healthwatch Coventry

Report of enter and view visit to Victoria Manor Care home

Published May 2020

Home Visited	Victoria Manor
Date and Time of visit	March 4th 2020 10.00am – 3.00pm
Address	31-33 Abbey Road, Coventry CV3 4BJ
Size and Specialism	Accommodation for persons who require nursing or personal care, dementia care, caring for adults under 65 years, Caring for adults over 65 years
Authorised Representatives	Mary Burns, Tom Garroway, Louise Stratton

1. What is Enter and View?

The Health and Social Care Act 2012 allows local Healthwatch authorised representatives to observe and report on service delivery and to talk to service users, their families and carers in premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. This is so local Healthwatch can learn from the experiences of people who interact with these services first-hand.

Healthwatch Authorised Representatives carry out these visits to find out how services are run and to gather the perspectives of those who are using the service.

From our findings, we look to report a snapshot of users' experiences accurately, highlight examples of good practice and make recommendations for improvements.

2. Reasons for the visit

Healthwatch Coventry's Steering Group has agreed that Enter and View visits to care homes form an important part of the current Healthwatch work programme to ensure that people who may be vulnerable and less able to raise their voices have the opportunity to speak to Healthwatch. In the light of several pieces of national work looking at meeting health needs of residents we have a focus on find out how resident's physical health needs are supported. We draw on recent good practice publications:

- *Smiling matters: oral health care in care homes;* Care Quality Commission[1]
- *Supporting older people with hearing loss;* Action for Hearing Loss[2]

We also looked at dementia friendly design and quality of life factors such as activities and choices.

[1] https://www.cqc.org.uk/publications/major-report/smiling-matters-oral-health-care-care-homes
[2] https://www.actiononhearingloss.org.uk/how-we-help/health-and-social-care-professionals/guidance-for-supporting-older-people-with-hearing-loss-in-care-settings/

3. Methodology

We collected our information by speaking to the care home manager along with an Area Director for the home's group and two staff members. We spoke to four residents. We received one returned questionnaire from a visitor who was there at the time.

Information was recorded on semi-structured questionnaires asking open questions to establish what people liked most and what people felt could be improved.

Before speaking to each resident Authorised Representatives introduced themselves and explained what Healthwatch is and why they were there. It was established that the resident or staff member was happy to speak to Healthwatch. It was confirmed that their name would not be linked to any information that was shared and that they were free to end the conversation at any point. Healthwatch Coventry Authorised Representatives wore name badges to identify who they were and provided the Care Home Manager with a letter of authority from the Healthwatch Coventry Chief Officer.

Observations were made throughout the visit and notes of what was observed around the home were taken by each attending Authorised Representative.

4. About the Home

Victoria Manor is run by HC-One[3]. It provides care for up to 30 residents aged under and over 65 whose primary health need is dementia care. On the day of our visit there were 28 residents at the home.

At the time of the visit 22 residents were self-funding (i.e. paying for their own care); six were funded by the local authority.

No beds were occupied by residents funded through Continuing Healthcare Funding (CHC). We were advised that the company did not wish to tender for CHC funded care because they felt that under the current funding structure for CHC funding is often a temporary funding stream for a resident. They said this creates issues when resident has been supported to become more well/independent and funding is withdrawn.

The home is currently tendering for seven beds to be allocated to be used for the local re-ablement pathway (a care package for up to six weeks to enable patients who are not quite ready to go home to leave hospital and receive the right support before long term assessment is made to decide what future care they will need).

There are 29 staff in total, which includes one admin person, one maintenance person, catering staff and care staff.

[3] https://www.hc-one.co.uk/Carehomes/Victoria-Manor.aspx

The care home's Care Quality Commission inspection report can be found at https://www.cqc.org.uk/location/1-320756045/inspection-summary

5. Summary of findings

Victoria Manor is a care home belonging to a large independently owned organisation, HC-One. It is set in spacious grounds with ample parking but without a designated space/spaces for visitors with mobility support needs.

At the time of our visit the property was going through an overall refurbishment.

The internal areas which have been refurbished were fresh and new. The temperature in many rooms was very warm, with many windows needing to be opened on a chilly March day.

We observed positive interaction between residents and carers addressing ah other by their first names.

