# Visits to Care Homes

# REPORT

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# OXFORDSHIRE LINk
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This report describes the second phase of the project to assess the quality of life in the care homes of Oxfordshire.

**The enter and view visitors** Twenty duly accredited visitors worked in pairs and followed pre-determined guidelines. They brought to their visits different sorts of professionalism, expertise and specific interests but all were operating on behalf of the public and of recipients of social care in Oxfordshire. They were not inspecting.

**The care homes visited** Twenty four homes from across Oxfordshire were visited between the end of March and August 2012. In addition there were notes from one home visited in May 2011. The homes came in a large variety of denominations: residential homes; care homes; care homes with nursing care; nursing homes; homes caring in whole or in part for those with dementia; a few for those with learning difficulties; and one drug and alcohol rehabilitation project. They ranged in size from caring for three residents to over seventy, two of the bigger ones being part of larger complexes. Some were family owned and run; some were part of longstanding professional organisations; others were part of looser groupings. A few had been established only in the last couple of years or so; considerably more had changed overall management or individual managers in the same time frame. The life-span of most of the homes is not recorded. In location they vary from the grandly – sometimes remotely – rural to the most restrictedly urban, and from the determinedly and recently purpose built to the homely and quirky adaptation of private houses or in one case of a redundant public house. Some homes set a distinctive style, of their own choosing or their parent organisations. To make a modest point, residents' drinking might be sherry parties or even Pimm's but more often in the part-time in-house 'pub'.

**What is or isn't in a name** The notes of visit make plain that the description of a home is not a matter or fixed definition. 'With nursing care' does not necessarily mean the home has qualified nurses on the staff; on the other hand a simple 'care home' may well employ qualified nurses as carers. 'Special care for those with dementia' clearly varies according to the home's understanding of this diagnosis and there was concern that the term was at times loosely applied. At a more practical level, 'single rooms en suite' might mean with full bath or shower and w.c. or perhaps more often with basin and w.c. only or even washbasin only. Visitors favoured the more generous provision.

**Diversity and choice** It does not need saying that every would-be resident of a care home brings a totally individual character, life history and need. A degree of non-conformity in the homes is therefore to be welcomed, but the visits emphasised how essential it is for potential residents and their families or carers to visit and fully understand what is actually on offer. As our visits showed, understanding calls for more than printed information and managers' reassuring words.

**How close can short visits get** Most visits lasted about two hours. For a variety of reasons they often became more 'enter and ask questions or be talked at' than 'enter and view'. Some managements remained stubbornly vague about the standing of the LINk; some owners and managers had work programmes which led to their constant distraction; key staff likewise; in many of the homes the apparent frailty of residents made meaningful conversation with them impractical. All of which made visitors the more grateful for the open welcome and the sharing of thoughts offered confidently in some homes.

**The general picture given by management** National media attention to unfortunate happenings in one or two care homes seems to have re-inforced care home managers' understanding of what visitors are interested in, but not all managers directly control the detail of what they describe. In matters of staffing, almost all quote the same standard ratios though only a minority could actually say how staff were deployed; all stressed their care to appoint only those with 'adequate' English; all said they provided induction and mandatory training, usually using NVQs, but only a few had schedules of individualised training programmes; many spoke of dementia training but only a handful specified courses of known standing. If training is given in stimulation, activities or even reminiscence, it is barely mentioned. Managers are quick to speak of 'personalisation' or 'individualisation' of care but visitors did not see much in practice. Food is said to be fresh and locally sourced where possible, offering choice, with differences in size of portion and snacks available on demand. A few homes stressed the attention paid to hydration and weight, gain or loss. (In one case, proper attention to these matters had allowed the return home of a new resident labelled as a dementia sufferer.) Special diets are said to be no problem, with only a minority using medical prescriptions for, say, gluten free foods. All managers describe satisfactory arrangements with GP practices and district nurses though there are two cases of a retainer being paid for extra local medical cover. Some homes further cite with approval their links with the Falls clinic, the local hospice or psychiatrists from the local hospital. All claim suitable arrangements for podiatry, physiotherapy, dentistry and the like, usually against payment and not necessarily in house. Where the question arose, they all profess very careful medication policies. But if one is really looking for unanimity of answers, it comes in the listing of activities and in the confidence placed in one or more 'activities co-ordinators'

