Enter & View
Tri-annual Summary Report

Visits commissioned by Derbyshire County Council 2016-2017

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

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

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

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1. The context

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

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

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

This is the second of three summary reports being produced throughout the commissioning period, the first being published on 13th October 2016. This report represents those visits undertaken from the end of August until 24th October 2016 where reports have been fully completed. Such reports are normally published within six weeks of visits being undertaken.

As the Enter and View reports were commissioned primarily for DCC's own consumption, individual reports are not placed in the public domain as is usually the case with

Healthwatch Enter and View reports. However, a tri-annual summary report was agreed to be made public and published at the end of September, January and March.

2. Completed visits

No.	Service Visited	Type of Service	Date of Visit	Authorised Representatives
1	Thomas Colledge House, Bolsover	Older Persons	Tuesday 30th August	Brian Cavanagh & Caroline Hardwick
2	Rowthorne Care Home, Alfreton	Older Persons	Monday 12th September	Dave Mines & Caroline Hardwick
3	Castle Court, Swadlincote	Older Persons	Tuesday 27th September	Shirley Cutts & Madeleine Fullerton
4	East Clune Care Home, Clowne, Chesterfield	Older Persons	Monday 3rd October	Helen Barker & Philip Arrandale
5	Whitestones Care Home, Chapel-en-le-Frith	Older Persons	Monday 3rd October & Tuesday 25th October	Dr Lesley Surman & Shirley Cutts (1st Visit) David Weinrabe (2nd Visit)
6	Briar Close, Borrowash	Older Persons	Thursday 5th October	Brian Cavanagh, Barbara Arrandale & Yvonne Price (shadowing)
7	Ladycross House, Sandiacre	Older Persons	Monday 24th October	Madeleine Fullerton, Shirley Cutts & Ruth Barratt (shadowing)

Two additional visits were due to be undertaken within the same timeframe as the above but were unable to be completed due to one home being 'quarantined' during the two visiting attempts made, and another due to ill health of an Authorised Representative. Both visits have been re-scheduled and will form part of the next published summary report.

Five further visits have been undertaken since the above were fully completed. At the time of this report, three of these are out with the service concerned and awaiting their response whilst two others are in process of the draft reports being developed.

It should be noted that the visit undertaken to Whitestones Care Home whilst part of the commissioned schedule of visits, was also initiated independently by Healthwatch following the receipt of concerns raised by relatives of users of the Ecclesfold Resource Centre during the consultation about the closure of its short term care facility. Consequently, Section 4 of that individual report included an additional statement of purpose over and above the purposes outlined for all other commissioned visits.

Some visits included an additional Authorised Representative who were newly appointed and undertaking their first visits with experienced Authorised

Representative colleagues to prepare themselves for more independent working in the future.

3. Acknowledgements

Healthwatch Derbyshire would like to thank DCC, the care home unit managers, residents, 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 Authorised Representatives (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, 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 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
- To ascertain how respite care services are organised and identify implications for the service and users following the closure of respite care beds at the Ecclesfold Resource Centre (**additional for Whitestone's visit only**).

5. Disclaimer

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

6. Methodology

During visits ARs are provided with a set of standardised evidence gathering tools developed by Healthwatch Derbyshire especially for the DCC commission of visits (Appendices 1-4).

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

- Direct observation of interactions between staff and residents
- 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
- Observing the delivery and quality of care provided
- Talking to residents, 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 four hours to undertake
- Observations by ARs generally included the full range of residents and staff present during the visit plus any visitors who were present
- Due to the nature of the capacity limitations of many residents, discussions and/or questionnaire based interviews were restricted. In total approximately:

  (i) Thirty-five individual residents were engaged with and participated within their capacity in responding to questionnaire based interviews
  (ii) Nine relatives/friends participated in questionnaire based interviews
  (iii) Twenty-six members of staff participated in questionnaire based interviews

- Generally the services provided homely, welcoming, clean and pleasant environments of care
- The homes overall demonstrated a very good standard of care being delivered by committed and skilled staff
- Most homes in reception areas did not display any staff information for visitors
- Five of the seven services required some attention to internal signage to improve dementia and visual impairment friendliness plus attention to décor improvement in terms of quality and dementia friendly design
- Two of the services referred to above also needed attention to garden/outside space maintenance improvements
- Two homes were undergoing refurbishment at the time of the visits
- Staff pressures in some homes reduced the staff's wishes to have more time to interact socially and therapeutically with residents.

