care homes in Stockton-on-Tees. Your feedback will be used in a report aimed at improving residential care home experiences and sharing good practice.

All responses will be anonymous.

If you have any questions or would like us to send out a paper copy then please get in touch with a member of the Healthwatch team on 01642 688312 or email healthwatchstockton@pcp.uk.net.

1. What is the name of the care home where your relative/friend lives?

2. Do you receive financial support from either the council or from the NHS towards your care home fees?

Yes	No	Don't Know
◯	◯	◯

3. The home is managed well, and the Care Home Manager is available to talk about any issues I may have:

Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
◯	◯	◯	◯	◯

Any further comments?

4. The care home staff have the necessary skills and time to carry out their role:

Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
◯	◯	◯	◯	◯

Any further comments?

5. Staff involve residents and, where required, their family and friends, in discussions about their care needs and how these may change over time.

Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
◯	◯	◯	◯	◯

Any further comments?

6. Residents receive adequate daily stimulation and there is a varied programme of activities for residents to enjoy.

Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
◯	◯	◯	◯	◯

Any further comments?

7. Staff are able to support the residents to get involved in community activities outside of the care home environment where possible.

Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
◯	◯	◯	◯	◯

Any further comments?

8. There is always a choice of meals available and the food is of an acceptable quality.

Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
◯	◯	◯	◯	◯

Any further comments?

9. The home is kept clean and tidy.

Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
◯	◯	◯	◯	◯

Any further comments?

10. There is regular access to healthcare professionals (nurses, doctors, dentists, opticians, chiropodists etc. as required.

Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
◯	◯	◯	◯	◯

Any further comments?

11. There is regular access to social care professionals e.g. Social Workers.

Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
◯	◯	◯	◯	◯

Any further comments?

12. The care home can accommodate residents' personal, cultural, religious and lifestyle needs.

Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
○	○	○	○	○

Any further comments?

13. Care home staff actively seek out the views of residents and their family/friends.

Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
○	○	○	○	○

Any further comments?

14. Care home staff take action based upon feedback from residents, their family and their friends.

Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
◯	◯	◯	◯	◯

Any further comments?

15. There is a clear and understandable complaints procedure which I have been made aware of.

Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
◯	◯	◯	◯	◯

Any further comments?

16. Is there anything else you would like to tell us about your care home experience?

If you would like a copy of the report and to sign up for the newsletter please leave either a postal or email address below:

Name:	
Address:	
Postcode:	
Email Address:	
Phone Number:	

If you do not wish to leave your contact details then the report will be published on our website: www.healthwatchstocktononteees.co.uk

APPENDIX 4 – Questionnaire for residents

Care Home Resident Survey

Healthwatch Stockton-on-Tees works with local people, patients, services users, carers, community groups, organisations, service providers and commissioners to help improve local health and social care services to ensure they are meeting the needs of the local community. As part of our 2018/19 work plan, we would like to hear the views of residents, staff and those who have friends or relatives who live in care homes in Stockton-on-Tees. Your feedback will be used in a report aimed at improving residential care home experiences and sharing good practice.

All responses will be anonymous.

If you have any questions or would like us to send out a paper copy then please get in touch with a member of the Healthwatch team on 01642 688312 or email healthwatchstockton@pcp.uk.net.

Name of Care Home

1. Do you know the Manager of the home?
2.

3. What do you think of the Manager?

4. What do you think about the staff here?

5. Do the staff have the time to stop and chat with you?

6. Do the staff know what you need and what you like and don't like

7. What activities are there for you to do in the home?

8. Is it easy to join in the activities? Are you helped by the staff if necessary?

9. Do you get a chance to do any of the things you used to enjoy before you came here?

10. Do you go on trips outside?

11. What do you think of the food here?

12. Is there enough choice of what you eat and when you eat?

13. Do you enjoy mealtimes?

13. If you need to see a doctor, a nurse or other health care professional such as a dentist or optician is this arranged for you?