A Professor is leading the organisation with its approach to 'Dementia Friendly design', this is not a traditional view as recommended by Alzheimer's Society and other dementia organisations. See appendices provided by HC-One.

The management team has introduced innovative ways of maximising the one to one time that residents can have, which pool the resources of the entire staff team. They have also a quality process in place that review the overall needs for a resident monthly.

Food quality was good but consistency in the way residents are offered choice of food needs consideration to ensure all residents have a choice of meals.

All the residents the Healthwatch Team spoke to were very happy living at Victoria Manor.

6. Findings

6.1 Initial Impressions

We were greeted by the deputy manager who was friendly, knew who we were and was expecting us. We were invited in and asked to sign in. There was hand sanitiser available, but we were not asked to use it. The Healthwatch team was introduced to the home manager and the organisation's Area Director who was present.

The reception area was very warm. A thermometer in the building read 81°. We were invited into the manager's office where there was no external window. An air conditioning unit was blowing cool air which made the temperature in the room acceptable.

In the downstairs entrance hall, there was an interactive board with a touchscreen, which staff and visitors could use to comment on anything to do with the home called “Have your say”.

In the downstairs lounge music was playing. Some residents were singing and others were asleep. A staff member was holding one resident’s hand and dancing with them. Residents were not interacting with each other but seemed happy to observe what was going on around them. It was a quiet area except for the music.

In the upstairs lounge, a young man who was not an employee of the home who was contracted to the home privately was providing an armchair exercise class.

Reminiscence music was playing e.g. Vera Lynn and other tunes from bygone eras.

6.2 Facilities and environment

Exterior

The façade of the front of the building was in good repair and well presented. It was March when we visited and there were dead plants in the pots at the front of the building.

Some cigarette ends had been discarded at the front of the building around the entrance even though there was a wall mounted cigarette disposal unit to the left-hand side of the front of the property. We raised this with the manager who said this could be linked to the contractors that were refurbishing the building.

Accessibility

There were plenty of parking spaces. However no spaces were reserved for disabled parking. There was available parking upon arrival but when we left there were no free spaces.

There were two routes of access to the front door one was step free. The step free access had an initial but short steep incline followed by 90° left hand turn to access a narrow pathway without any guardrails to prevent wheelchairs or scooters from tipping off the left-hand side of the ramp.

Interior

The accommodation was divided into two floors. The upper floor was home to residents who had a higher level of need.

The ground floor has been fully refurbished other than the final touches of soft furnishings and pictures and relevant signage (although the organisation’s preferred model of design doesn’t promote a lot of signage). The first floor is the second phase of refurbishment.

The design, colour schemes etc used was based on advice from Professor Graham Stokes who is the organisation's adviser on the living environment and meeting the needs of residents who have memory care needs. Professor Stokes has been the Honorary Visiting Professor of Person-Centred Dementia Care at the University of Bradford since 2012.

The walls and handrails had minimal contrast in colour; between white and a very pale grey. Doors that had controlled access were white to blend with the walls. There was minimal signage seen.

On the ground floor the main reception, where the manager's office is, leads on to a long corridor which accommodates the ground floor bedrooms all of which are have a private toilet and wash hand basin.

There is a recently refurbished lounge with a large TV overlooking the garden. A hairdressing salon, a dining room, a toilet and a bathroom are positioned centrally on the ground floor.

The first floor has a similar long corridor as the ground floor but there is an open area directly above the reception area on the ground floor. This space is not currently formally used but there are plans to convert it into a bistro area. In the lounge there were a variety of different chairs. All of the furniture looked well looked after.

The temperature was observed to be 81° in the lounge area, residents were heard saying it was too hot some were wearing short sleeved T-shirts. All of the communal spaces in the home were overly warm as well. At the lunchtime period in the downstairs dining room four windows were open.

At each end of the ground floor were spaces which were being developed into a garden scene and market street scene. In one of the spaces there was currently a cot, a baby's car seat and a pushchair with baby dolls for residents to interact with.

On the ground floor the doors of resident's room were either very pale green or a very pale blue depending on which end of the building they were.