8. Detailed findings across all visits

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

All services were noted to be generally sited in good locations in proximity to their local communities. Most services visited tended to be homes of an older type/style and as such the buildings inevitably provide challenges in terms of external appearance and maintenance.

Some services have been found to have limited parking facilities but it is recognised that this may not always be something that could remedied easily.

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

Regardless of the age of buildings, ARs reported consistently positive impressions when visiting services. Wherever they went ARs felt warmly welcomed by all services.

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

It was noted that there tended to be little or no staff information in reception areas for visitors. It has been suggested that a photographic display board with staff names identified and maybe an indication of who is in charge that day may be useful.

8.3 Facilities for and involvement with family/friends

All homes generally provided good facilities for visitors and maintained flexible visiting times. Most homes discouraged visiting during meal times in order to ensure that residents were not unduly distracted. However, if this was the time that visitors could come, then they were happily accommodated. Most homes had more private areas where visitors could meet their loved ones, alternatively the communal areas were used or the option to use the bedrooms of the resident if wished.

Most homes had freely available refreshment facilities for visitors to use.

All homes had some facilities to offer visitors overnight stays especially where their loved ones were unwell or in the period of end-of-life.

All relatives/friends of residents tended to speak with evident satisfaction with the overall care that their loved ones were receiving. They felt adequately involved in the support of their loved ones acknowledging invitations to Relatives/Residents' Meetings when they occurred. Most, but not all, homes appeared to have regular meetings of relatives. All relatives felt comfortable with raising concerns if and when they arose.

8.4 <u>Internal physical environment</u>

8.4.1 Décor, lighting, heating, furnishing & floor coverings

Overall this was considered generally satisfactory across the homes visited. It was noted that refurbishment programmes were in place albeit that ARs considered that about half of homes visited were in need of some decorative improvements.

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

8.4.2 Freshness, cleanliness/hygiene & cross infection measures

In the vast majority of homes ARs often noted the absence of offensive odours which reflects well on the standards of cleanliness and freshness within them. However, one home visited was perceived as having a "faint smell of urine" in two of the resident's smaller lounge areas.

Some homes maintained hand sanitisers mainly in reception/entrance areas. In one case hand santiser bottles were carried by staff. It is acknowledged that hand sanitizers are a secondary means of reducing cross-infection compared to effective hand washing.

It was noted by ARs that there appeared to be no routine hand hygiene

encouraged/provided for residents before or after meals.

The inconsistency of hand sanitisers being present in homes was raised within the previous Summary Report and elicited the following response from DCC:-

"The Derbyshire County Council Infection Control Policy states that in some areas of establishments water free sanitizer will be provided where there are no suitable washing facilities."

8.4.3 Suitability of design to meet needs of residents

All the homes visited were supporting older persons who commonly were living with varying degrees of dementia and mobility problems. The homes in many respects were designed well in meeting such needs particularly accessibility for those with mobility challenges. There was however evidence to suggest that in some homes dementia friendly decorative design and signage could be greatly improved, particularly in communal areas. In three of the homes specific comments were made by either residents or relatives regarding the sense of confusion in finding their way around the home.

This issue was raised in the previous summary report with DCC offering the following response:-

"Improving way-finding and signage has been agreed as a priority for our Capital and Revenue budget spend this year and all care homes have recently used the King's Fund audit tool to assess "dementia friendliness", and one aspect highlights appropriate signage. Procurement of appropriate signage is being arranged centrally to ensure consistency in our approach in future."

Of the homes visited, about half had en-suite facilities in bedrooms which was previously commented on within the last summary report. However, with this group of visits there appeared to be no major problems for residents accessing the choice and availability of baths and/or showers as also identified in the last Summary Report.

8.5 Staff support skills & interaction

8.5.1 Staff appearance/presentation

The impressions given by all staff encountered was of appearing both physically smart and professional in their approaches as well as being polite and cheerful as they went about their work. They commonly talked about the pride they had in conducting their work which reflected in their approaches taken.

