Enter & View DCC Summary Report

March 2018

For visits commissioned by Derbyshire County Council 2017-2018

WHAT IS ENTER AND VIEW? Healthwatch Derbyshire (HWD) is part of a network of 152 local Healthwatch across the country established under the Health and Social Care Act 2012. Healthwatch Derbyshire represents the consumer voice of those using local health and social services.

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

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

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1. The context

During 2017/2018, Healthwatch Derbyshire was re-commissioned by Derbyshire County Council (DCC) to conduct a range of unannounced visits to 13 of their 26 residential services across the county. The service profile and range included 11 services supporting older persons and two services supporting people who have learning disabilities/difficulties.

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

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

These Enter and View visits were commissioned to complement DCC's own internal quality audit system and individual reports have only been made available to DCC. However, as with the previous year, summary reports are agreed to be placed in the public domain as is usually the case with all other Healthwatch Enter and View reports.

2. Completed visits

No.	Service Visited	Type of Service	Date of Visit	Authorised Representatives (ARs)
1	Rowthorne House	Older Persons	May 16th 2017	Barbara Arrandale & Yvonne Price
2	Goyt Valley House	Older Persons	May 23rd 2017	Lesley Surman & Caroline Hardwick
3	Gernon Manor	Older Persons	June 20th 2017	Caroline Hardwick & Helen Barker
4	Morewood Centre	Learning Disabilities	29th June 2017	Shirley Cutts, Brian Cavanagh, Denise Bowles (SAR) supported by Margaret Morrison
5	Beechcroft	Older Persons	9th August 2017	Brian Cavanagh & Andrew Latham
6	Thomas Colledge House	Older Persons	15th August 2017	Philip Arrandale & Yvonne Price, Emma Kellett (SAR) supported by Margaret Morrison
7	New Bassett House	Older Persons	19th September 2017	Barbara Arrandale & Jacquie Kirk, Emma Kellett (SAR) supported by Dave Mines
8	Ladycross House	Older Persons	29th September 2017	Dave Mines & Keith Eaton
9	The Grange	Older Persons	6th October 2017	David Corrigan & Dave Mines
10	Briar Close	Older Persons	11th October 2017	Brian Cavanagh & Mary Beale
11	9 Victoria Street	Learning Disabilities	10th November 2017	Barbara Arrandale & Jacquie Kirk
12	Hazelwood	Older Persons	15th November 2017	Keith Eaton & Kay Durrant
13	Castle Court	Older Persons	23rd November 2017	Ruth Barratt & Mary Beale

Some visits are attended by our Specialist Authorised Representatives (SARs) who are people who have learning disabilities. They have been trained since 2016 and whilst initially using their expertise with visits only to learning disability services, they now act as ARs across all services.

The SARs require support by another AR during their visits, as identified above, and have an easy read checklist to use (Appendix 2).

3. Acknowledgements

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

4. Purpose of the visits

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

5. Disclaimer

This summary report collates the findings gathered across the range of visits undertaken on the specific dates as set out in Section 2. Such individual visit reports are not suggested to be a fully representative portrayal of the experiences of all residents/clients and/or staff and/or family members/friends encountered, but do provide an account of what was observed and presented to HWD ARs at the time of their visits.

6. Methodology

During visits ARs are provided with a set of standardised evidence gathering tools and generally employed the following techniques in undertaking each visit:

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

7. Summary of key data and findings across all visits

- Each visit on average took approximately 3 hours 10 minutes to undertake
- Observations by ARs generally included the full range of residents/clients and staff present during the visit plus any visitors who were present
- Due to the nature of the capacity limitations of many residents/clients, discussions and/or questionnaire based interviews were restricted. In total:-

(i) 56 individual residents/clients were engaged with and participated within their capacity in responding to questionnaire based interviews

(ii) 27 relatives/friends participated in questionnaire based interviews

(iii) 38 members of staff participated in questionnaire based interviews

- Healthwatch reports from previous visits were broadly comparable to those findings from this set of visits with good standards maintained in most cases
- Services provided homely, welcoming, clean and pleasant environments of care
- The homes demonstrated a good standard of care being delivered by committed, enthusiastic and skilled staff
- There is a high degree of satisfaction with the quality of care experienced and confidence in the staff expressed by both residents and relatives encountered
- Some general improvements in dementia-friendly design and signage was noted compared to last year's findings
- The challenge of expanding en-suite provision within the mainly older buildings which prevail, is acknowledged
- A few homes still require attention to garden areas with some posing possible safety/security concerns due to being easily accessible from outside.

8. Detailed findings across all visits

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

Generally homes were noted to be sited in good locations in close proximity, (except for three) to their local community facilities. Most of the buildings were of an older type of design (1960s -1970s).

Externally, all but three of the homes presented well with a satisfactory level of maintenance evident. The homes, where maintenance was required, included up-dating of windows and to varying degrees, house frontage redecoration and attention to front garden areas. It was noted that one home visited was at the time under consultation for proposed closure due to the costs of repairing and refurbishing the building.

Parking facilities were noted to be limited at three locations and this included some restrictions to, or absence of, any dedicated disabled parking. One relative at one of these locations informed ARs that, ***"Parking is a nightmare"***, whilst at another location a relative explained to ARs how much difficulty they had had in parking their mobility scooter.

It was noted at one home that the issue of a dedicated disabled parking bay had been raised at the previous Healthwatch visit in 2016, but did not appear to have been acted upon. Following this year's visit Healthwatch were assured that the matter would be referred to DCC Property Maintenance.

Adequate signage to clearly locate the home was generally satisfactory. Two homes had sign boards obscured by overgrown trees/bushes which were attended to according to the response to the recommendation received. Another home was seeking support from DCC to introduce an additional sign to make the location of the home clearer to visitors.

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

In the vast majority of sites, ARs consistently reported positive impressions on entering the homes. Generally the entrance areas were clean, welcoming spaces and provided seating and relevant information for visitors. Two homes were noted to have less spacious entrance areas which were more physically restrictive and were considered less accessible for anyone who may have been a wheelchair user. In all visits, ARs were warmly welcomed by staff.

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

Visiting times across services were flexible with some maintaining 'protected' meal times and requesting relatives/friends of residents to avoid visiting at such times wherever possible.

