Oxfordshire LINk
Your voice on local health and social care

OXFORDSHIRE RESIDENTIAL CARE AND NURSING HOMES REPORT November 2010 – April 2011

Introduction

There are 142 homes in Oxfordshire. We planned to visit 36 in a first phase and hope to do more in future months. It may be appropriate at some stage to extend visiting to Community Hospitals. Volunteers visited in pairs, writing a short report from each visit. Twenty eight sets of notes have been received so far. Comments and views expressed were those obtained during discussions with managers, staff, residents and their relatives. They reflect the personal perceptions of the individuals.

Each volunteer was asked to undertake a CRB check, to have a short training to make sure that he or she understood the delegated powers under the Act, and each was interviewed for suitability by two members of the LINk Stewardship Group. Guidelines were agreed to ensure that visitors were looking at similar issues.

An e-mail letter was sent by Andrew Colling, Service Manager for contracts, in the name of John Jackson, Director Social Services, to all homes. This was followed by a letter from the LINk project with reassurance that what was proposed was a visit and in no way an inspection, and naming the two people who would make arrangements to visit them. A preparatory visit was thought to be useful when possible but did not usually happen. Many of the homes visited said they had not received the e-mail from the County Council or the letter from the LINk which explained the process. This perhaps points to a general problem in their systems of processing information.

The sample

The homes visited are broadly representative of all homes in Oxfordshire, though with a bias towards larger ones. More than half the twenty eight have between 31 and 60 beds, while a further nine have between 61 and 90. More than half are situated in the city or in the major towns of Oxfordshire and another third in larger villages. More than half are purpose built. A few are in older properties, occasionally listed. The providers may be not-for-profit charities, one or other of the larger commercial companies for care homes, religious orders or private owners. The managers, who generally received visitors with courtesy, even when they were uninformed of the purpose of the visit, were more often concerned with the day-to-day running of their homes than with the administrative details, so that visit notes are sometimes short on some facts, particularly about funding or reasons for vacancies. But despite the non-statistical base, some trends and matters of concern can be confidently recorded, especially as the survey is primarily concerned with the quality of care and of life experienced by residents.

Occupancy

Not all the notes record the numbers of beds occupied. But it is worth remarking that on the days of the visits over a four month period more than a hundred beds were standing

empty. This does not of course mean that at any one time 100 beds were simultaneously empty: nevertheless, this is a gravely disconcerting figure. Some of both the medium sized homes and the larger ones could have a third of their beds unoccupied. Occasionally the cause is given as modernisation or other building work, and a couple of homes are too new to be fully established. But more often it is stated or implied that the cost of the room may be an issue, particularly if County Council funding is involved. The problems arising for management from these vacancies cannot be underestimated, while the problems for those seeking admission are probably even greater. Attention is drawn in one report to the coincidence of empty beds and reported bed-blocking at the Horton.

Respite beds

Visitors paid particular attention to the availability and use of respite beds, which are so important for both those with long-term conditions and for their carers. The picture that emerges is unclear, not very reassuring and with signs that things may be getting worse.

The most common situation recorded is for respite care to be obtainable only when beds are available, sometimes only for weekends. But in about a third of the homes, it is noted that the County Council retains respite beds, usually one per home. These were, however, not always occupied and managers said there were problems over the rate of payment. Interestingly, in two homes, respite beds were regularly occupied by a rota of users, in one case for a week or two at a time, and in the other for anything from a weekend to twelve weeks.

There is some uncertainty in a few sets of notes over beds classified as ‘short stay’ or ‘intermediate care’, and in one case nine intermediate care beds had recently been withdrawn because of unsuitable occupancy.

The managers usually made it plain that they would be happy to provide respite care whenever they were not full and payment could be made at a rate satisfactory to their companies. But, from what we were told, it seems likely that the County Council may be retaining beds which, in the event could not be used because of local funding rates. And would-be occupants of such beds seem likely to have a fairly bleak time when seeking one.

