AGENDA ITEM NO: 12

Report To:	**Inverclyde Integration Joint Board**	**Date: 21 March 2022**
Report By:	**Allen Stevenson** **Interim Chief Officer** **Inverclyde Health & Social Care Partnership**	**Report No: IJB/13/2022/LM**
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Subject:	**CARE HOME ASSURANCE THEMES AND TRENDS REPORT**	

1.0 PURPOSE

1.1 The purpose of this report is to provide an overarching report on the themes and trends identified from the care assurance visits undertaken in the 13 older adult care homes across Inverclyde in late 2021. The report highlights the emergent themes and trends in addition to areas of good practice and areas for improvement. The report is being presented to the IJB for information and assurance.

2.0 SUMMARY

2.1 Care Home Assurance Tool (CHAT) visits commenced across all NHSGGC partnerships in May 2020 in response to the impact of COVID-19. The visits set out with the aim to provide additional clinical input, support and guidance to care homes which were under extraordinary pressure.

This report is based on a series of visits to the older adult care homes which took place in November and December 2021 using the GGC CHAT tool.

Outputs from the assurance visits have been analysed and this report provides a summary of emerging themes, including what care homes are doing well and where improvement work is required.

The report includes feedback and learning captured from the process itself as well as a series of recommendations and next steps.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Inverclyde Integration Joint Board notes the content of this report.

Allen Stevenson
Interim Chief Officer

4.0 BACKGROUND

4.1 Care Home Assurance Tool (CHAT) visits commenced across all NHSGGC partnerships in May 2020 in response to the impact of COVID-19. The visits set out with the aim to provide additional clinical input, support and guidance to care homes which were under extraordinary pressure. This work also aligned to the Executive Nurse Directors responsibilities set out by Scottish Government in which they were to provide nursing leadership, professional oversight, implementation of infection prevention and control measures, use of PPE and quality of care within care homes. Towards the end of December 2020 the roles and responsibilities of the Executive Nurse Directors were again extended to June 2022.

All care homes across Inverclyde received assurance visits in early 2021. Additional supportive visits particularly during COVID-19 outbreaks were also undertaken. Good practice and improvements were identified during the assurance process, with care homes taking ownership of the actions required and working in collaboration with HSCP colleagues to achieve improvements.

The assurance process has continued to be reviewed and updated using a Plan, Do, Study, Act (PDSA) approach. This report is based on a series of visits to the older adult care homes which took place in November and December 2021. The tool utilised for these visits was the current version at that time – version 7, which was updated and agreed in October 2021.

Outputs from the assurance visits have been analysed and this report provides a summary of emerging themes, including what care homes are doing well and where improvement work is required. It should be noted that care assurance visits are just one part of the supportive framework around care homes and sit alongside HSCP day to day relationships with individual care homes, HSCP oversight Huddles and the Care Home Assurance Group. However, the CHAT outcomes give the opportunity to discuss with care homes areas of strength as well as key priorities for the next 12 months. Going forward the Care Home Collaborative (CHC) model will support ongoing improvements.

The report includes feedback and learning captured from the process itself as well as a series of recommendations and next steps.

4.2 **Process**

Visits were planned in accordance with the NHSGGC Standard Operating Procedure (SOP), which was agreed in October 2021. The aim of the SOP is to ensure that the CHAT visits are approached in a consistent, collaborative way that promotes partnership with care homes to achieve high quality care that enables residents to live their best possible life aligned to what matters to them. CHAT visits should be person centred, supportive and collaborative in their approach and provide a link between HSCP to GGC Care Home Hubs to support improvement.

Care Home managers were informed of the planned visits and were sent the CHAT tool a couple of weeks prior to the visit and were asked to self-assess their current position against the criteria. Visiting teams utilised the previous visit report and the self-assessment to provide them with a background on the home pre the visit. Visiting teams were made up of a group of up to four staff representing nursing, commissioning, social work with a senior nurse leading the visit from the HSCP or Care Home Collaborative.