The following sub-sections (8.5.2-8.5.4) were often reinforced by the testimony of residents spoken to as well as relatives and reflects the overall undoubted quality of the care work-forces across the homes visited.

8.5.2 Affording dignity & respect

This was generally considered to be managed in a highly skilled manner. Staff appeared to be constantly employing high level practical and interactional skills to support each individual's dignity and respect. Consent appeared to be naturally obtained during all interactions. Conversations with residents were often conducted using a quiet tone to promote privacy.

As reflected by the 'caring professions' generally, staffing in the homes is

predominantly female. In one home a male resident said he would rather have his personal care managed by a male and whilst male staff were employed they were not always available on duty. Other homes sought preferences from their male residents and another was actively recruiting for male staff.

One home was observed to have a serious challenge with a male resident who exposes himself in front of female residents who expressed their distress at such behaviour to the visiting ARs. This resulted in a safeguarding dialogue between Healthwatch and the home who put in place additional measures to address the issues.

In one home a particular issue of residents wandering into private bedrooms of other residents has been addressed by installing threshold gates to bedrooms where the resident prefers to keep their door open at night. In addition to this, sensor mats have been installed to alert staff if someone is approaching the bedroom.

8.5.3 Calm, empathic approach to care giving

All interactions between staff and residents appeared to reflect care and sensitivity. Staff created a calm approach to all interactions and showed high levels of skill in their gentle approaches especially when interacting with residents who showed distress or confusion. Staff listened patiently to residents and employed good communication skills. There was evident pride and satisfaction during interactions with residents. This is something that staff commented on in at least two homes as feeling that they do not have as much time as they would wish to do this.

8.5.4 Attentiveness & pace of care giving

Staff were noted in their interactions to be focussed on the person being engaged with. They were also proactive in supporting individuals showing 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 generally work with the resident at their own pace.

With the exception of one home, staff were observed to respond in a timely manner to the needs of residents. ARs in one visit were informed by both a resident and relative that staff were not as responsive and considered 'too busy' elsewhere in the home to be able to offer the support needed.

8.5.5 Effective communications – alternative/augmentative systems & accessible information

The personal communication strategies employed by staff were generally very good as outlined under 8.5.3. However, as indicated under 8.4.3, some improvements in dementia and visual impairment friendly design and signage is needed in some areas.

Alternative/augmentative systems of communication were not readily in evidence nor necessarily obviously required by residents.

In some homes the doors of bedrooms are distinguished from one another by personalisation, and one home has developed **"this is me"** profiles displayed in the bedrooms which provides new staff with significant information portraying the person as an individual and outlining their care preferences.

One relative suggested that some form of communications book or diary might be

left in residents' rooms as a two-way communication system when they visit.

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 chosen appropriately on their behalf. Only at one home were one or two male residents considered having a less tidy and cared for appearance compared to others.

Residents and relatives considered laundry services to be efficient.

The predominant population of women residents had regular access to and used hairdressing and manicuring services available in most of the homes.

At one home a resident explained how her chest of drawers in her bedroom had been labelled in order for her to find the clothing she wants more easily.

8.6.2 Nutrition/mealtimes & hydration

Generally meals were considered by residents and relatives to be of a good standard with a range of choice. In two homes there was less satisfaction expressed by an individual in one home, and two residents in another. ARs observed a lunch of soup and sausages in one of these homes not appearing to be so popular with residents. In two homes, including one just referred to, a few residents suggested that the serving of their meals was too slow. Within the home previously referred to, two residents said that it was a regular occurrence for them to wait for their dessert to be served. In another home an individual resident suggested that, ***"They need more staff on to help at mealtimes as there are only two moving the trolley and serving."***

ARs shared mealtimes with residents during some visits and felt that the food they had was of a good standard.

The dining experiences generally were managed well to create a dignified and pleasantly social occasion in which residents could take their meals. It was noted that in many of the homes residents wore bibs at mealtimes but no one seemed to object to this.

In one home it was noted that staff eat with residents. In some homes residents ate in intimate groups of four and in another residents had been consulted as to who they would prefer to share their dining experience with. In one or two homes some residents suggested that the serving of their meals was slowed down by there being insufficient staff on duty.