The majority of services provided good facilities for visitors to meet their loved ones in socially comfortable areas and if more privacy were required the option was to use the bedrooms of the resident or a staff office space. Some homes had managed to create dedicated spaces one of which was described by ARs as, ***"… an extremely well appointed and tastefully decorated room named the 'tea room' … where visitors and residents can make refreshments and relax together."***

Two homes had more challenges in providing adequate spaces with one suggesting that residents and visitors chose to congregate in what was a rather confined foyer/reception area. However, following the report's recommendation the home is reviewing how best to improve the spaces available. Another home with difficulties in providing adequate space for relatives to meet loved ones had previously requested, without success, for DCC to convert a bedroom for this purpose. Following the report's recommendation they are due to consult further with relatives on the matter.

Refreshment facilities for visitors were generally good with a majority having dedicated kitchenettes where hot drinks and other refreshment could be taken.

Provision for overnight stays for relatives was available across all homes but in some there were only chairs to sleep on unless there happened to be a spare bedroom to use at the time. However, no relatives interviewed were believed to have had a need to use overnight facilities and had not raised this as a concern.

Relatives/friends interviewed all felt adequately involved in the support of their loved ones and they all felt comfortable with raising concerns if and when they arose. Relatives interviewed appreciated the regular invitations from most homes to Relatives/Residents' Meetings to ***"keep them in the loop"***, as one relative expressed it. One home had established themed events including a meal for relatives which are always well attended. The same home produces a regular newsletter to alert family and friends to the programme of activities which, space permitting they are able to attend, and report on the outings and events that have been undertaken.

Relatives/friends interviewed tended to speak with evident satisfaction with the overall care that their loved ones were receiving. Example comments received about staff and homes were, ***"first class"***; ***"excellent"***; ***"warm and caring"***; ***"totally welcoming"*** and ***"a home from home"***.

8.4 Internal physical environment

8.4.1 Décor, lighting, heating, furnishing & floor coverings

Generally this was considered very satisfactory across the homes visited whilst acknowledging that all homes are in a constant cycle of maintenance repair, redecoration and refurbishment. Where deficits were noted and reflected in recommendations, Healthwatch were reassured that the issues were to be addressed in the refurbishment planning process or more immediately with maintenance issues. For example, in one of the learning disability services clients interviewed referred to the environmental comfort of the home and commented, ***"It gets hot and cold – hot at night."*** The manager confirmed with Healthwatch after the visit that, ***"A heating engineer has been out to resolve the problem with the heating and to bleed the radiators."***

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

In some homes it was noticeable that extra thought had gone into making corridor areas appealing and stimulating environmental features. In one home there were various themes displayed around the corridors and incorporated an old style telephone box, a mannequin wearing a wedding dress, an old sewing machine and a china cabinet all of which presented opportunities for conversations with residents. In another there were a range of eye catching and colourful pictures, posters and ornaments which adorned the walls.

8.4.2 Freshness, cleanliness/hygiene & cross infection measures

The standard of hygiene and general cleanliness across the homes visited is very good. In the vast majority of homes ARs often noted the absence of offensive odours which reflects well on those standards. This left ARs with a positive overall impression of the majority of homes being unquestionably fresh, clean and tidy environments.

Some faint odours were discerned during two visits and ARs were reassured that the source i.e. specific bedroom carpets were known and these were due to be replaced.

Other than this there was only one other isolated incident of the overall high standards of cleanliness not being maintained where a bathroom hoist was noted to be soiled and to which the manager responded very positively to the resultant recommendation stating, "***This was an isolated incident at the time of an inspection. Senior care staff are aware that they need to prompt staff to ensure no reoccurrence and the issue will be raised at our next team meeting."*** During the same visit, dirty and faulty extractor fans were observed and these were equally confirmed to have been addressed and rectified.

Resident hand hygiene particularly pre-meals, has been noted as an issue raised by Healthwatch in previous reports. There was no evidence that this was not now being addressed within all homes and in one visit a number of residents were observed being assisted by staff to wash their hands before lunch.

8.4.3 Suitability of design to meet needs of residents

Eleven of the homes visited were supporting older persons who commonly were living with varying degrees of dementia and additional mobility problems. The other two homes supported people who have learning disabilities (some with additional physical disabilities) offering short term/respite care and independent living training facilities. Overall each of the homes were designed well in meeting the needs of those using the services.

The majority of homes used the communal spaces well, creating a variety of areas for quieter or more interactive purposes and the ambience created was purposeful but relaxed and sociable. Observations reflected that residents, with a variety of additional needs, moved around their home environments with comfort and ease. Residents and relatives interviewed consistently expressed their general satisfaction with the care and provision that each home offered.

As referred to under 8.1, the majority of homes are of an older style and the designs tend not always to be ideal. Bedrooms tend to be modest in size and only 3 three of the 11 homes were recorded on visits as having shower en-suite facilities and another equipped with wash basins. In one home ARs were informed at the previous year's visit of plans to create a large dementia friendly unit providing five fully en-suite bedrooms. However, at the visit this year it was discovered that this project had not developed as anticipated and had been changed to create a well-appointed activities facility and residents' kitchen. Nevertheless, this development is welcomed as previously it was reported that the home had lost the use of the rehabilitation kitchen which used to be much enjoyed by residents.

It was also noted that in a few homes that corridor areas tended to be relatively narrow. However none of these issues were commented upon negatively by either residents, relatives or staff. In one of the homes where en-suite facilities were available residents told ARs that they, ***"… liked their rooms"*** and were ***"very comfortable"***. Another resident told ARs that they had, ***"… books and music and a TV"*** which enabled them to do the things that they enjoyed.

Internal navigational and orienting signage has been identified previously by Healthwatch as an area to improve in some homes but the vast majority appeared to have satisfactory systems in place. Further attention to dementia friendly signage was only identified as part of recommendations in three visits but a further recommendation was also made to improve signage in a learning disability service.

In one of the older person's homes, a staff member identified the issues stating, ***" … the doors ought to be colour coded and the signs improved"*** and the response to the subsequent recommendation from the manager indicated that this had, ***"... been added to our improvement list"***.

Within the learning disability service some signs were not adequately designed with colour contrast, and menu images were in need of attention. The response by the manager to the recommendation made stated,

"Widget software to be purchased to enable person centred signage and larger context. Reminder for all staff to change pictures to reflect menus is to be discussed in staff meeting".

The majority of older person's homes incorporated various memory stimuli for residents throughout the homes including displays of physical objects, as referred to under 8.4, and nostalgic images on the walls such as pictures of 1940s film stars. In one home, bedroom doors not only had the name of the resident but a photograph of them and a memorable image such as a picture of a much-loved pet.