Two vacant rooms were open for viewing. They were presented 'hotel style' with toiletries and towels presented on the bed along with a portable bed tray set out with tea facilities. The rooms were tastefully decorated and adequately spacious. The curtains were in very good condition; however, both pairs of curtains were too short for the window. This was flagged to the care home manager who said they would address this. The bedroom had a sensor mat in situ to detect falls. It is unknown whether this is a standard practice in all rooms or whether it is provided on a 'needs' basis.

The chairs in the lounge on the first floor were all same size except for one recliner. There was a clock, day date and time displayed in the room and there

were plenty of books. The carpet was blue, the room looked homely and welcoming. Smooth radio station was playing.

There was a room called the coffee shop lounge, but no coffee was available in the room. Staff said this room was used by residents when visitors came. It had bright colours with lots of seats and patterned soft furnishings. There was an area of the room that resembled a games room with table football and bingo. The room was on the first floor, it had large windows overlooking an unused area of the garden.

On two occasions during our visit people tried to access the downstairs communal toilet whilst it was being used by a resident who had not/not been able to lock the door. The door lock was found to be difficult to use by a member of the Healthwatch team who had reduced dexterity in their hand.

We were shown the Meds room and it was clean and tidy, but was dusty. We were informed that some shelving had been taken down a couple of days before.

Outside space

The home has a large outside area with mature shrubs, trees and lawned areas which residents can access. There is a barbecue with benches, tables and chairs.

The coffee lounge area has a view over an inaccessible outside space which houses a large maintenance shed and has a scree garden that did not appear to be well looked after. This is quite a large area that is enclosed by a tall fence that is partly painted blue. Staff advised us that there is a plan to make this into a beach scape.

Dementia Friendly Design

The ground floor has recently gone through extensive refurbishment which has been led on the advice from Prof Graham Stokes who is the organisation's in - house adviser on the living environment of care settings and meeting the needs of residents who have memory care needs.

The refurbishment programme is not in line with routine guidance on dementia friendly design as outlined by Alzheimer's Society. Please see appendices.

6.3 Staffing

Staff training and support

We spoke to two members of staff in addition to the senior management team. This included a newly joined carer who joined the company in December 2019 and the deputy manager who had been in post two years.

Managers said staff are supported in their roles by receiving an induction when they join the care home. A carer informed us this was a three to four day induction

which they were paid for. They also stated that shadowing was provided when a new member of staff starts working at Victoria Manor. We were also informed that all staff receive face-to-face support and internal training which can be shadowing with a senior.

Touch training which is an IT based online internal system is used by staff for mandatory training e.g. safe lifting and handling.

Any online training was completed in staff's personal time. The online training that is provided for staff is a modular approach, both IT-based and paper based. On completion staff gain certification, which is nationally accredited. This is a self-assessment process.

A care worker informed us that whilst they had not received any training related to residents' health needs all the information is held in a resident's care plan

There is an appraisal system online which focuses on the KinderCare company brand. The organisation has 'kindness in care awards' where individual staff members can be recommended for an award.

We were informed by staff members that they received quarterly one-to-one support as well and a monthly staff meeting but the staff meeting is not always held in work time. We were told that the sort of information that was shared at monthly staff meetings was: *"Progress and problems are the type of stuff to share with all staff", a*s well as: *"Any falls, choking incident, attendance, staff etc."*

How staff get to know residents

One member of staff explained that carers work in pairs to support 10 residents and share the responsibility to find out how best support them. We were also informed by staff member that:

"I spend a lot of time working one-to-one with residents to find out their likes and dislikes, and wants, personal histories etc."

We were advised that each day of the month one resident is the 'resident of the month', and every aspect of this resident's care is considered. The care planning will be monitored this will be flagged to care staff; this enables staff to take time to review the care plan all staff have a responsibility within this for example:

"A deep clean of the room happens then meds are reviewed; their likes and dislikes are updated. This process is currently hardcopy, it will be going electronic in September".

Dignity and Care

The Area Director told us that Victoria Manor delivers memory care service which is led by Prof Graham Stokes who is based within the organisation at their head

office. Their model focuses on environmental factors and activities to include mind body and soul which happens every day. This is management led.

There is a daily feature called ‘stop the clock at 3 o'clock’ where everybody stops this includes all staff whether their job is care based or not (including maintenance, admin and catering staff). Each member of staff spends 15 minutes focusing on one resident to sit and spend time with them.