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

8.6.3 Support with general & specialist health needs

Homes visited appeared to generally be well supported in meeting the health needs of the residents. It was apparent that, in many, district nurses or nurse practitioners visited regularly as did some GPs. Regular access to chiropody and physiotherapy services appeared to be available as needed and some homes mentioned regular vision tests being provided. One of the homes, however,

appeared to have particular difficulties in obtaining health and social work support for the changing (often deteriorating) conditions of some of the residents. Particular mention was made of accessing social work reassessment of needs and obtaining mental health support services.

8.6.4 **Balance of activity & rest**

Homes generally reflected a stimulating but unpressurised atmosphere for residents to choose to be active or more restful during each day. Communal areas incorporated comfortable seating and foot stools to aid relaxation with music or television available for entertainment. Generally there were areas where, for example, books or board games were available although ARs did not observe these facilities being used during their visits. Gardens were also available to access during good weather (see 8.7.6).

Bed times and getting up times were considered flexible and residents appreciated this choice and freedom.

One or two homes had an on-site tea-room/café which was generally well used by residents and some members of the local community. One café was also used as a focus for gatherings before and/or after the event of any funeral.

Some homes appeared to employ an activities co-ordinator organising programmes of activities to meet residents' needs (see section 8.7.4).

8.6.5 **Ensuring comfort**

ARs overall identified a clear sense of both physical and emotional comfort in all of the homes visited. All residents appeared to be relaxed and comfortable within the environment of the home.

8.6.6 **Maximising mobility & sensory capacities**

Across all visits it was noted that residents were generally encouraged to maintain their mobility. As indicated under 8.6.3, homes seem to have access to and or regular visits from chiropody and optician services and one home mentioned visits from an audiologist. No mention was made and no evidence collected regarding dental service support. There was evidence that glasses were looked after by care staff but no mention was made of support with hearing aid maintenance. Hearing loop systems were not evident in three of the homes visited despite the DCC response from the previous summary report stating that,**"All homes have a loop system installed".**

It was also less common for ARs to come across clear evidence of sensory and/or cognitive stimulation being routinely used.

8.7 <u>Resident's social, emotional & cultural welfare</u>

8.7.1 **Personalisation & personal possessions**

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

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

All homes encouraged and supported the pursuit of any hobbies residents had and

involvement in local community activities was evident for some. Whilst pets were evident in some homes, in others there appeared to be an absence of pets, large or small but all homes indicated that this could be possible for residents within reason.

One home however had been innovative and developed some good links with outside agencies in providing activities including "ZooLab" who provided visits to the home with interesting 'petting' animals and others of interest.

8.7.2 Choice, control & identity

As indicated through preceding sections of this report, there appeared to be a good level of choice and control afforded to residents with their unique identities generally being promoted and respected.

Where capacity allowed residents maintained control of their money and held their own bedroom keys. Residents had lockable drawers in their rooms or could use the homes safe if preferred.

Where possible residents had freedom of movement outside of the home following appropriate risk assessment.

Alcohol was available to residents who enjoyed it and some visited their local pubs. Some homes had facilities for those residents who smoked.

There was no evidence of residents having close personal relationships but homes indicated that ways of supporting these would need to be found if they occurred.

8.7.3 Feeling safe & able to raise concerns/complaints

All residents encountered by ARs expressed their confidence in raising any concerns, as did relatives that were met. Residents' Meetings appear to be held in most homes but ARs did not obtain any evidence as to the effectiveness of these in raising issues or ideas to help improve the experience of residents.

One home required any complaints to be put in writing which would be challenging for residents, but on further enquiry it seemed that the system would be facilitated effectively.

8.7.4 Structured & unstructured activities/stimulation

As indicated under 8.6.4, some homes employed activities co-ordinators to organise activities and events for residents but some had activities co-ordination managed in different ways, i.e. one as a team approach, one associated with the deputy unit manager role and one home had a domestic also employed for this role.

The issue of activities coordinators featured in the last summary report with DCC responding as follows:

"The recent reconfiguring of staffing arrangements within care homes has involved the introduction of the Senior Care Worker role. One of their responsibilities will be to coordinate a programme of activities which will be delivered by the staff team as a whole. We have moved away from the idea of having one stand-alone activities coordinator and expect all staff to engage in activities with residents whenever possible."