8.5 Staff support skills & interaction

8.5.1 Staff appearance/presentation

All staff encountered presented themselves in a smart professional manner. Most staff wore a uniform with different colours discriminating their roles. Name badges, however, were not worn and this was explained by one manager as follows:

"Staff are all issued with DCC name badges but do not wear these when on duty due to manual handling [activities] ***and risk of injury to client. Management and seniors have name badges that are worn but taken off when assisting staff with clients."***

All staff were observed whilst engaging with residents to be polite and cheerful. They all appeared to know the residents well and were able to adopt a warm, relaxed approach with each individual accordingly. In some of the homes the staff group consisted of mixed genders.

The views obtained from residents and relatives about staff were consistently complimentary. Residents typically said,

"They are lovely."
"I get on with them grand."
"We get on pretty well together, they are friendly."

Relatives provided such comments as,

"The staff are lovely."
"There's a lot of TLC in this home."
"No problems at all with staff … we have worked together … they do an amazing job in very difficult circumstances."
"They bend over backwards to help you."

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

8.5.2 Affording dignity & respect

Staff were considered by ARs to be constantly providing practical care in a highly skilled manner to support each individual's dignity and respect. Staff were always courteous and polite, speaking in a friendly quiet manner to support privacy. Each resident spoken to confirmed that they were addressed by their preferred name. Staff sought consent of each resident when offering assistance and appeared to be appropriately tactful and discrete during interactions.

Where male staff were employed it was apparent that residents were consulted about whether they had a staff gender preference in their care. When asked about this a resident in one home confirmed, ***"If you want, you can choose."***

Evidence of thought and attention to detail was apparent at one home, where a relative recounted to ARs, how the home manager advised the family that if they brought in some trousers for their mother this would provide her with greater dignity when she was being hoisted.

8.5.3 Calm, empathic approach to care giving

As stated in 8.5.2, Healthwatch has consistently found across all homes that the quality of personal care is delivered within a calm, caring atmosphere.

In their interactions with residents, staff are noticed to use patience and gentle persuasion to meet the individual's care needs without causing undue distress to the resident. At the same time appropriate humour and friendly 'banter' between staff and residents was not uncommon. Staff were observed to maintain good eye contact during care and made sure the resident could see their face when they were talking to them.

Much satisfaction was expressed by both residents and staff across the range of visits undertaken. Comments from residents typically included:

"I'm looked after well and the staff are friendly."
"I'm grateful for being looked after."

Comments offered by relatives included:

"… spot on … I cannot fault the care."
"Looked after properly."
"The care my mum gets here is excellent."
"I didn't want her [referring to their relative] ***to come into a home but they have been amazing."***

8.5.4 Attentiveness & pace of care giving

As indicated in the preceding sections, staff were noted in their interactions to be focussed on the person being engaged with. They showed great awareness of the needs of people being supported and their capacities. There was no sense of people being rushed, and staff were observed to work with the resident at their own pace.

Across all homes except one, there were no concerns raised about the efficiency or timeliness of care/support being offered to residents. Whilst levels of staffing do not explicitly come in to the aspects of consideration of Healthwatch visits, it would appear that these are likely to be satisfactory in the main. Comments from residents reflected high levels of satisfaction in how they experienced the support and care offered,

"I get plenty of help when I need it … it's a really good home."

"If I tell them I'm feeling poorly they are very good, will help anyway they can."

"I always get help when it's needed."

"They [staff] ***are really good and will do anything for you."***

The one concern raised during all the visits came from a resident who commented about the staff saying,

"They could be slow in the morning getting around to helping people," then added, ***"Lots of the residents need help with dressing and getting up now and there aren't many staff so you just have to wait in the morning as they are attending to other people's needs."***

8.5.5 **Effective communications – alternative/augmentative systems & accessible information**

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

The application of the Accessible Information Standard in terms of having alternative forms of written communication according to the needs of residents, seems to have been managed effectively in the majority of homes visited. Pictorial material, for example, was used fairly consistently throughout homes for food menus and to discriminate bathroom and toilet areas. In one home the display menu for meals required some improvement and the response from the recommendation stated, ***"A new menu has been completed and this is also being produced pictorially. It will be displayed on notice boards outside dining rooms and on the tables in the dining rooms."***

At one home, over a lunch time period, ARs observed how a resident who was completely deaf had a carer sat beside her with a pen and note pad helping the resident select what they wanted. The resident was able to indicate her preferences with this assistance. The carer also came back whilst the resident was eating her lunch and wrote on the pad, ***- Is everything OK?*** to which the resident responded with a 'thumbs up' gesture.

Reference has already been made to dementia-friendly signage within the homes (8.4.3) and also where homes have introduced decorative themes and/or memory stimulating pieces (8.4.1). It was evident where homes had introduced such additions such as in corridors (cinema and seaside themes in one home) or bathrooms and/or personalised bedroom doors that it greatly assisted the residents capacity of orientation.

8.6 Resident's physical welfare

8.6.1 **Appearance, dress & hygiene**

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

Laundry services appeared to work effectively in the majority of homes, although in two of them ARs were informed of items occasionally going missing.

Recommendations regarding this were responded to satisfactorily with one home adopting a revised system to reduce future mishaps, ***'Separate laundry boxes have been placed in the laundry room for each resident's items to be placed in once they have been ironed. A lost property box is in place for any unidentified items and laundry staff have been reminded to be extra vigilant.'***

In the other service the response from the manager stated that laundry care was a known difficulty for staff and that senior managers had approved advertising for, ***'a relief laundry assistant'*** who was confirmed as being due to start in November 2017.

Previous Healthwatch reports, as does this one (8.4.3 refers), have noted the limited availability of en-suite provision and acknowledge the challenge of expanding this within the older buildings which prevail. Regardless of this, the last summary report highlighted issues about the frequency and choices residents had with their personal hygiene and washing preferences i.e. either baths or showers. The last summary report recommendation was responded to by DCC as follows:

'The commitment to providing individual support and choice with personal care is laid out in the 'Service User Guide' which is issued on admission and discussed when reviewing their plan of care. The offer of this choice is at times compromised due to staffing constraints and available facilities within the establishment, but these are addressed and contingency plans put into practice.'