**Daily life as visitors saw it**

First, **who are the residents?** Little detail is available. There are certainly more women than men. Of only one home is it recorded that men and women are fifty fifty. In one home records show that the average age on entry is mid-80s and the average length of stay four years. Other homes quote three years as the average, while pointing out individuals who have been with them much longer. Some homes distinguish between those who are elderly frail and socially isolated and others who have a degree of dementia (undefined). It is understood to be Oxfordshire's current policy only to fund new placements in residential social care in exceptional circumstances. Many residents are part or fully self-funded – not that homes make any distinction in care according to who pays what. Visitors did not, of course, have access to admission assessments or individual care plans. In some homes they had the benefit of conversation with individuals or groups of residents, but in many

homes the state of residents' health made this impossible. On the whole visitors' notes describe a large majority of markedly frail men and women, very accepting of their limitations. (The exception is the drug/alcohol rehabilitation project, which takes ten people at a time for ten week courses, and where 76% of those accepted are said to complete their course.)

**The shape of the day** Any visit is a minute proportion of a resident's week. The weather was often unfriendly. But still the collective notes of visit, with a few encouraging exceptions, portray an unmistakable picture of a life lived almost entirely indoors, mainly sitting or lying down, either in one's own room or more commonly in ordered groups in small or large communal rooms, and often doing nothing in particular. Life is secure – sometimes almost to a fault, with controlled doors and lifts and restricted access for wheelchair users; clean and mainly uncluttered; warm; familiar and comfortable; even comforting – though visitors questioned the need for quite so many soft toys and baby dolls. And all this despite most homes' lists of events, activities and visits, inwards or outwards; and despite the range of facilities available in some homes with their sensory rooms and gardens, their shops, cinemas, tea rooms and so on.

**Activities** The tension seems to be between the irregular happenings organised by usually very keen activities co-ordinators and the more modest and personal activity which can be part of an individual's day to day existence. Further tension may come from the assumptions made by the co-ordinators and care assistants about the attitudes and interests of residents. Not all residents want enforced jollity or pub-type sing-alongs; not all of them will have the background to join in film or television quizzes. Even in reminiscence sessions, there will not necessarily be important communal memories as residents recall the vast differences in their situations some sixty years ago. All the same, visitors welcomed the records of many distractions, even though some of the lists make strange reading with manicurists, hairdressers, visiting clerics, 90-year-old guitarists, primary school children and pat-a-dogs all listed on a par. In all the accounts of activities, there are few signs of specifically male interests – if one may make a sexist remark. And there is limited reference to art, crafts, and music, let alone helping in kitchen or garden or simply reading or knitting – for those who might enjoy these things. It is noted in particular that the range of music on offer does not cater for many tastes.

**Mobility and physical exercise** It is not for occasional visitors to say how much physical exercise and of what kind is suitable for the residents of any given care home, but it is striking that none was seen in 25 visits. One home has a purpose-equipped physiotherapy room, which is promising in that it offers targeted care. Otherwise the reports speak of some music and movement and the like listed as activities, but do not say who directs it. A few homes either have no outside space or have not yet set up what they have so as to allow residents to have access. But others have well set out gardens or grounds, though we saw little use of them. On the other hand, a fine morning and a genuinely open access policy found eight or nine people outside in one home, doing their own thing, with care assistants keeping an unobtrusive eye. This home has well organised generous staffing. ( It must be recognised that the standard 1+4 or 1+5 ratios simplistically applied to rather vague numbers of residents do not easily allow for individuals to be accompanied into the

garden or further afield. It may be that these ratios are too tight given the condition of residents, but staffing costs must be a major concern for proprietors.)

**Encouraging exceptions**

It was reported of one medium-sized specialist home for dementia that 'perhaps the most striking thing in our visit was the activity going on....We found people all over the building in a calm quiet atmosphere....It was hard to believe how very demented residents were. Care staff were very evident talking to, reading, playing a game or just sitting holding a comforting hand'.

And of a very small residential home: 'Although there are no formal 'activities' offered, (the residents) enjoy each other's company.....They were listening to an audio book when we were there, and there are books and games within reach and (the owner's son) assists them with a large print computer, bingo or with television programmes.....They talk lucidly about their past lives and their families.....We were struck by their contentment.'