Nevertheless, ARs found the range and frequency of activities a little 'patchy' across the homes ranging from very good and satisfied residents to some homes that were not able to fully use the facilities and resources available to them.

One home acknowledged that activities needed reviewing and another could not operate its café as there were insufficient volunteers. In two homes whilst residents were satisfied overall with activities they expressed a wish to be able to get out more within the local community facilities but this appeared to be dependent upon staff availability.

8.7.5 **Cultural, religious/spiritual needs**

It appeared that the majority of residents were local people coming from a predominantly Christian background. Homes appeared to generally have made satisfactory links with local churches of different denominations who either visited the home or could be contacted if needed.

There was no evidence that the cultural needs of residents either in terms of lifestyle, customs, practices or dietary preferences were not being satisfactorily met.

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

The state of many garden/outside areas has been raised in many individual visits and featured in the last summary report; the response from DCC from then stated:-

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

Within this range of visits, five of the seven homes had well maintained gardens/outside spaces with one of these receiving attention from the DCC Maintenance Division at the time of the visit. Two homes however had neglected, potentially hazardous garden/outside space areas.

9. Additional issues

9.1 Following discussions with CQC colleagues in September 2016, Healthwatch was asked to observe that the current CQC rating certificates were suitably displayed in the homes visited. This has been incorporated within visits and were seen by ARs on most visits. The DCC website is also checked and has always been up-to-date with the CQC information clearly evident.

9.2 In addition to the above, the Healthwatch Enter and View Officer has introduced a comparative analysis of the most recent CQC report with the Healthwatch draft report following its production for each home. This is then embedded into the final Healthwatch report issued. With respect to the common dimensions that both Healthwatch and CQC examine, there has generally been a consistently close correspondence between the two reports.

9.3 The report on Whitestones Care Home was published fully as per Healthwatch policy and sent to DCC, the service, the CQC, Healthwatch England, North

Derbyshire CCG, Hardwick CCG and appears on the Healthwatch Derbyshire website. With respect to the short term care provision, this was considered to be a well-managed service overall with dedicated staff overseeing the service.

10. Elements of good practice/standards of care

- Good facilities for visitors, and in most homes overnight stays are available
- Relatives very satisfied with the overall care of their loved ones
- High standards of cleanliness and freshness within the homes visited
- Staff polite, cheerful and professional in approach
- Staff skilfully supporting each individual's dignity and respect
- Staff/resident relationships reflecting care and sensitivity
- Residents generally appeared clean, tidy in appearance and well dressed
- Dining experiences were dignified and pleasantly social occasions
- Staff taking lunch with residents
- Residents and relatives confident in raising any concerns
- Use of external organisations like "ZooLab" who provided visits to the home with 'petting' animals
- "This is me" profiles of residents in their rooms which capture the person and their care preferences
- Labelling of resident's bedroom chest of drawers to enable ease of finding correct clothing
- The use of bedroom threshold gates and sensor mats to enable greater privacy, dignity and security
- The appointment of dedicated staff to short term care service co-ordination.

11. Recommendations

Individual reports for each home include recommendations that have already been responded to satisfactorily by the services concerned. 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 residential services.

12. Considerations for DCC from this summary report

12.1 To introduce staff information boards in entrance/reception areas for visitors (8.2)

12.2 To advise of the DCC policy regarding homes maintaining relatives' meetings and what systems exist for recording and actioning suggestions or concerns raised by relatives and/or residents (8.3)

12.3 To ensure that residents hand hygiene before and after meals is routinely and consistently provided by care staff (8.4.2)

12.4 To advise on progress being made with the procurement of dementia/visual impairment friendly signage and decorative design for homes (8.4.3)

12.5 To monitor the gender mix of staff groups where male residents have indicated a preference for personal care to be conducted by male staff (8.5.2)

12.6 To ensure that all homes have adequate links and access to social work and community mental health service support for the changing mental health circumstances presented by residents (8.6.3)

12.7 To reaffirm that hearing loop systems are installed in all homes and that staff are aware of how to use them for residents who may benefit from the facility (8.6.6)

12.8 To confirm that dementia-friendly systems for residents to raise concerns or make complaints are in place (8.7.3)

12.9 To advise of the progress and effectiveness in the introduction of the Senior Care Worker role with additional responsibilities to coordinate a programme of activities for residents across teams (8.7.4)