During this range of visits there were no specific concerns identified except within one of the homes where a resident said that by choice they would, ***"Like to have a shower every morning,"*** but this seemed not to be possible with the limited time of staff. Another at the home enthusiastically stated, ***"It's great they come and let me know when there are enough spare staff and offer me a bath and I really enjoy my bath."***

Two other residents at the home talked about having regular strip washes using the basins in their rooms and supplement these with a bath each week. In response to the recommendation regarding opportunity, choice and consistency of bathing, the manager suggested that the issue was one of staffing limitations, ***"We have more staff starting in the next two weeks."***

8.6.2 Nutrition/mealtimes & hydration

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

When talking to residents about their meals the vast majority seemed very satisfied and referred to the food as being,

"… lovely and we like the choice, if we want something special they try and do it for us."

"really good"

"choices available every day"

"very filling"

"My plate is empty every meal."

"My friend and I like vegetable curry and the cook will do it for us."

"I find it good. If there is something I don't like they change it."

"… generally very good" [but] ***"occasionally poor when the regular chef is off."***

Menus had variety and choices each day. Some mealtimes at some homes were flexible with residents commonly having options to eat in their rooms or join the majority in a more communal dining occasion. The dining experiences, when observed, were managed well to create a dignified and pleasantly social occasion.

In one service in order to improve meals, the cooks had started to serve meals to residents and get their feedback directly. One of the cooks told ARs that this new initiative sometimes meant that mealtimes were not as well supported by the care team and this made it hard for them to get food out at a good pace. This was noted by the managers and change was promised.

In one service 'flexi breakfasts' were being introduced although the manager told ARs that this is challenging to provide. Equally the manager considered respecting all residents' wishes for where they preferred to take their meals was difficult from a staffing perspective.

In all homes, snacks and drinks were made available by staff throughout the day. In some homes residents could access these themselves if they wished. However, in others these kitchenette facilities were locked and residents were discouraged from making their own drinks, albeit ARs did not receive any comments about this restriction.

In one home ARs observed a water dispensing machine located in the main communal area with jugs of fruit juice and glasses placed on tables in the lounges throughout the day.

8.6.3 Support with general & specialist health needs

Whilst not nursing homes, the nature of the vast majority of residents is that they have a range of health care needs associated with growing older and acquire conditions that the homes need to be able to support. Homes visited indicated that they were well supported in meeting the health needs of their residents.

ARs were informed that in the vast majority of homes, district nurses or nurse practitioners visited regularly as did some GPs or did so as and when required. Services stated that regular access to chiropody and physiotherapy services was available as needed. In one home the deputy manager stressed that there was a comprehensive screening and assessment process on admission ensuring that few residents were admitted with any major existing medical or nursing needs.

However, health needs that inevitably arise need supporting and include enabling residents to attend medical appointments which, whilst only raised in one home, is undoubtedly a common challenge across all the services. One manager informed ARs that she now had a staff contingency to help her plan for staff accompanying residents to hospital appointments.

A resident at one home, who was diabetic, had been started on insulin injections and the district nurse had been going in to the home to give them. However, the resident said that, ***"I couldn't have breakfast until they'd been and sometimes they didn't turn up until ten o'clock or later."*** Some care staff had now been trained to help him administer his insulin of which he was appreciative.

In another home ARs were informed of having a few residents with respiratory conditions and were told that in their bedrooms an electronic device is in situ which indicates, through colour change, the temperature of the room.

For the majority of residents however it is the more common health issues around vison, hearing and mobility that need regular monitoring and intervention (8.6.6 refers). Some homes mentioned regular vision and hearing tests being provided. In one home the manager said that they also have regular liaison with speech and language therapy services.

Following the publication of the NICE guidelines on oral health in residential care homes (July 2016), Healthwatch visits reported on their findings from those referred to within the last summary report. Healthwatch sought confirmation from DCC about their policy on dental care which elicited the following response:

'Professional dental care for individuals is discussed, planned and documented when agreeing their plan of care. This is either arranged by the manager or family members by means of home visits or escorted trips to the practice. The staff provide ongoing monitoring of individual needs and report to the manager any concerns so that issues can be dealt with swiftly.'

During these visits throughout 2017, dental care was only mentioned on a few occasions. One resident told ARs that they couldn't eat properly and needed to see a dentist. The manager confirmed that in this instance the resident had already had an appointment made. In another home, the manager informed ARs that a community dentist also visits on a regular basis.

8.6.4 **Balance of activity & rest**

Homes reflected a stimulating, unpressurised atmosphere for residents to choose to be active or more restful during each day. In the older persons' services, communal areas incorporated comfortable seating and foot stools to aid relaxation. However, in one service a resident commented it could be ***"noisy first thing in a morning"*** explaining that it was because the staff have to raise their voices to allow some residents to hear them, and drawers and cupboard doors are being opened.

In all services music facilities and television was available for entertainment. In the vast majority of homes ARs observed the availability of board games, magazines, DVDs and books. Some homes accessed a visiting library service and newspapers are available on request.

One or two homes had WiFi facilities enabling residents to use their own music devices and lap-top/tablet computers. Whilst ARs did not observe these facilities being used during their visits to the older persons' services, one resident spoke enthusiastically about this, ***"I have brought my computer from home and enjoy using it when I'm in my room. I use it when there are activities I don't want to do and when everyone else has gone to bed."***

In one home residents and staff were also enthusiastic about the parties they organised and ***"… found any excuse they could for one."*** At the time of this visit they were preparing for a BBQ evening and that they had a bar facility to go with it!

Another home had created a social venue in the form of a coffee shop which is set up in a 1950/60's style but the full functioning of this depended on volunteers.

All homes had garden areas and in some homes the residents were involved in gardening activities **(see 8.7.6).**

8.6.5 Ensuring comfort

ARs identified a clear sense of both physical and emotional comfort experienced by residents/clients in all of the homes visited. A number of residents commented on their overall satisfaction of living at their particular home. One told ARs, that they were ***"satisfied"*** with the comfort of the home and that they enjoyed the peace and quiet.

Others said,

"… more than satisfied … can't fault it."

"very comfortable, nice company, home comforts."

"***This place is fantastic I don't know how they do it."***

"… home from home."

8.6.6 Maximising mobility & sensory capacities

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

As referred to previously under 8.4.3, the corridors, in a few homes visited, were thought by ARs to be somewhat narrow to easily navigate with a wheelchair or adequately assist clients who had mobility difficulties. In most cases the services confirmed that the width of corridors was adequate and did not restrict wheelchair mobility or other types of mobility assistance.

In one home it was acknowledged that, ***"… moving around the public areas is sometimes difficult as these spaces are small and can be crowded when relatives visit."*** However, at the same home ARs were informed that in 2007 a new wing of the home was constructed providing wider corridors in order for wheelchairs to pass adequately and substantial hand rails were also fitted.