Or again of a small residential care home: 'the most remarkable thing about this home was the attitude of the many residents we were able to talk to. They feel themselves to be part of a community which enjoys each other's company and, with the help of the staff, find plenty to do to amuse them.....They would not wish to be anywhere else....(and) were grateful to be able to live a supported life but still to be themselves.'

**Fees** The range of fees quoted varies from £500 to £1,400 a week, in some cases varying according to need. Most homes visited are in the £700 to £800 bracket. The major concern for both homes and visitors is what happens to a resident when funding fails. Wherever this was discussed, it seems clear that homes do their utmost not to have to shed a resident.

**End of life care** For homes with a limited remit, end of life can be a very difficult problem. Most again do their utmost to retain the resident and, with expert advice and reinforcement, to care for them appropriately. It is one or two of the more highly professionalised homes which make clear that if extremely challenging behaviour, pain management or palliative care requires, residents will be sent to hospital. The visitors would have liked to be clearer about whether or not living wills or DNR were discussed with residents so that their wishes could be complied with.

**Occupancy and respite** Many of the homes visited are full with waiting lists. Some have empty beds either because they are new or have building works. Most recognize the need for respite beds and many would offer respite beds when they had vacancies. A few have planned respite programmes and a number have a respite bed retained by Oxfordshire, occasionally temporarily unoccupied. One home quoted an arrangement by which local GPs had limited dedicated funds to buy respite care.

**Is there enough support?** Not all the homes have been recently CQC-inspected and some found the process a bit disappointing in focus. Some have had an Oxfordshire social services visit. Those run by a major organisation can and do call upon its collective experience and professionalism. But for many homes, and

particularly managers of homes, it is vital to recognize the complexity of their task and the unremitting commitment asked of them. The best managers take great care to support their staff but without equivalent arrangements for themselves. It is too easy to suggest they visit homes popularly judged particularly successful in this or that: that takes time out from the day to day job, and in any case implementing change in a different context may call for changes of attitude and the acquisition of new skills which daily duties do not easily permit But with the potential growth in the number of care homes and the probable complexity of residents' needs, it would be rash not to seek solutions.

**Reflections on these visits** The first and overwhelming thought must be of gratitude to all the staff, residents and their families and friends who made us welcome and were prepared to talk with us about their work and experiences. No visitor could fail to appreciate the complex demands they all daily confront. But we hope they will understand that, coming from the outside, we may have areas of general concern – which we know do not arise in every home. For those building new accommodation or remodelling the existing, we see a clear need to ensure the maximum freedom of movement, consistent with security, for all residents both within the building and in respect of access to gardens and the larger outside world. Thought may also need to be given to the appropriate extent of private bathroom facilities and the range and nature of spaces for spending time out of one's own room. But above all we wish we could have recorded greater stimulus of residents and greater mobility, with more interaction between care staff and residents and less unintentional condescension in some interchanges. If residents are to spend several years in their chosen care homes, everyone needs to give their minds to the enormous challenge of helping them still to be as far as possible themselves.

## Annex – Profile of homes and district

A total of 30 care homes were visited across Oxfordshire.

Table 1 Care homes visited and district

| Care home | District |
|---|---|
| Fairholme House | Cherwell |
| Lake House | Cherwell |
| Manor House Nursing Home | Cherwell |
| St Anne's Residential Home | Cherwell |
| Wardington House Nursing Home | Cherwell |
| Yarnton Residential and Nursing Home | Cherwell |
| Eden House | Oxford City |
| Fairfield Residential Home | Oxford City |
| Howard House | Oxford City |
| Jack Howarth House | Oxford City |
| St Andrew's Residential Care Home | Oxford City |
| The Albany Nursing Home | Oxford City |
| Vale House | Oxford City |
| Oxford Beaumont | Oxford City |
| Acacia Lodge | South Oxford |
| Lashbrook House | South Oxford |
| Watlington and District Care Home | South Oxford |
| Winterbrook Nursing Home | South Oxford |
| Abingdon Court | Vale |
| Mon Choisy | Vale |
| Oxenford House | Vale |
| Richmond Letcombe Regis | Vale |
| Shrublands Centre Care Home | Vale |
| Sterlings | Vale |
| Enstone House | West Oxford |
| Henry Cornish Care Centre | West Oxford |
| Jasmine House | West Oxford |
| Madley Park House | West Oxford |
| Ramping Cat House Nursing Home | West Oxford |
| The Cotswold Home | West Oxford |