On the day of the visit, visiting teams spent a short amount of time outlining the purpose of the visit with the Care Home manager emphasising that this is a supportive process and asking the Manager about areas of good practice or concern that they would like to discuss. Members of the assurance team spent time walking around the units observing practices – e.g. handwashing, donning and doffing, social distancing and the interactions between staff and residents. Other members of the team looked at training records and care plans, discussing these with staff from the care home. At the end of the visit the

visiting team spent time with the manager giving preliminary feedback highlighting areas of good practice and any areas of improvement.

The visiting team worked collaboratively to complete the visit reports and these were sent back to the Care Home managers for factual accuracy checking and sign off. It is these reports from all 13 older adult care homes which have been analysed to produce this report.

It should be noted that only 12 of the 13 homes received actual visits from the visiting team. Due to upgrade works at Balclutha it was agreed to carry out their visit in late December, however due to the rise in the Omicron COVID 19 variant within the wider community, it was decided to carry out as much of the visit virtually as possible to minimise non-essential footfall to the home. The commissioning officer and Chief Nurse undertook virtual conversations and reviews of evidence and in January 2022 the Care Home Liaison Nurse did a walk round of the home when she was visiting the home to carry out a care visit.

4.3 **Thematic Analysis of Assurance Visits**

The GGC agreed assurance tool which is utilised for the visits focuses on three main areas:

1. Infection Prevention and Control
   - Environment inclusive of effective cleaning
   - PPE and handwashing
   - Laundry and waste management

2. Resident Health and Care Needs
   - Anticipatory Care Planning, caring for people who are unwell and at the end of life
   - Caring for people with cognitive impairment during lockdown
   - Resident safety

3. Workforce, Leadership and Culture
   - Staff resource
   - Staff wellbeing

This report will comment on the key areas of strength and any areas of improvement required in each of these areas, pulling out themes and trends from across all of the homes visited in relation to each of the three key areas.

There were many areas of exemplar practice identified throughout these visits. To illustrate these practices, examples of direct quotes from across the reports themselves have been included at the end of the health and care need section to share good practice. It is beyond the remit of this report to include every example of good practice that was evident, however the random selection included gives a good representation of the levels of care and practice that were observed.

4.4 **Infection Prevention and Control**

There are 69 questions within the Infection Prevention and control section of the CHAT tool, the section encompasses visualisation of the environment, observation of practice and discussion in relation to national Infection Prevention and control guidance. The aim of this section is to provide assurance that the home can keep their residents safe and prevent transmission of infection.

Areas of strength:

All of the homes visited showed a very high level of compliance against the IPC criteria in the report.

In particular –

- Homes had robust processes in place on entry to the home to undertake risk assessments and check LFT status of visitors
- The home environments were noted to be clean, tidy and odour free
- Physical distancing amongst staff and handwashing practice was good and consistently followed as per national guidance
- PPE was readily available and donning and doffing practices were good. Signage and guidance was clearly displayed around the homes
- In relation to admissions and visiting, all homes were implementing open with care, and had good processes in place to ensure regular contact could be maintained with the people who matter to the residents including virtually if required
- Good communication methods were being used to ensure staff were kept up to date of latest guidance
- Equipment and Sluice areas were clean and well maintained
- Housekeeping staff were knowledgeable about cleaning requirements as per guidance, cleaning schedules were in place and maintained
- Laundry areas demonstrated segregation of laundry and clear processes were in place
- The majority of homes are over 85% compliant for their IPC and COVID training
- All homes were aware of the processes to be followed in the event of an outbreak and knew who to contact
- Staff were aware of actions to be taken in the event of a suspected or confirmed case of COVID in the home, and were aware of isolation procedures
- Many homes had IPC champions in place
- Many homes had remained COVID free throughout the pandemic or for significant periods of time during the pandemic

There were a few areas in some of the homes visited where the review team noted that further work remains necessary to support all homes to achieve consistently high standards. These areas of improvement are listed below, and are all included in the actions plans for those individual homes.