Structured approaches to promoting mobility was observed in some homes. In one (cited in the previous paragraph) ARs were informed that a member of the care staff had attended the 'Strictly No Falls' training and holds chair based exercise sessions on a weekly basis. Further staff members are due to attend this training.

In another home, which had fairly short corridors, enabled the less mobile to do the short walk from rooms to communal areas with little assistance, and chairs were sited for rest at regular intervals. However, at another home ARs were informed that there aren't enough staff to facilitate the need of one gentleman who needed support but who wanted to walk a lot.

Vision and hearing issues for residents are commonplace across the services and as referred to in 8.6.3. Some homes mentioned regular vision and hearing tests being provided. In one home, ARs were informed that an optician attends on a regular

basis and a new hearing service had been recently introduced as a result of a request from one of the residents' meetings.

Support for hearing impairments was an area of focus in the last summary report particularly in relation to availability of hearing loop systems across the homes. From this report, DCC was requested to clarify the situation and responded as follows:

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

During this set of visits, the situation with availability of hearing loops appeared to be much the same as previously with some homes having them installed and others without. In two of the homes ARs were informed:

"There is a hearing loop available but it is rarely used by residents." and ***"A hearing loop system is available, in all lounges, but not many residents use it."*** Whilst at another home the manager said, ***"A hearing loop is fitted but despite attempts by technical staff it still does not work satisfactorily."***

A few residents with hearing impairments were interviewed and/or observed and appeared to be satisfactorily supported. Aside from the resident who was totally deaf referred to under 8.5.5, ARs observed staff ensuring that hearing aids were properly in place. At one home ARs were informed by the deputy manager that, ***"… maintenance of hearing aids was provided but residents could also arrange their own maintenance via a relative or carer if they preferred."***

At another home the manager reported, in relation to a particular resident that, ***"There is a considerable delay in the supply*** [hearing aids] …**"** and that the family, of this resident, is now considering ***"… going private to speed the matter up."***

One resident informed ARs that they had been for a hearing aid assessment but due to wax being in his ears he wasn't able to have one. Although he had been treated for the wax nothing had been done about sourcing a hearing aid. He also said his spectacles needed changing. The formal response from the manager assured Healthwatch that all relevant appointments had been made.

Those residents with visual impairments appeared well supported and ARs observed that glasses, where worn, were suitably maintained. In some homes large print books were evident as were large print notices on some of the communication boards.

8.7 Resident's social, emotional & cultural welfare

8.7.1 Personalisation & personal possessions

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

Bedroom doors in some homes were personalised with pictures and the person's name (8.4.3 refers). An initiative in one home extended this with the development of, '***This is me ...***' posters for each individual. With one particular resident, this identified a particular activity enjoyed which has now been able to be incorporated

into their care.

Residents were all able to keep personal possessions in their rooms. One resident interviewed had personalised their bedroom with many pictures and items which appeared typical across all homes, and said, ***"… well, it's my home."*** At one home a resident suggested that if a personal item is requested, ***"… we usually get it."***

There appeared to be only one set of 'couples' living at the homes and only a few homes have double bedroom facilities should this be required. The couple that ARs met, a husband and wife, had only been in the home a relatively short time but stated that they wanted a double room but currently they were accommodated in two singles. They commented that, ***"We are desperate for a double room, but we will only get it if someone dies."*** They did go on to recognise that the managers were aware of their situation and that, ***"… it was early days yet."*** From this visit in late September 2017, the report requested clarification on this situation to which the manager stated, ***"The married couple have now been allocated a room and the decorating of their room commences on 8th January 2018."***

In general terms there was a range of evidence about individuality being catered for across homes. All services were able to offer facilities for any residents who smoked with one home having recently refurbished its smoking room. Residents have alcoholic beverages available to them with some maintaining their own drinks. One resident interviewed told ARs that he and his 'neighbour' share a 'nip' of whisky or brandy occasionally. Alcoholic drinks are also commonly made available on special occasions.

Pets were evident in some homes with visitors being welcomed to bring pets with them. Some residents kept their own pets following being duly risk assessed. One resident had two dogs living with them in their room and having them meant a great deal to them.

An initiative on personalisation was introduced in one home by the senior care worker who leads on activities. She had introduced a concept called, "Pimp my Zimmer" which had been presented as a personalisation idea in The 'Caring Times'. The idea being to promote the individualisation of Zimmer frames in making them more attractive and unique to the identity of the individual user.

8.7.2 Choice, control & identity

As indicated through preceding sections of this report, there generally appeared to be a good level of choice and control afforded to residents/clients acknowledging their general lifestyle preferences. This included regularly comments by residents that were able to get up and go to bed at whatever time they wanted. The few limitations that appeared to occur are referred to under 8.6.1 (one resident expressing a wish for a daily shower) and 8.6.2 (free access to drinks and snacks).

Overall the evidence obtained by ARs indicated that the unique identities of residents/clients was being satisfactorily promoted and respected (8.7.1 refers).

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

In one home where some residents had good capacity there was a resident who went to the local shops every day and bought items for other residents on request. Another resident helped part time at a local shop and one commented he liked it as he could come and go as he pleased. Another attended a local social club regularly. One resident was able to sing in a choir occasionally. A resident liked to feed the birds in the garden area as she had spent a lot of time outside previously, and this helped her feel that connection.

Maintaining independence and continuing to be involved in daily living self-care activities is an important element within issues of personalisation, choice, control and identity. The availability and/or encouragement of such activities appeared variable across services visited. Involvement in activities such as making drinks, small scale cooking, washing, ironing or other housework was less commonly evidenced.

Some homes had kitchenettes potentially available to be used by residents but these did not appear to be regularly used in some homes. The resultant recommendations where made, in one instance assured Healthwatch that such opportunities were available, ***"Residents are encouraged to carry out domestic tasks if they wish. Residents … often set the tables for meals … are encouraged to assist with putting their laundry away …"***

In another home the manager responded by saying, ***"Care staff will be using the kitchen for residents to do baking activities. They are currently being used by some residents who wish to make their own cups of tea."***

However, activities such as cake decorating was encountered at one home and, in another one, a resident enjoyed assisting with washing up and staff would provide some dishes after meal times for the resident to attend to in one of the kitchenettes.

One home had introduced an initiative to help with residents' choice and control over the purchase of clothing. A local retail outlet visited the home two or three times each year where residents can buy clothing for themselves.