Carers were observed interacting with residents in a calm and appropriate way and offering reassurance where required. The staff were observed communicating well with residents on both floors. Staff were observed to be communicating in a friendly manner.

All residents had drinks, one resident was observed gently patting a health worker who was being very friendly and chatty.

Staff were observed addressing people by their first names. Residents were also noted to call staff by their first names.

Staff did not appear to be rushed and are all going about their duties in a relaxed efficient way. No assistance bells were heard during the time of our visit.

A resident who was in the lounge rose to their feet quite abruptly and was observed saying they felt nauseous, immediately a member of staff responded. They were supported appropriately in a calm and discreet way to go to the toilet.

One resident who feels the need to constantly walk the corridors can do so by staff not obstructing them and apologising if they felt the resident had perceived them as ‘being in the way’.

All the residents we spoke to, bar one, felt they were always listened to. One resident said, *“They always do, nice to have a chat”. The resident who felt slightly differently said “Sometimes they do, sometimes they don't”, but did not expand any further”.*

There we no concerns expressed from our sample group of residents. The comments we gathered form residents ranged from “it’s all right” to “100%”.

Only one resident was able to express with clarity how they were asked by care staff if they were happy with the support and assistance they were given, they said: *“Yes, always asking questions. I like what's what, what's happening”.*

Residents were asked how staff supported them to do things for themselves where possible, some replies were:

- *“I can't do what I used to, they understand me, what I can and can't do”*
- *“They also help me with washing”*
- *“Sometimes they do”*

All the sample group said they had never felt uncomfortable or embarrassed was living at Victoria Manor.

Residents are appropriate dressed in the lounges they look like they have been supported with presenting themselves well: eg men were clean-shaven. One resident chose to be barefooted; the reason was not clear, but their choice was respected.

All residents we spoke to were very happy living at Victoria Manor. Some of their comments were:

- *"It's ideal for me, very happy"*
- *"Everything is nice. Everyone is nice. Kind Staff"*
- *"Please myself a lot"*

A resident also told us: *"I've lived here a long time now. Two years. Very happy. Enough visitors. Go out to shops"*.

6.4 Residents' Health

GP services

We were advised by the manager that a GP visits every Thursday from Chase surgery, she said: *"The same doctor which is Dr Moffatt always comes"*. The staff we spoke with were aware of the process, one said, *"The doctor (Dr Moffatt) will come, most times or a telephone consultation with the doctor or they will send another doctor out from same surgery"*.

The residents in our sample group had all been visited by the GP and all spoke positively about the experience, they said:

- *"Yes, yes good"*
- *"Yes. Good. When I need them. Six months"*
- *"I went to see him. He was nice"*
- *"Yes, nice doctor visit"*

Support for the home from NHS services

The home receives support from some NHS services. These include GP services, district nurses, specialist nurses eg diabetes, and support from the clinical nurses at the CCG e.g. Infection control/tissue viability.

Looking after residents' feet

The manager said that the external chiropodist leads on this, if staff notice any issues, they put it on the resident's care plan. The chiropodist organises their client list themselves. One resident uses their own chiropodist.

The Deputy Manager told us: *"The chiropodist comes in every six weeks, if this is required any earlier, they will come in. Diabetics get it free. We will do everyday care for hands and nails except for diabetics".*

All the residents we spoke to indicated they saw the visiting chiropodist regularly, some comments were:

- *"Yes, I don't have to ask, just arrive"*
- *"Just nail filed, the chiropodist comes to cut them"*
- *"Yes, they come about my feet, Yes I can request a visit"*

How residents' sight is looked after

Staff advised that this is led by Specsavers, which visits the home regularly and sees residents on an individual basis. Staff said residents' glasses are photographed for identification purposes and also have the resident's name on them so they are easily identifiable if lost/misplaced/taken by another resident. The manager said: *"We received pictures of residence glasses and kept in their care plan and the name is also etched onto their glasses".*

Both of the care staff we spoke to were aware that this was dealt with by an outside agency.

Looking after hearing aids and residents hearing

We were informed by the manager that staff check hearing aids, clean them and change batteries. This is integrated into care planning. This is covered in the communication module of the training. There is no formal assessment of residents hearing who do not use hearing aids. This will be raised by the GP if they had concerns.