Areas for improvement:

- Training was not at 100% for all homes in relation to IPC and COVID, this tended to be due to new staff, lack of time to release staff and difficulties accessing the training
- There were some areas of good practice that were not being captured, for example where homes were carrying out frequent handwashing audits but these were not being documented. Documentation is required to evidence this good practice
- Cleaning schedules didn't always cover all of the areas being cleaned or were not signed. Spot checks were reported but not documented. Documentation is required to evidence these practices
- There were some issues with lack of storage space, which led to inappropriate storage or decommissioning of bathrooms to accommodate storage of equipment
- Some of the homes had environmental improvements to be undertaken which were on work programmes

4.5 **Theme 2 - Resident Health And Care Needs**

There are 33 questions in this section of the tool which is focused on the care being planned and delivered across the home. A selection of resident care plans are discussed to assist understanding of the care planning process - including how staff are facilitating person centred care and personalisation, in addition to application of evidence to provide

safe and effective care.

Overall there was a lot of good practice evidenced in relation to resident health and care needs, which the assurance teams were impressed with. Particular areas of strength are noted below.

Areas of strength:

- There was evidence of homely atmospheres within the homes and that residents rooms were personalised with their own belongings and in some instances décor and furniture
- Positive and caring interactions were observed between staff and residents, and staff were observed to be kind and caring
- Activities were observed to be in progress in some of the homes which residents were clearly enjoying and care plans were observed which articulated 1-1 interests and music preferences
- There were only 6 Pressure Ulcers reported across the 13 homes during these visits and the majority of these had been acquired pre admission, good assessment processes were noted in relation to pressure area care and all homes reported timely access to pressure relieving equipment
- Care plans were person centred and up to date with evidence of regular reviews
- Anticipatory care plans were in place and homes were fully aware of specialist palliative care services if input was required
- DNACPR documentation was observed to be in place

Areas for improvement:

- MUST 5 is in use across all care homes, however in several homes training has not been completed
- Several managers reported issues with regard to contacting GP services due to long delays to get through on the phone. Some homes noted that they now had designated phone lines which had assisted with this, however there appeared to be a degree of inconsistency in provision of this service
- There were several homes who require Confirmation of Death training

Examples of Good Practice:

The below examples have been copied directly from the reports, and provide examples of good practice, high quality care and a person centred approach to care –

There were lots of different areas within the home, for staff to provide meaningful activities that supported individual resident's needs i.e. the quiet lounge with busy bench for a resident who now has dementia, but used to like to work with tools.

The home is involved in many community projects such as Together with Music project which connects them with a local school to carry out various activities.

The home is carrying out a North Coast 500 challenge at the moment and aim to "travel" a total of 500 miles collectively either walking or cycling. Residents are using pedalling machines and total distance being recorded. It has been noted that residents who had difficulties with mobility previously have improved due to participating in the challenge.

One member of staff talked openly about spending time with individuals who walk with purpose, and that with time he has learnt how to engage with them and make them smile.

There is a private Facebook page for the home and families can see resident activities and their family members' participation in these online.

One resident recently successfully visited family in England, this was done in conjunction with various other professionals and family.

There was a strong focus on person centred care, with residents being facilitated to enjoy activities and to eat together in small groups of 2 or 3 where this was their preference and facilitated nutrition and social contact.

We spoke to one family member who noted that in 3 years she had always been very happy with the care her Mother received. She discussed several scenarios where she had been able to have an open conversation with staff about her Mother's specific requirements, where she had been involved and felt supported by the team who clearly understood her Mother and her specific needs in relation to her cognitive impairment.

Evidence of 1:1 activities, include list of interests, music playlists recorded for each resident.

Care plans cover all physical and mental health needs as well as social and communication. They show resident choices for things like food and clothes. Also what toiletries they like, what bedding they prefer and how they like their room to be when they are asleep.

One of the files that was read had a stress distress care plan. It was up to date and detailed distraction techniques. Importantly it identified triggers and signs that the resident's mood was changing.

4.6 **Theme 3 - Workforce Leadership And Culture**

The final section looks at the workforce, culture and leadership within the home. There are 9 questions focused on current leadership, how supported staff feel and the overall culture of the home.