8.7.3 Feeling safe & able to raise concerns/complaints

Residents and relatives, as well as staff, all appeared comfortable to talk about and question anything of concern with the confidence that what they had to say would be listened to and heard. The close and open relationships between staff and residents/clients was demonstrated across all the homes. Residents were regularly observed speaking freely and openly to staff. One resident captured this sense of trust saying to ARs, that, ***"Right from the beginning*** [of coming to the home] e***verybody speaks to you, everybody is genuine."***

Other residents across homes often expressed that if they had any issues or concerns that they told a member of staff and it was addressed:

"No problems but if I had I would be able to raise them."

"Nothing was any trouble."

It appeared clear to residents and relatives how they might raise a concern or make a complaint should they have one, and this was commonly displayed as a poster on notice boards. It was consistently evident that residents felt safe and secure

within the homes both during the day and at night. They said they knew how to use the call buzzer to get help if needed at night.

Residents' meetings are held in homes with some evidence obtained from an older persons' service about the effectiveness of these e.g. a new hearing service being introduced (8.6.6).

Whilst there were no concerns raised across all visits and all felt confident about their safety and security, ARs did raise some concerns of security with the outside spaces at three of the homes. In these instances it was observed that garden areas were easily accessible from outside and safety concerns were duly raised in reports.

In one instance, however, the fully locked rear gates were suggested in the report to be a possible evacuation danger. The manager responded to confirm that gates had been fully padlocked as a result of the previous Healthwatch visit recommendation, but would now refer the matter to a senior manager indicating that securing the gates would require them, ***"… to be linked into the home's fire alarm system to ensure safety."***

In the response from another (learning disability) service, the manager indicated that the concern had been noted by a landlord's inspection previously and would be reviewed again.

A third setting had an unsecured rear gate which had been a recommendation to address in the previous Healthwatch visit. However, this was not able to be addressed with the issue explained as being problematic due to the rear boundary not being the property of the care home.

8.7.4 Structured & unstructured activities/stimulation

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

DCC in their response from the last summary report explained that:

"… the introduction of the role of senior care worker enables the staff team to have greater opportunities for a variety of direct work with residents. An additional, flexible pot of staff hours has been allocated, which the manager can deploy at their discretion to organise different activities throughout the week."

Further to this a request for some preliminary evaluation of this change was requested and responded to as follows:

"At present it is too early to offer a broad overview in the development of this role. There is, however, signs that in some areas the senior care workers are embracing and developing a leadership role within their service. They are supported through a well-planned and coordinated training programme alongside a framework of professional development to assist them in new skills and to develop confidence. Information with regards to residents' interests and hobbies is being used to develop meaningful activities."

In the main, from the range of visits undertaken, there was broad satisfaction

expressed by residents in relation to what was on offer in the home, whilst there were also others where the same degree of satisfaction was not expressed. In one home, residents interviewed maintained that they were not really aware of there being any organised activities, and in another despite some evidence of arranged activities, a resident said that:

"[the frequency of activities has] ***gone down … they just don't have enough time.***" At the same home, a relative stated in relation to the introduction of the new senior care worker responsibilities that, ***"… there were fewer activities taking place."*** The manager in response to the recommendation regarding this in the report maintained:

"Activities do take place … both in-house and also in the community, when they are accessed by use of taxi or mini bus service. An activities book is used to record all activities that have taken place and this is monitored by senior care workers and management. There is a schedule of upcoming, planned events displayed in the establishment. Many activities have been carried out recently and continue to be, along with upcoming events, also advertised within the establishment for families and visitors to view. Proactive future planning is being undertaken by the deputy manager and supported by senior care workers."

Regardless of the level and frequency of activities offered, ARs only experienced seeing activities being conducted during one of the 13 visits undertaken. Where activities were an established feature in the homes, the most popular appeared to be when some form of entertainment/sing-a-longs were arranged:

"We have visiting entertainers several times a week and I enjoy that."

On the occasion that ARs did witness activities, they observed a game of 'Connect 4' being played, which was well attended and accompanied by much singing and smiling faces from the participating residents.

Other activities that were noted and enjoyed were, arts and crafts sessions which, in one home included creating 'woollen dollies' aimed at helping to maintain dexterity in residents' hands/fingers. In addition to these popular activities were, outings to the theatre, Bingo as well as the visit to the annual pantomime. More active pursuits were also enjoyed such as, chair-based exercises, and on resident said that, ***"They bring in those cones and we have to throw hoops over them."***

Some homes introduced aspects of interest/education into the homes which residents talked about. For example, when a member of staff brought in some chrysalis and residents were able to watch them turn into butterflies over a period of time.

In homes where activities appeared less organised/consistent the staff interviewed told ARs that it is difficult to give time to activities at current staffing levels but they tried. Where recommendations arose regarding the activity offer in homes, responses were encouraging with managers stating,

" …** [the team]* ***is working … to ensure there is regular activities for the residents. There will be an events list done monthly to look at where there are gaps to ensure we can provide a full."

Another response directly to ARs was that the manger had drafted a new proposal to introduce a range of activities that included a coffee morning, music, puzzles, play dough, hand massages and seated yoga.

A further formal response said that:

"A new activity programme has been drawn up and will be displayed pictorially as well as written format. A system has been established for staff to record when activities have and have not taken place. This will be in place by the end of February 2018."

Whilst not commented upon during visits, nor explored to any great extent, was the provision of specific therapeutic activities such as memory stimulation, reminiscence and/or reality orientation interventions. (8.4.3 refers).

8.7.5 Cultural, religious/spiritual needs

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

Most homes have made satisfactory links with local churches of different denominations who either visited the home or could be contacted if needed.

In one of the learning disability services ARs noted that a recently bereaved client had found comfort in the presence of flowers which had been a favourite of loved one that had died.

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

Consistently within previous home reports from 2016 onwards, Helathwatch has identified garden maintenance as a significant issue across a range of the settings. Following the publication of the summary report produced in February 2017, Healthwatch were informed by DCC that a garden maintenance audit across all homes was taking place. In the last summary report (May 2017) where a progress up-date was requested, DCC stated:

"Areas of responsibility and a maintenance programme has been outlined and agreed. The council's property services will provide a low maintenance landscape which they will maintain through a regular service programme. There will be designated garden areas where the manager can involve residents, families and staff to become involved and which will also assist in the development of activities."