A member of the care team explained *"They have boxes to put the hearing aids in, we clean them and change batteries. An outside audiologist comes for maintenance and hearing checks".*

No residents we spoke to used hearing aids, nor had they had their hearing checked whilst living at Victoria Manor.

Oral health

The manager informed us that this area is covered on Touch Training (an online course). It is also part of a two-day workshop for induction training.

A carer explained that they make sure that teeth/dentures are cleaned and oral health is checked when they do this.

The deputy manager said that one resident had dental problems but does not want to see a dentist.

No residents that we spoke to had experienced any dental problems, one resident said, *"No, I see my own dentist. Both dentists come here. Six months* [referring to how often they had dental appointments]"

The manager had accessed community dentistry services and said of the experience: *"The dentist, this is a difficult one. We try and take them to the dentist. Using community dentistry is very difficult to get them here for check-ups. A while ago they came and started to do some check-ups but didn't come back".*

When a resident feels unwell

The manager explained that in a situation where a resident informs a carer that they feel unwell or are in pain this is escalated to the senior on duty or manager who go through the health check process. Dependent on the outcome they may be given home remedy for 48 hours or NHS 111 would be called. The GP practice is always used in opening hours in preference to NHS 111 as there is an ongoing relationship here.

Both staff members we spoke to knew how to escalate the situation where a resident had indicated that they felt unwell. They informed us that they would immediately tell the senior or manager.

Two residents we spoke to had never felt unwell whilst living at Victoria Manor and two had. When asked, the two who had felt unwell whilst living at the home said:

- *"I tell a carer"*
- *"Sometimes in pain. They give me medicine"*

Taking medication

Staff advised that this is reviewed on a monthly basis as part of the resident of the month process where all staff have input into one resident care plan.

No residents currently self-administer medication. Where this would be requested a risk assessment would be carried out to incorporate looking at capacity issues and if it was deemed to be unacceptable risk the medication was be kept in a lockable cupboard in the residents' room.

Staff said Victoria Manor use Boots pharmacy, and there is an electronic system in place for ordering repeat prescriptions for residents.

6.5 Activities

The Area Director told us *"We do not have an Activities Coordinator; we have a Well-being Coordinator. We turned the model upside down to ensure it was person centred. We accommodate one-to-one support for people. As mentioned through 'Resident of the day' and '3 o'clock stop the clock'. This way we ensure that*

people have at least 15 minutes per day one-to-one contact that is not care task - related".

We were advised that the home has a weekly programme of activities that is combination of activities that are delivered by internal and external means. Other ad hoc activities are also planned.

One resident said that the music that is generally played in the home does not appeal to them, when asked what they would like to see done differently they said: "*A little bit of dancing. I can't do it but I'd like to try. I don't like heavy wartime music, too old for me. I like Meatloaf. It's very warm, too hot* [in the home]".

An armchair exercise activity was being delivered between 10:00 and 10:30 am, one of four residents were singing along one was asleep.

There were jigsaws and books in the lounge which were labelled.

This home has a school connection who come into sing for the residents to practice the school concert. There is also a connection with the British Legion coming to support some members who live at the home.

Currently the home is having contact with Asda to look to establish relationships within the community. The organisation is doing singing for the soul which is done at Brandon house. This is based on the model of 'singing for the brain' which is a community-based initiative led by the Alzheimer Society but is an internal option.

The home manager said *"We do have volunteers at Victoria Manor and we also have work experience for students who are studying/interested in working in the care sector".* There was one volunteer in the home at the time of our visit supporting in the upstairs lounge.

A hairdresser visits on a Tuesday, a notice was observed stating a charge for a cut and blow dry was £17. In the hairdressing salon it was observed a member of staff blow drying a resident's hair. The residents looked like they were enjoying the experience, there was also another resident having their nails painted in the downstairs lounge.

Only one resident said they liked to take part in activities, which was doing exercises. This was the activity that was taking place whilst Healthwatch were visiting.