12.10 To advise on the outcome of the review of the garden maintenance contract for care homes (8.7.6)

Service Provider Response

Consideration	Response
12.1 To introduce staff information boards in entrance/reception areas for visitors	We have considered our current position with relation to staff information boards and based on that review we have agreed that they have little value on the basis that both residents and regular visitors already have relationships with staff and know who is who. On that basis the only people likely to gain some benefit from them are infrequent visitors. Therefore we have concluded that the benefits are not sufficient to justify the time commitment required for managers to obtain consent from staff to have their photograph displayed and to maintain up to date photographs. As a result we have decided that we will not display these in our care homes.
12.2 To advise of the DCC policy regarding homes maintaining relatives' meetings and what systems exist for recording and actioning	DCC do not have a specific policy with regards to holding residents/relatives meetings. As part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 addressing good governance, we actively seek their views through meetings and questionnaires. Meetings are held within the care homes throughout the year and all comments are listened to and recorded, the information is then acted upon and the findings and measures taken are

suggestions or concerns raised by relatives and/or residents	fed back. Minutes of the meetings are accessible via the manager. Informal comments made by residents and/or relatives are logged on the clients records and acted upon immediately. These informal comments are monitored to ensure that minor issues are not being repeated and that where necessary, complaints are escalated to formal procedures. The formal Adult Care Complaints policy is available on the DCC Intranet for all staff to access easily. There is also a staff toolkit for dealing with complaints as well as recommendations published by the LGO on producing a high quality response letter. All complaints are logged on clients' records, and responded to by operational managers who are familiar with the circumstances. Where this is inappropriate, an independent Operational Manager can carry out investigations instead. Overseen by the Adult Care Efficiencies and Performance Team, Learning Reviews may be carried out where complaints have been upheld, to identify any learning and ensure learning is shared across departments, as well as improvements to services and/ or procedures made as a result.
12.3 To ensure that residents hand hygiene before and after meals is routinely and consistently provided by care staff	Managers have been asked to raise this concern with their staff team and to observe practice on a daily basis. This not only promotes dignity but also adheres to infection prevention and control.
12.4 To advise on progress being made with the procurement of dementia/visual impairment friendly signage and decorative design for homes	Internal signage for the care homes has now been ordered and managers have been asked to submit requests for artwork after consultation with their residents.
12.5 To monitor the gender mix of staff groups where male residents have indicated a preference for personal care to be conducted by male staff	The gender mix of our workforce is monitored within our Workforce Development group. We recognise that attracting male carers is difficult and we are trying to do this against a backdrop of a national shortage of front line care staff. Direct Care is actively seeking new recruits through new and innovative ways such as advertising through social media. This process is proving positive as more applications are being received from the wider community. Individual preferences are recorded on the

	Personal Service Plan and wherever possible the provision of male support is accommodated.
12.6 To ensure that all homes have adequate links and access to social work and community mental health service support for the changing mental health circumstances presented by residents	Each establishment has links with both their local GP surgery and the local social work team. Managers are responsible for referring changing needs to these services where assessments can then be made. It is important for the managers to build relationships and joint working with these services to ensure that the most appropriate care is given in the quickest possible time.
12.7 To reaffirm that hearing loop systems are installed in all homes and that staff are aware of how to use them for residents who may benefit from the facility	Currently a review of the hearing systems in our care homes in 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.
12.8 To confirm that dementia-friendly systems for residents to raise concerns or make complaints are in place	Adult Care has an easy-read complaints leaflet and handbook. Complaints can be taken in a variety of ways – in person, by email, letter, and telephone or by using our Putting People First complaints leaflet. Our care homes run a key worker system therefore building on the development of trusting relationships. Staff are able to offer support to residents enabling them to raise any concerns about the service they receive and also assist in rectifying it. An easy-read quality questionnaire is sent out twice a year for residents to comment on the care they receive.
12.9 To advise of the progress and effectiveness in the introduction of the Senior Care Worker role with additional responsibilities to coordinate a programme of activities for residents across teams	The introduction of this role has not yet been fully implemented in all establishments. Where this is the case the manager on duty currently allocates activities to the staff on duty that day. We are currently seeking to develop further links with local voluntary groups in order to expand the activities offered and to maintain community involvement.