Visits undertaken over 2017 took place between May-November and naturally garden areas present differently over the seasons. However, in general there appeared to be more garden spaces that were well maintained compared to those that needed more attention.

Garden areas in many homes are large spaces that demand concerted up-keep in order for residents to fully, and consistently, enjoy, such up-keep includes lawns, planting areas, trees/bushes, fencing and garden furniture. In addition to the presentation of garden spaces, in some instances within this report period, the security of garden areas was also identified as an aspect in need of consideration (8.7.3 refers).

Of the 13 visits made there were four homes where the garden areas were considered by ARs to be in need of distinct attention. Where these were raised within recommendations, the following sample responses from mangers were received:

"New fencing has been erected on one area of the garden. County are currently carrying out a review of the upkeep of the gardens."

"A programme of works is to be completed by 'maintenance' to clear the gardens by Feb 2018. A programme of planting flowers/shrubs/herbs is due in the spring. The issues have also been discussed in the Amenity Committee Meeting regarding buying extra plants/flowers."

"… maintenance of the garden was now in place and had started to improve the space. There were plans to mend and renovate all the wooden items. Maintenance of the grounds is an ongoing task across the whole of our DCC Adult Care residential services. A schedule will be agreed and we can follow up any maintenance not completed."

"Plans are in place and work has begun on the frontage of the building to include seating areas and plants. Residents are taking part in the development of hanging baskets and planters and we have also purchased a garden shed for storage. Derbyshire County Council are providing trimming and mowing of outside areas on a regular planned basis".

As indicated however the majority of homes had well maintained gardens appreciated by residents. At least in one home the garden formed a focus around which the home has been constructed as observed by ARs, ***"… the building design gives all bedrooms a good view of the grounds and every room has access to the garden."***

Some homes had made useful links with their local communities to assist with the costs of the garden maintenance. ARs were informed at two homes that one had been donated a range of garden supplies/equipment by a local retailer and the other had secured funding from a local supermarket Community Grant Fund.

A few homes had residents involved in gardening and had designed the gardens with raised beds and installed greenhouses which residents were involved in growing fruit and vegetables. At one home ARs were informed by residents that they were very proud of the work they had put into the raised beds in the garden and the care of the greenhouse, they were also clearly enthusiastic about being included in a local gardening competition judging event of their garden and were looking forward to attending the awards ceremony coming up soon.

In one of the homes where the garden was in need of attention, a resident told ARs that they, ***"loved gardening"*** and that was the thing she missed most after coming into the home.

For many residents observed and/or interviewed, ARs found the garden to be a 'therapeutic' feature whether they are actively involved or not, as one resident emphasised to ARs about how much she liked the view from her room, particularly the willow tree, and she enjoyed watching the squirrels.

9. Additional issues

9.1 This year, at the request of the CQC, Healthwatch have monitored the display of the CQC rating certificate at each residence visited. In the main these were displayed satisfactorily with two homes needing to ensure that the certificate was up-to-date or displayed more clearly in the entrance area. The DCC website is also regularly checked and this has always been up-to-date with the CQC information clearly evident.

10. Comparisons with previous visits and CQC inspections

10.1 In addition to the above, the Healthwatch Enter and View Officer has introduced two additional elements to report systems generated. One of these is a brief comparative analysis with previous Healthwatch Enter and View visit reports and the other is a similar exercise in comparing the Healthwatch report from each home with the CQC inspection report at the time.

10.2 Generally, the Healthwatch reports from previous visits were broadly comparable to those findings from this set of visits. It was pleasing to note that in most cases good standards had been maintained and in a few instances improvements were noted within areas previously raised as part of recommendations.

In four reports, however, recommendations previously made had only either been responded to partially or not at all and those recommendations were repeated accordingly. In one or two areas there appeared to have been a slight decline in some care aspects compared to previously, with one having made little progress on some of the refurbishment/décor issues that had been noted at the previous visit.

In comparing Healthwatch reports with those from CQC inspections, it is important to note that the Healthwatch visits do not operate in the same way and/or cover exactly the same range of issues which CQC address, but there are commonalities and some overlap. This is with particular respect to the CQC 'domains' which are readily observable or can be judged by resident and visitor feedback and this relates most closely to the domains of 'effective', 'caring' and 'responsive'.

In the main the Healthwatch reports have concurred with those areas that the CQC have identified as either being *'good'* or *'requiring improvement'* with particular reference to these three areas of care delivery.

The CQC ratings, at the time that each Healthwatch report was issued, provided three with an overall rating of ***'good'*** with the remainder all rated as ***'requiring improvement'*** to varying degrees. One home was 'requiring improvement' across all five CQC domains whilst 'requiring improvement' was attributed to two homes over four domains, three homes over three domains (including one domain at one home judged as *'inadequate'*), two homes over two domains and one home over one domain.

11. Elements of good practice/standards of care

- The creation at two homes of a 'tea room' and 1950/60's style coffee shop where visitors and residents can make refreshments and relax together
- Producing a regular newsletter for relatives about the programme of activities and to which they were invited to participate
- Making corridor areas appealing and stimulating environmental features using decorative themes and artefacts from bygone times
- Designing bedroom doors to include the name of the resident, a photograph and a 'memorable' image from their life
- Residents consulted about staff gender preference in their care
- Flexible mealtimes and options where to take meals
- Support of a totally deaf resident in choosing meals
- Cooks serving meals to residents to get their direct feedback
- Snacks and drinks made available throughout the day where residents could also access these themselves if they wished
- Community dentist visiting on a regular basis
- Personalisation of Zimmer frames to make them more attractive and unique to the identity of the individual user
- The construction of personalised '***This is me*** ...' posters for each resident
- The attendance of a visiting library service
- Staff attending Strictly No Falls training and applying this in the form of regular chair based exercise sessions
- Introduction of a new hearing service as a result of a request from residents
- Availability of large print books and notices on communication boards
- Visits of a local retail clothing outlet two or three times each year
- Use of local community funding to assist with the costs of garden maintenance
- Residents actively involved with gardening and growing fruit and vegetables.