When sample group were asked what they did when they spent time on their own their responses were:

- *"I like to spend time on my own quietly"*
- *"I like nothing. I love music. TV and radio in my room"*
- *"I like to read, I like to drink tea"*
- *"Not much, I have the radio on"*

One resident said that they did not go into the garden. It is not understood whether they were referring to it being winter or whether they chose not to go into the garden at all for different reasons.
Management explained that there are plans to develop the garden space which will make it look less large, be more interactive and hopefully encourage more residents to use the space in a more independent way.

Other comments were:

- *"Yes. Not a lot, (meaning they don't go to the garden very often). I'm being nosy. Barbecues"*.
- *"It's very cold now. Perhaps in the summer"*

One resident was happy with the activities provided, one was unsure of what other activities they might like to do other than what was provided, and two others said they would like *"dancing"* and *"Throw the ball to me*".

Food and drink

Residents were being offered drinks quite frequently, each time carers came into the lounge on the ground floor. There was a water dispenser on the first floor in the lobby area this was the only facility for residents to help themselves to drink that we observed. No residents were seen getting themselves drinks.

A staff member in the ground floor lounge was observed giving a biscuit to a resident directly from the packet. Residents said there were snacks available if they asked. Staff said snacks are provided on request downstairs and this doesn't happen upstairs because of residents' dietary needs.

The food is all cooked on-site. The menu choice on the day we visited was roast pork or minced beef with apple crumble and custard for pudding. There was a beverage choice of water, lemon or blackcurrant offered at the table. The menu was on the laminated A4 sheet in the dining room. Lunch was served at 1:20 PM in the ground floor dining room.

In the ground floor dining room residents were all served roast pork. We asked the carers serving lunch why no one was offered the mince dish. A carer replied by saying, *"Who'd choose mince over roast pork, they all love a roast"*.

This practice was different to how residents were offered the choice of menu upstairs. In the dining room on the first-floor residents were taken both dishes to be able to make as informed a choice as possible by seeing the meals.

In the ground floor dining room residents were supported to be seated one person at a time. This took at least 10 minutes as people required differing levels of support. Each meal was served one by one to residents. The person who was seated first was served last, meaning they had been seated for over 20 minutes before being served. There were five residents dining with three carers supporting the lunch process. Some residents were offered appropriate support and

encouragement to eat. One person was offered a second helping. This seemed to be an offer made by the carer because they understood that this resident liked their food.

One resident was served carrots with their meal at which point the resident reminded the carer they did not like them, this was then replaced. One resident asked for a bib and one resident asked for more mash, both requests were addressed immediately.

All residents seem to enjoy their lunch and those we spoke to all commented positively. The roast pork lunch was sampled by the Healthwatch team, which was suitably warm, an ample portion and of good quality.

A resident was in the ground floor dining room (who was understood to have challenging behaviour and who was in the process of being reassessed as the home felt they were not able to fully meet there needs any longer) was highly agitated, a carer removed the condiments from the table where this person sat and relocated another resident who was sat at the table.

In the first-floor dining room there was soft music playing. Most residents didn't need support to eat but the staff were verbally encouraging them. They seem to be enjoying their meal. Three residents were observed as having a soft diet. Food looks appetising, a carer was observed to be cutting up the food for some residents. The atmosphere was quiet.

The tables were nicely set with tablecloths and linen napkins, also artificial flowers are on the table, knives and forks were brought out with the meal.

6.7 Anything that could be done differently

When asked if there was anything they'd like to change, only one resident expressed they'd like to hear a different genre of music played and the home was too warm. The other residents spoken with felt there wasn't anything they would change, one resident expressed this with gusto.

There are significant plans in place for development of the home to broaden the options for residents to be involved differently to promote more stimulation and interaction for residents, some of these include:

- Creating a beachscape which can be viewed from the coffee shop area
- Creating an outside space in the garden which will accommodate a market/shop scene that will look a less big space that might encourage residents to go outside more and interact with the market setting
- Creating the bistro environment on the first-floor lobby area
- Completing the refurbishment