Residents

It is not possible to categorise the populations of the 28 homes visited, other than to note that the very great majority are women. Several homes note having only one or two men. Of only one home is it noted that men are present in sufficient numbers to hold their own. The last traces of the ‘home for gentlefolk’ can still be found and a small number of homes have ‘residential’ wings. Two thirds of the homes visited have numbers of residents with varying degrees of dementia. As a caveat, it has to be said that the terms ‘dementia’ and ‘early onset dementia’ are not always used in their clinical sense. But there is no avoiding the prevalence of the condition. Several homes not registered for dementia nevertheless cope with it to some degree and make clear that, unless there were disturbance for other residents, they would not move anyone on if he or she developed the condition. The other patients in the homes were visibly the ‘elderly frail’, sometimes in need of considerable nursing care. A problem which seems to be of homes’ own making arises when beds are reserved for the young brain-damaged. In one home the only young man in this group had been given dementia training so that he could relate to his fellow residents.

Staffing numbers

Here again there is no clear picture. We have no details from some homes and others list the overall numbers of 'care staff' available to them, without distinguishing between nurses, care staff and care assistants or explaining how they are deployed. About half the homes employ nurses day and night, and those homes that quote their ratios for care staff vary from the standard variations between day, evening and night to the more generous. Most homes list chef, maintenance man and part-time activities co-ordinator. On the whole no problems of recruitment are mentioned, other than for nurses in Abingdon, and most managers insist that they would never employ anyone whose English might not be up to scratch. In many homes notices about staffing suggest that considerable numbers do not have English as their native tongue. We have no information about rates of pay.

Funding

Understandably we cannot say who pays what for whom in the various homes. Some managers were not the right people to tell us. Also, while some homes classified anyone even part funded by the local authority as council funded, others classified anyone topping up a degree of council funding as self funded. We do know that self-funding costs are high, usually between £700 and £800 a week, and even as high as £1096 a week. Against this, figures for funding by Oxfordshire were variously quoted as £367 (reduced from a previous £552) a week or £452 for dementia care. An NHS figure of £760 for nursing care is also given. Without putting too much weight on these reports, one can see the problems for those homes who report 70 or 80% of their residents funded by Oxfordshire compared with those who have mainly self-funding residents. A few managers point out that Oxfordshire pays less than some other authorities. But in any case what anyone pays makes no difference to their care. Staff do not know and in any case would not discriminate.

What managers do make plain is that the rates of local authority reimbursement are a factor in the number of beds left empty. We are sure Oxfordshire is well aware of these problems and is much better informed than we are. We hope, however, that they can reassure us and future would-be residents about the constancy of future provision.

The physical environment

Most of the homes are purpose-built and the rest well-modified. All are well cleaned and fresh smelling. The buildings have lifts and good wide stairs. The great majority of rooms are singles and most are equipped with en suite facilities, wet rooms in the most modern. Less modern homes provide only hand basins and lavatories, and a very few have all sanitation along the corridor. Bathrooms for the disabled are usually available. A few very modern homes provide flatlets which include kitchens. The rooms are generally of a good size, sometimes large. Doors to rooms are normally fire doors, though kept open during the day. In one home where residents with dementia have a tendency to wander, rooms also have either stable doors or hanging blinds so that they are not invaded and occupants still feel in touch. Most rooms have call bells and some, telephones.

Almost all the homes have welcoming, functional, secure entrance halls, some described as of good hotel standard and occasionally with background music. Information is on display, with details of staff and notices in decent size type. Occasionally the information needed up-dating, and it was dispiriting in one home that the manager thought it of no importance that notices were ill-spelt and ungrammatical. The use of jokey notices may

also need thinking about.