12. Recommendations

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

13. Summary report themes and issues for DCC

13.1	To review the adequacy of parking facilities generally and ensure that each home has defined disabled parking spaces available (8.1)
13.2	To consider having 'fold-out' beds available for emergency overnight stays of relatives where homes have no other alternative provision (8.3)
13.3	To seek an alternative safe form and way in which staff name badges may be worn (8.5.1)
13.4	To ensure that opportunities for residents to access drink/snack making facilities are always provided within the least restrictive way possible (8.6.2)
13.5	To provide WiFi access facilities in all home settings (8.6.4)
13.6	To provide an up-date on the DCC development plan following the review of hearing loop systems/auditory support in homes (8.6.6)
13.7	To confirm that opportunities to maintain residents' daily living skills and self-care is optimised across all settings (8.7.2)
13.8	To review the external safety and security of all homes to minimise access risks (8.7.3)
13.9	To provide an evaluative up-date on how effective the introduction of the senior care worker role has been in enabling each service deliver a rich and varied programme of activities for residents (8.7.4)
13.10	To advise on what provision for residents is made for access to therapeutic activities/interventions such as memory stimulation, reminiscence and/or reality orientation (8.7.4)
13.11	To confirm that the agreed garden/property maintenance programme, operated by the council's property services, will provide an effective level of service to all homes (8.7.6).

14. Service Provider response

Derbyshire County Council are invited here to respond to the themes and issues outlined in Section 13 above and provide any comments on the work and impact of the visits undertaken by Healthwatch Derbyshire over the commissioned period.

No	Theme/Issue	Response
13.1	To review the adequacy of parking facilities generally and ensure that each home has defined disabled parking spaces available (8.1)	**Not all establishments have marked disabled parking spaces. We cannot increase the amount of parking space at existing buildings but we will review the available disabled parking facilities at all our residential establishments**
13.2	To consider having 'fold-out' beds available for emergency overnight stays of relatives where homes have no other alternative provision (8.3)	**Not all rooms in our older buildings have space to add a fold up bed. Our new establishments do have space available for relatives to stay.** **Wherever possible we will make a bed available in either a vacant room or with a fold up bed or comfortable chair to enable relatives to stay. We will review our current provision to see if a more effective use can be made of what space is available.**
13.3	To seek an alternative safe form and way in which staff name badges may be worn (8.5.1)	**We will investigate what alternatives are on the market to enable staff to have name badges to enable clients and visitors to identify them.** They would have to be of a type and style that would ensure residents would not be injured when staff are carrying out moving and handling duties.
13.4	To ensure that opportunities for residents to access drink/ snack making facilities are always provided within the least restrictive way possible (8.6.2)	**The opportunity to make drinks and snacks are made available wherever possible. However, this facility has to be risk assessed to ensure they are appropriate to the residents' level of support needs and safety.** **All establishments now offer flexi breakfasts which allow the choice of time and location that residents take this meal.**
13.5	To provide WiFi access facilities in all home settings (8.6.4)	**We are currently reviewing the availability of WiFi accessibility in all our establishments. We will make a decision on improvements once the options available have been identified by the review.**
13.6	To provide an up-date on the DCC development plan following the review of hearing loop systems/auditory support in homes (8.6.6)	**A review of hearing loop systems in all our homes has already taken place. Quotes are currently being obtained for the work required. Once the cost is known consideration will be given to how this will be funded.**

No	Theme/Issue	Response
13.7	To confirm that opportunities to maintain residents' daily living skills and self-care is optimised across all settings (8.7.2)	**The level of resident's abilities and wishes to maintain involvement in daily living tasks and personal care independence are highlighted on admission and recorded in plan of care. These plans are reviewed regularly and amended in accordance with resident's wishes and any deterioration or improvement in their health.** Understanding and knowing more about our residents work history or life style helps us to know if there may have been a task they formerly did and would want to do now. Being able to relate to activities, especially for those with dementia, means past experiences can be used in a positive and creative way. Staff are made aware that residents should be encouraged to maintain involvement in living tasks if they want to, and that they should talk to residents about their wishes and preference to be involved to help inform the updating of Care Plans. Residents are involved in the running of their home through residents meetings, decisions about what their amenities fund should be spent on, activity planning and their own personal care as far as possible. Establishments have safe systems of work to follow to support people needs appropriately.
13.8	To review the external safety and security of all homes to minimise access risks (8.7.3)	**Some work has already been approved to improve the security of outside areas. This issue was also raised as part of a review by the Council's Scrutiny Committee. A review of external security fencing and gates is taking place. Once the outcome of the review is known a plan can be made in accordance with available funding.**
13.9	To provide an evaluative up-date on how effective the introduction of the senior care worker role has been in enabling each service deliver a rich and varied programme of activities for residents (8.7.4)	Not all Senior Care Workers are in post yet and some are currently undergoing training to be Team Leaders. **An ongoing monitoring process is in place to assess the success of the changes whose aim is to provide staff time to offer a programme of activities. Where the Senior Care Worker post is in place informal feedback is that they have allowed for a clear definition of roles and responsibilities and variety of activities are taking place as a result.** This organisational change is allowing staff time to enable residents to get involved in something that is meaningful and individualised for them. Activities are displayed for residents, and staff reminded to residents in a timely manner what is available. Activities are planned at staff handover

No	Theme/Issue	Response
13.9	Cont……..	of shifts for the allocation of activities between the staff.
13.10	To advise on what provision for residents is made for access to therapeutic activities/ interventions such as memory stimulation, reminiscence and/or reality orientation (8.7.4)	**Information on life and work history and preferences is gathered through use of the 'One Page Profile' and in conjunction with information gathered on admission. Information is sought from the resident themselves and those people important to them.** **Families are encouraged to put photo albums and memory boxes together, that can be used by staff to help strike up conversation, get to know the resident, understand what has been important in their lives and get a holistic picture that can be used to best support them.** Understanding what makes someone happy or calm, their preferred routine, etc improves the quality of their life with us. All residents have an identified key worker who will collate this information, update their Profile and Care Plan, and pass it on to other staff. Where we cannot provide an activity or therapy identified as beneficial, outside services are sought. **All our establishments are being reviewed and some work has already taken place to ensure dementia friendly decoration and signage, the upgrading of carpets and provision of pictures. Any work will be undertaken in accordance with the dementia friendly design principles identified by Stirling University.**
13.11	To confirm that the agreed garden/property maintenance programme, operated by the council's property services, will provide an effective level of service to all homes (8.7.6).	**Remedial work has already been undertaken at a number of establishments and it is anticipated that the work will soon be completed.** A monitoring process is in place to evidence progress. Establishments are being consulted about preferences for planting in Spring 2018. **A new service level agreement has been agreed and a meeting has been arranged for ongoing monitoring discussion and re-evaluation after a year.** **Consideration is also been given to the role or Handyperson for establishments to take care of a range of issues including, minor garden maintenance. Our Community Care Homes already have these staff.**