Many staff reflected on how difficult it had been throughout the pandemic, particularly when there were resident deaths in the homes and when the residents were not able to receive visitors. Staff reported that they felt supported by their management teams and were happy in their roles. There were a few homes who have experienced management changes but in the main management teams have remained relatively stable.

Areas of strength:

- Managers reported having structured 1-1 time with their senior management and that they felt supported
- Staff reported strong and visible leadership from their managers
- Managers are involved in walk rounds and audits to gain assurance that policies and procedures are consistently applied
- Good handover processes between shifts were reported with manager input
- Several homes have received awards recently – including Investors in People, RCN – Award for Meaningful Visits during Covid-19 Pandemic and awards from their companies

Areas for improvement:

- Recruitment of staff is an ongoing issue for many of the homes as per the national picture
- Mandatory training is an area which features on several of the homes action plans, as due to unprecedented pressures as a result of the COVID pandemic and in some cases accessibility of training staff are not all fully compliant

4.7 **Action Planning And Hscp Continuing Assurance**

All improvements that were suggested by the visiting team were discussed with the care home manager and captured within action plans by the assurance visitors. Actions are specific and measureable, and all have a named person in the care home as a lead and an agreed timescale for completion.

Many of the homes took immediate action to address areas of concern and fed back once they had reviewed the reports on actions already completed.

4.8 **Feedback And Learning From The Process**

The CHAT process is relatively new and therefore it is useful to gain feedback on the process which can be used as learning, and to develop the process for the next visits. In order to gain this feedback all of the visiting team staff members were asked to attend a virtual feedback session. The session was well attended and several areas for improvement were identified.

Overall the visiting team felt that the homes felt friendly and welcoming and it appeared that care home staff were more relaxed about the process, saw it as supportive and were keen to participate. It was agreed that asking the homes to undertake a self-assessment was really helpful and did meet the aim of the visits being more focused as a result of this.

Several areas for improvement were identified, most of which focused around evidence prior to the visit, clarity around the process and collation of the final report.

Key learning points are noted below –

- To continue with the self-assessment approach, but allow homes a longer time to complete this and request that they complete this electronically to assist with collation of the final report
- Clarity required around the process, particularly pre and post the visit, individual responsibilities and timescales to ensure all of those who are undertaking the visits are clear on what is required and that there is a consistent approach
- Participating in the visits and completing the reports is very labour intensive and is hard to accommodate in busy diaries – more notice and planning around the visits would assist this
- Contacting the home pre the visit to discuss what information is required on the day and confirm who will be attending is helpful preparation
- Until now only 1 nurse has attended the smaller homes as part of the process. Two nurses is beneficial if one of them (CHLN) knows the home and this assists with feedback and follow up of actions
- Collation of 4 separate reports per home is time consuming, having one master copy which everyone adds to, which once completed can be saved in the Master file would be much easier and reduce administrative burden. Process to include feedback to all contributors

- Action plans from visits require monitoring as part of commissioning team regular meetings with homes, to ensure all actions are completed as per timescales
- The feedback meeting was a useful exercise

Feedback was also obtained from the care homes themselves who were sent an email asking them for their experience of the visit and thoughts on what went well and what could be improved for next time. Only one home replied to the email however others provided informal feedback at the time.

Key points from the care home feedback were that overall the experience was positive and staff were happy to liaise with the visiting teams. Care homes found that completion of the self-assessment documentation prior to the visit was very helpful in helping them to analyse their current position.