14. Is there respect for your religion or your culture here in your home?

15. Do you get asked what you think about the home and about the care you receive?

16. Are your views taken into account?

17. Would you like to change anything about the home? Have you told anyone about this and what happened?

18. Would you know how to make a complaint?

18. If you would like a copy of the report and to sign up for the newsletter please leave either a postal or email address below:

Name:

Address:

Postcode:

Email Address:

Phone Number:

If you do not wish to leave your contact details then the report will be published on our website: www.healthwatchstocktononteees.co.uk

APPENDIX 5 – Questionnaire for staff

Care Home Staff Survey

Healthwatch Stockton-on-Tees works with local people, patients, services users, carers, community groups, organisations, service providers and commissioners to help improve local health and social care services to ensure they are meeting the needs of the local community.

As part of our 2018/19 work plan, we would like to hear the views of residents, staff and those who have friends or relatives who live in care homes in Stockton-on-Tees. Your feedback will be used in a report aimed at improving residential care home experiences and sharing good practice.

All responses will be anonymous.

If you have any questions or would like us to send out a paper copy then please get in touch with a member of the Healthwatch team on 01642 688312 or email healthwatchstockton@pcp.uk.net.

1. Which care home do you work in?

2. You receive good support from the care home manager?

   - ○ Strongly Agree
   - ○ Agree
   - ○ Disagree
   - ○ Strongly Disagree
   - ○ Don't Know

   Comments:

3. You are able to talk to the manager when you want to ask a question or raise an issue?

- ○ Strongly Agree
- ○ Agree
- ○ Disagree
- ○ Strongly Disagree
- ○ Don't Know

Comments:

4. Do you feel you have enough time to care for residents and meet their needs appropriately?

- ○ Strongly Agree
- ○ Agree
- ○ Disagree
- ○ Strongly Disagree
- ○ Don't Know

Comments:

5. Have you been adequately trained to do your job and are you encouraged to continue to develop your skills? In what ways?

6. What do you enjoy about your job?

7. How do you ensure that staff get to know a resident's life history, personality and health and care needs when the resident first arrives?

8. How is information about a resident's likes/dislikes and their health care needs updated as these change?

9. Residents are offered sufficient daily stimulation in the care home and there is an adequate activity programme that residents are helped to enjoy?

- ○ Strongly Agree
- ○ Agree
- ○ Disagree
- ○ Strongly Disagree
- ○ Don't Know

Comments:

10. Staff are able to support the residents to get involved in community activities outside the home where possible?

- ○ Strongly Agree
- ○ Agree
- ○ Disagree
- ○ Strongly Disagree
- ○ Don't Know

Comments:

11. There is always a choice of meals available for the residents and the food is of an acceptable quality.

- ○ Strongly Agree
- ○ Agree
- ○ Disagree
- ○ Strongly Disagree
- ○ Don't Know

Comments:

12. Residents have regular access to healthcare professionals such as GP's, dentists, opticians, chiropodists as well as social care professionals?

- ○ Strongly Agree
- ○ Agree
- ○ Disagree
- ○ Strongly Disagree
- ○ Don't Know

Comments:

13. Can you give an example of how the home caters for different religious, cultural and lifestyle needs?

14. Residents, and where necessary, their family have opportunities to have a say in how the care home is run?

- ○ Strongly Agree
- ○ Agree
- ○ Disagree
- ○ Strongly Disagree
- ○ Don't Know

Comments:

15. Can you provide an example of how a resident or their family member has influenced how the home is run?

16. Do you feel staff can have a say in how the home is run?

17. There is a clear and understandable complaints procedure and this is shared with residents and their family and friends?

- ○ Strongly Agree
- ○ Agree
- ○ Disagree
- ○ Strongly Disagree
- ○ Don't Know

Comments:

18. Do you have any other feedback you would like to share about the care home?