Administrative offices are usually near the entrance. Care staff common rooms are less obvious as are the points where call bells register. The common rooms, dayrooms, dining rooms and conservatories, all usually of good size, are generally on the ground floor, though some homes find advantage in having a variety of day rooms spread throughout the home. Dining rooms in the more modern homes provide separate tables. In others the tables are large and sometimes also used for crafts or games. There is only one mention in the notes so far received of a craft room and none of an exercise room.

The majority of homes speak of gardens or patios while others have lost them to car parking, still sometimes in short supply. Some gardens are only to be looked at and quite a number are accessible to residents only when a member of staff can accompany them or the home puts on a barbecue. Comparatively few homes give access to residents to walk in the garden, use their wheelchairs, sit or even garden. A very fortunate few have larger grounds with farm animals and glasshouses. Particularly given the lack of in-house exercise space, access to gardens warrants greater importance than it is given.

Daily life

We had planned to talk to residents as well as managers and staff but, mainly because of the fragility of many residents, could not often do so. In most homes we spoke to one or two, who expressed general satisfaction. The few homes where there were groups of residents able to express views were clearly at an advantage, as were the residents. On the other hand, the occasional resident who was fitter than her fellows, made us aware of how isolated she could feel, how lonely and even a bit resentful of being followed around by staff. In two cases we were alerted to existing residents' disquiet about the greater needs of recent incomers. The picture given to us by managers did not always correspond with what we saw, but this may be explained in part by the fact that many visits were made in the mornings when the staff were busy helping residents to get bathed and dressed.

Daily life in all the homes is gentle, kindly and broadly respectful of individual wishes. But within that common description are variations that do not seem to correspond to residents' state of health. In some homes residents are mainly lying in or on their beds, only emerging for meals and not always then; in others, they are mainly in the day rooms, talking with or at least flanked by care staff; in a minority they are involved in a variety of activities and have the possibility of being taken out locally by carers or further afield in the home's minibus – even limousine. Each home's degree of involvement with the local community and volunteers is a key factor. Admittedly staying in one's room can be a statement of independence and a wish to decide one's own television diet or even a vote of no confidence in the activities offered. These in general seem rather limited and possibly childish; there is perhaps a mismatch sometimes in the levels of education of residents and carers. But one has to remember that the average stay in a care home is two to three years and ask serious questions about the desirable degree of stimulation. Residents can of course receive visits from friends and families at any time but this cannot compensate for the lack of stimulus observed in some homes.

Almost all the homes have an activities co-ordinator rather than an occupational therapist and programmes of planned activity are often on display. In a very few homes the co-ordinator is said to visit individuals in their rooms to ensure that they have help with activities of their choosing rather than the public flower arranging or bingo. There seem to be few group activities with any particular appeal to men. In some homes the visit of the

hairdresser or manicurist is claimed as an activity. In a very few homes residents help with the daily chores like laying tables or preparing vegetables but more commonly the programme is board games, crosswords, painting, memory boxes, concerts by visiting schoolchildren, PAT dogs and the like in many different mixes. (A number of homes make benevolent noises about how welcome residents' pets are, but in the event no more than one or two cats seem to have been brought into residence.) The offer is mainly sedentary, even sometimes when it involves exercise, though there are exceptional dances and full exercise sessions. Even more exceptional but growing in favour are sensory rooms and sensory gardens.

Only two homes mention access to a computer for residents. This hardly seems to correspond to the real world.

No-one should underestimate the difficulty of programming to meet the many needs of residents, and managers were often keenly aware of how much more there was for them to do. But the best homes are so almost effortlessly successful that we can only advocate that more time, effort and possibly cash are devoted to finding solutions. The effort needs to involve the local community. Room perhaps for the Big Society?

Care

All homes know how to summon medical care when necessary. A large number have arrangements with local surgeries and some receive regular visits from local doctors. Because of the distance some residents are from their former homes, it is not always possible to honour the promise that they can keep their own GP. All homes also know how to provide podiatry, dental care and physiotherapy for their residents, usually against payment, but this often involves being taken out to local services. For a few homes this causes transport problems. The quality of both dental care and physiotherapy is not always as good as homes would like.