4.9 **Recommendations For Future Visits**

All of the feedback gained has been pulled together to form the following recommendations, which are being taken forward in preparation for the next visits to refine the CHAT process -

- Self-assessment period to be extended to 1 month and homes to be asked to complete this electronically
- Flow chart to be developed to outline the overarching process, responsibilities and timescales. Flow chart to include preparation calls to the homes
- Flow chart to include process for collation of the reports, so that there is only one version
- Feedback sessions for all involved in the visits to be held routinely
- Programme of visits to be developed and shared for the year
- Two nurses to attend all visits, one from CHLN in addition to the lead nurse
- Action Plans to include names of responsible HSCP staff and to be monitored at regular meetings with the homes
- Action Plans to be collated in to one overarching document which includes every home, to provide assurance of monitoring and outcomes
- Overarching action plan to be discussed with the Care Home Collaborative team to identify areas where they can support homes to achieve compliance, particularly in relation to training requirements and access to this
- To work with the Medical Director, commissioning and primary care colleagues to address the issues of delays to being able to contact GP colleagues when required

Next Steps

CHAT visits will continue to be held on a six monthly basis, or more frequently if there is an identified need for a specific home. All of the agreed recommendations from this report will be implemented to assist both this process and the ongoing support to the care homes locally.

Each CHAT visit where improvements are identified, has led to a specific action plan for that home. These action plans will continue to be discussed and monitored regularly with the homes to ensure that any required support is identified and provided. In addition Managers of the care homes will be able to access the Care Home Collaborative to assist with the provision of advice and/or resource to support improvement, with the hub also offering support for the continuing development of the managers themselves.

CHAT reports for individual homes will all be submitted to NHSGGC for analysis as part of the Quarterly CHC CHAT reports, which are presented to the CHC Steering Group. Overarching themes and trends for GGC are pulled from this process which assists with the ongoing development of the CHC.

This report will be presented to the Senior Management Team (SMT) at the HSCP including the Chief Social Worker and Medical Director for information and assurance, in addition to the Clinical and care Governance Committee and the IJB.

The report will also be shared with the care homes themselves and teams who participated in the visits for information.

5.0 IMPLICATIONS

Finance

5.1

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

Legal

5.2 No implications.

Human Resources

5.3 There are no specific human resources implications arising from this report.

Equalities

5.4 Has an Equality Impact Assessment been carried out?

	YES
X	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

5.4.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	The CHAT process applies to all care homes and residents including individuals from protected characteristic groups
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	HSCP and the visiting teams would act appropriately to any identified issues regarding discrimination
People with protected characteristics feel safe within their communities.	The visiting team work to ensure that all people using the services feel safe.
People with protected characteristics feel included in the planning and developing of services.	Visiting teams speak to all residents and families willing and able to participate in the visits
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	As part of the process visiting teams examine care plans to provide assurance around holistic assessment - to ensure individual need is identified.
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	Any relevant opportunities would be highlighted in reports and actioned

Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	Positive attitudes are always encouraged in all aspects of these visits

5.5 **Clinical Or Care Governance Implications**

There are clinical or care governance implications arising from this report as this report is directly related to the care of residents within the care homes of Inverclyde. The report will be presented to the Clinical and Care Governance committee and all recommendations will be monitored through that governance route. The report is provided for quality assurance purposes.

5.6 **National Wellbeing Outcomes**

How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	**Implications**
People are able to look after and improve their own health and wellbeing and live in good health for longer.	The visits are focused on the well-being of care home residents and person centred care to enhance this
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	The visiting team specifically look at the homeliness and patient centeredness of the care home environments
People who use health and social care services have positive experiences of those services, and have their dignity respected.	The visiting teams observe and discuss aspects of the care home residents experiences and dignity in all aspects of care provision
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	The visiting team are looking at all aspects of quality of life as parts of the process
Health and social care services contribute to reducing health inequalities.	The visiting team foster this approach at all times and take a consistent approach to visits
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	Families and carers are included in the visit discussions if available to do so
People using health and social care services are safe from harm.	The CHAT tool and visiting teams specifically look at this across several domains
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Discussions take place with care home staff as part of the visits and training needs are identified and monitored as part of the action plans
Resources are used effectively in the provision of health and social care services.	Visiting teams look at the effective utilisation of resources in the provision of care

6.0 DIRECTIONS

6.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	x
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

7.0 CONSULTATION

7.1 The report has been prepared by the Interim Chief Officer of Inverclyde Health and Social Care Partnership (HSCP) after due consideration with relevant senior officers in the HSCP.

8.0 BACKGROUND PAPERS

8.1 None.