Healthwatch recommendations and care home response

Recommendation	Response from home manager
1. **Temperature Control** Reduce the temperature in communal areas to minimise the need to open windows to reduce temperature in communal spaces	The home currently has a thermostat system in which heat levels can be altered however regulation of heat from one individual to another can vary differently. Where possible heat control is supported with appropriate temperature level from the thermostat along with residents clothing to their needs. The home have thermometers in place to monitor heat and this is recorded daily via the maintenance operative to ensure a conducive heat for all within the home. The temperature recorded on the inspection was 81 (27 degrees Celsius) this was an ambient temperature for those residing in the home due to the climate of the day outside being chilly and windy. Where temperatures are excessively recorded the home take actions to reduce this i.e. opening windows and reducing temperature of radiators.
2. **Resident's health** Ensure that all residents' hearing is regularly reviewed whether or not they wear hearing aids. Some people are unaware of hearing deterioration Make use of the guidance from Action from Hearing loss: www.actiononhearingloss.org.uk/how-we-help/health-and-social-care-professionals/guidance-for-supporting-older-people-with-hearing-loss-in-care-settings/	As explained during the inspection and detailed within the report hearing is managed via a referral to the GP and then an audiologist will visit the service. Care plans are in place to support residents and their communicative abilities and within these care plans hearing and hearing abilities are recognised with actions for staff to support the individual resident. The management of hearing and hearing aids were clearly discussed on the visit and staff were also able to demonstrate this during the visit. We will review action hearing loss guidance and where possible incorporate this into our policies to support reviewing an individual's hearing abilities. (Timeframe to be established in line with our clinical quality team and as / when current policy is due to be reviewed)

Recommendation	Response from home manager
3. Choice and Control Put in place ways to support residents on the ground floor to make a choice about the food they eat at mealtimes.	The current systems adopted in the home are as follows at mealtimes: Ground Floor (Residential) – All residents in the ground floor dining room are offered their choice of meal at point of preparation to the meal so usually around 10:30am staff will go to all residents on the ground floor and take their option. There is always a small surplus prepared should at the point of serving someone changes their mind on what to eat. There is also a menu available in the dining room for the residents to read prior to their meal and change their option. First Floor (Memory Care) – Visual options are given to all residents to support the decision-making process along with written menus. The way in which choice is given is varied and dependent to the residents own ability.
4. Dignity and Respect Develop a way to let visitors know if communal toilets are in use or brief them to check in order to protect residents' dignity whilst using a communal toilet.	Signage for doors are in place along with coloured locks to indicate when a toilet is in use. Unfortunately on the day of the visit an independent resident (whom does not require staff support or supervision to go toilet) was accessing the toilet and did not lock the door. It would always be advised as any professional visiting or working in a care home you would knock any door before entering to promote dignity and as a home all of the staff in the service follow this guidance.
5. Signage Label taps to clearly show hot and cold	Taps where identified to be missing colours / lettering have been reviewed and will be replaced in an appropriate timescale. (Works approved pending risk assessment)
6. Disabled Access Review external disabled access to ensure this access is safe for independent users of wheelchairs/scooters	Disabled access into the home is via a ramp with no handrails at the side. The estates team are currently reviewing as to whether a hand rail can be implemented to support use of the ramp facility. (Works approved pending risk assessment)

8. Appendices -Provided by HC One

Appendix 1

The relevance of signage in the care of people living with advanced dementia

1. Minimising signage in our memory care communities is not about reducing the risk of harm, instead it is an issue of redundancy.

2. Signage in the absence of observable resident benefits contributes to environmental noise and an institutional feel when best practice consensus recommends domestic-style homeliness (Cantley & Wilson, 2002).

3. It is not being argued that signage and symbols have no value in supporting independence and orientation in the care of people living with dementia. When advocating any treatment or intervention the basic premise is who does the intervention benefit (not one size fits all), in what way, for how long, and at what point on the spectrum of progressive cognitive impairment is it no longer of value and should be stopped.

4. Signage was originally advocated when the resident population was less cognitively impaired and care settings were predominantly anonymous institutions (Hanley & Hodge, 1984; Stokes, 1990).

5. Hanley & Hodge built on reality orientation, and the appreciation that people with dementia could not remember what they were told, by recommending people living with dementia could be oriented to their environment through physical cues such as signage and directional information.

6. However, with severe dementia the prosthetic value of cues may never be acquired. For this reason, the results of orientation cues in counteracting the disabling consequences of dementia have been generally disappointing (Stokes, 2011).