All homes ensure that their staff receive mandatory care training, in some cases including end of life care. But most managers spoke sympathetically of how they managed the latter for both residents and families. Even in homes not registered for dementia care, staff generally had a degree of dementia training. There can be a problem with the provision of training when it takes care staff away from their normal duties and even out of their homes to another base.

Most homes spoke of good relations with local religious leaders for both routine and crisis needs.

Food

Food is commonly described as bland or comfort food. A choice is invariably given and confused residents are helped to choose. Monthly menus are often on display though not always closely followed. Residents were generally content though in one case the food offered was obviously not what one resident was accustomed to. In some homes there could be more fresh vegetables, and fresh fruit was also sometimes lacking. No resident need ever go hungry as snacks are always available. Catering done 'in house' was the most popular.

Help with feeding was regularly available, though it was occasionally observed that it was a bit automatic and without encouragement.

Inspection

There was some feeling that the old CQC regime of three year visits had caused a lot of paper work and taken staff away from their real work of caring for people. On the other hand some felt they could profit from more involvement and help from social services.

Finding a home

Several comments were made about the difficulty of finding a home which fitted an individual's requirements. Location, ease of access and charges are frequent criteria. Some people simply do not know where and how to start to find information about this poorly understood service. Some web sites are excellent but these still do not meet the needs of many people. Although considerable care has been devoted to communication, it does not cover all homes nor is it always up to date. There should be ways of making the information simpler and more user friendly.

Conclusions and recommendations

The members of the Oxfordshire LINk who took part in these visits would like to thank very warmly the managers, staff, residents and some of their families and friends for their welcome. We hope we have appreciated all the care and thought they give to running the homes and that we have not underestimated the complexity of the task.

The picture we describe is not peculiar to Oxfordshire and readers will be familiar with recent press reports of the costs to providers, residents and funders. But we think there is room for local action both by the local authority and by the homes themselves.

We found a wide range of practice in the homes we visited even when their populations seemed similar. Given the high level of charges and allowing for differences of style, it is vital to consider whether value for money is given in all cases and whether the care received by residents is always as good as it can be. Many of the residents are very frail and many have at least a degree of dementia. It is important that there is no underestimate of their need for and capacity to respond to stimulus. Nor should they be exposed to well-intentioned but over-childish activities. The best homes show what can be achieved, particularly when the approach is both personalised and socially integrating.

We are not in a position to know whether part of the problem may not lie in the content of some of the dementia training offered. We have also to question how far the language skills of some staff may contribute to what we observed. It is too easy to say 'a kind face and manner is a language in itself', true as this is. Meaningful conversation with those suffering from dementia is a considerable skill and not easy to conduct even when resident and carer share a mother tongue. We would in general like to see more interchange between staff and residents whenever possible, with the latter more often taking the lead and able to pitch the conversation at their own level.

Continuing mobility may also be a general problem. Exercise is often restricted and opportunities to walk out, with or without a care attendant, equally so. The need for homes to be able to draw on the active support of their community is very marked. Difficulties in arranging for attendance at outside medical appointments are an extreme and fortunately rare case of this problem.

The homes are all subject to inspection but it is not clear that the existing form this takes is the most helpful to their performance. All the homes want to do well and several said how much they would appreciate more contact with social services. Monitoring needs to be reinforced by support.

This is a matter for the local authority as is the need in these cash-strapped days to consider with providers, residents and the public how much money can be spent on care homes and what is its best use. The use of respite beds needs clarification as does the whole problem of empty beds, particularly when there is known bed-blocking in local hospitals. The latest national report on the cost of being in a care home gave the average figure as £30,000 per year and the average stay as 2.3 years, with the warning that costs in the south are higher and that prices are going up. The need is unavoidable and the older population is growing.

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