7. As residents with dementia can rarely remember experiences, including exposure to orientation information, serendipity is often the only means by which they find themselves in the proximity of the room a sign is identifying.

8. Yet, advanced dementia is more than a memory disability; it is also a reasoning deficit. Hence seeing for example a picture of an armchair assumes that a person with dementia can reason that what is being

communicated is that behind the door is a lounge, or a knife, fork and plate symbol can be successfully interpreted as 'I'm being told by this symbol that this is the room where I eat'. The probability is that this is several reasoning steps too far.

9. Judd at al. (1998) selected a number of homes that satisfied consensus criteria for what constitutes good design and the use of signage was conspicuous by its absence. Carntyne Gardens – "Internally there is very little signage in keeping with the attempt to create a domestic appearance." The Meadows – "There is a minimum of signage … cueing was integrated into the building design rather than conspicuously layered on top of it."

10. Cantley & Wilson (2002) in 'Designing and Managing Care Homes for People with Dementia' whilst advocating signage moved away from signs per se to raising the potential value of more natural cues by recommending

    - Multiple cues where possible, for example, sight, smell, sound
    - Use of objects rather than colour for orientation
    - Enhancement of visual access

11. Similarly, whilst the Kings Fund Environmental Assessment Tool advocates toilet signage the use of more general signage ("day rooms") is complemented by visual clues such as pictures/objects and/or colours to help people find their way around.

12. Bignall (1996) found that while orientation designs improved wayfinding and supported independence the most significant factor was the way in which staff became enthusiastic and adopted a positive outlook. How the fact that the severity of dementia found in care homes has changed over recent decades is observed in this study. Bignall reports residents living with dementia asking "Where's the toilet?", and she describes a resident standing in the lounge asking where is the toilet and being informed by another resident: "It's there where the red door is." Nowadays these are unlikely scenarios.

13. In a review of empirical studies Barnes et al (2002) concluded there had been little systematic research into the design of care environments. Addressing the issue of signs and cues the authors concluded signage lacked a sound knowledge base and is difficult to evaluate.

14. A Cochrane Review of physical environment designs and quality of life, including wayfinding cues is currently underway. This is required, for as the protocol states "the evidence for the impact of small-scale or large-scale whole facility changes to the model of care on the quality of life of residents remains unclear."

15. The Report 'Inclusive Symbols for People Living With Dementia. Feasibility Research' (2016) examined the support offered by symbols in daily life. The

results from a sample of people living with dementia in their own homes, and hence in all probability more cognitively-able than the residents we accommodate in our memory care communities, demonstrated an inconsistency in responses to a variety of symbols presented. Hesitancy, confusion and a variance in opinion was evident for some 'everyday' signs. A 'literal' translation of a symbol was frequently observed. These findings have implications for using signage in care settings.

16. Habell (2013) reported that room names and numbers are increasingly ineffective for advanced dementia …. but symbols and logos maybe indecipherable and confusing, and this can include female and male outlines on toilet doors.

17. Consequently in memory care communities 'natural cues' (along with good visual access) are better solutions to disorientation because they are less likely to be misunderstood and importantly encourage us to design environments that are meaningful, so a lounge looks like somewhere you would sit, rest and relax and a dining room looks like somewhere you would eat. You do not need a sign to tell you. Zeisel et al (2003) found that aggressive and agitated behaviours were reduced when the environment was one that residents with dementia could understand. Following this line of thought means the only design-critical symbol that is required is a toilet symbol as natural cueing is not possible because we preserve dignity and promote hygiene by having the toilet door closed.

18. This critique is only addressing the use and benefit of signage and symbols for residents living with dementia. It goes without saying that directional information for families and visitors is required as would be the case in any building that is welcoming members of the public. This would take the form of the written word. For example, in our Harmony memory care communities, the communal toilet doors are coloured blue with the male and female symbol, but the visitors' toilet door is a different shade of blue with words - 'Visitors' Toilet'.

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Appendix 2

HC one The kind care company

Ghyll Grove

Kennett Unit

Before & After Photographs
06/03/2019

Kennett Corridor Before




Kennett Corridor After




Main Lounge Diner Before

Main Lounge Diner After

9. Disclaimer

Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at and during the time of our visit.

10. Copyright

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