

DEFINING 'GOOD' IN HEALTHCARE

TOPLINE SUMMARY 2: RESIDENTIAL ADULT SOCIAL CARE SERVICES

1. INTRODUCTION, BACKGROUND TO THE RESEARCH AND OBJECTIVES

In April 2013, CQC published its new strategy '*Raising Standards, Putting People First*'. In this document, CQC stated its intention to redevelop its inspection methodology and the information that is provided to the public following an inspection. This change focuses not only on how services are inspected, but also the five key questions which inspectors will ask about services: Are they safe? Are they effective? Are they caring? Are they well led? Are they responsive to people's needs?

CQC is working to develop new fundamental standards that focus on these five questions.

As part of this work, CQC seeks to define the criteria that will be used to assign a rating to a service provider – in other words, understanding the features of a service that is considered inadequate, a service that 'requires improvement', is 'good' and 'outstanding'.

For this new inspection model to be credible with the public, it is essential that these criteria reflect the public's expectations. There is a particular focus on understanding what the public expects 'good' and 'outstanding' services to look like, across all care settings, and at all service levels.

Qualitative research was commissioned to provide a clear understanding of what the public and service users think 'good' and 'outstanding' look like in residential adult social services. In addition, the research will explore what information requirements the public have in relation to inspection reports about all of the above services. The business objective is:

<p>To inform the criteria that are developed for rating services and to inform the development of a new style of inspection reports for each of these services.</p>
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2. NURSING CARE SUMMARY

2.1 Method and sample

4 triads (3 respondents, 1.5 hours duration) were completed w/c 5th May with carers of those using nursing care services.

- 2 x triads with older people using nursing homes;
- 2 x triads with people with physical impairments using nursing homes;
- A mix of male and female carers was achieved.

2.2 Care standards experienced

The care standards experienced ranged from outstanding to good, however respondents felt that there were a significant number of elements of their care which required improvement.

Only one respondent felt that her care was 'outstanding' care overall, although several respondents felt that aspects of their care were 'outstanding'. Ultimately, 'outstanding' care was characterised as the individuals carers and the facility as a whole 'really caring' about the person and 'doing everything they can' for them. In practical terms, this was seen as:

- A large number and choice of activities to keep patients stimulated;
- Carers understanding the needs of individual patients and being free to respond to them (this was aided by low turnover of staff and efficient staff handovers);
- A high level of communication between the facility and the family;
- A high level of personal care / hygiene, e.g. carers cutting a patient's fingernails when required without prompting by the family.

A majority of respondents rated their care as ‘good’, however they found it easier to talk about aspects of their care which ‘required improvement’, almost as if ‘good’ care was defined by the (lack of) issues which require improvement. ‘Good’ care was characterised as:

- Sufficient stimulation (in terms of activities, games, outings etc.);
- Friendly staff – this was not only seen as the manner in which staff addressed patients, but also the patient not being left for a long period of time without an interaction with staff even if it was just a ‘friendly word’;
- Making contact with the family to communicate issues;
- Liaising with and policing external health providers, e.g. GPs, dentists etc. and other external services, e.g. hairdressers etc.;
- Clean and well-equipped environment and equipment.

Care which ‘requires improvement’ was largely defined as the converse of ‘good’ care:

- Lack of sufficient stimulation – *“residents being left for hours on end sitting in a chair”*;
- Lack of conversation / chat with staff;
- Unhygienic / unclean environment, e.g. dust, smell;
- Not keeping the residents clean and tidy.

Respondents also characterised care which ‘requires improvement’ as the lack of continuity of carers, and therefore carers not being familiar with the idiosyncrasies / personal needs of the patient. Others identified ‘laundry issues’ as requiring improvement, i.e. items of clothing being lost or patients being dressed in other’s clothing.

Whilst none of the respondents had encountered ‘inadequate’ care, they had a clear sense of what this would look like. Ultimately, ‘inadequate’ care was characterised as carers not having enough time or insufficient number of carers, leading to patients being treated in an abrupt manner and essential tasks not being completed thoroughly or quickly, e.g. washing a patient.

2.3 Definition of good care

General public priorities for safety were in the context of the environment: nothing to trip up on; cleanliness of the facility; and sufficient and working equipment. Unlike other service users previously researched, respondents also felt that regular and effective communication between frontline staff and management was essential for 'safe' care: frontline staff need to be able to pass issues back to management to ensure resolution.

Although all agreed with the description of 'safe', the elements from which respondents identified as particularly relevant to their needs were: *'people are safe because the service protects them from bullying, harassment, avoidable harm and potential abuse'; 'staff consistently manage medicines in a safe way'; and 'there were always sufficient and competent staff on duty with the right skill mix to make sure that practice is safe and they can respond to unforeseen events'.*

There was debate around 'the service respects people's human rights and diversity'. One respondent (who cared for a relative with Multiple Sclerosis) struggled to understand how the facility would be able to achieve this standard, given the physical and mental conditions of the residents. Whereas, another respondent felt that in her own experience the standard had been achieved (her mother was residing in a Jewish nursing home where her religious and cultural needs were being met).

For this sample, 'effective' care was care that met the patient's needs (staff did 'everything they are claiming to') and this was regarded as a priority. Staff should be completing expected tasks such as dispensing medicines, keeping the patient clean and feeding / watering them. 'Effective' care was also perceived as the facility contacting relatives to communicate any issues. However, the most important element of 'effective' care was the quality of staff, i.e. sufficient training and experience and the ability to communicate in English.

Although all agreed with the description of ‘effective’, the elements from which patients identified as particularly relevant to their needs were: *‘care and treatment which reflects people’s needs, choices and preferences’; ‘staff have the right competencies, knowledge, qualifications, skills, experience, attitudes and behaviours to enable them to provide support and meet people’s needs effectively’; and ‘people especially those with complex needs, are protected from the risk of poor nutrition, dehydration, swallowing problems and other medical conditions’.*

General public priorities for ‘caring’ were anchored in the personal qualities and other attributes of the staff. Respondents felt that staff should have the right skills, qualifications and the attitudes – ‘you’ve got to be a caring person’. A good standard of care was also characterised as: enough staff to spend time with the patient (rather than rush them); and providing care to meet individual needs. The ‘caring’ domain was perceived as the most important out of all of them because ‘that is what my relative is in there for – to be cared for’.

All strongly agreed with the description of ‘caring’ -- both the content and language resonated with respondents and it was felt that every element was extremely important.

Unlike previous research in other services, ‘responsive’ care was not only seen on an individual level, but also on a service level. Examples of ‘responsive’ care on an individual level were: following up on alarm pulls; and cleaning up incontinence problems. Examples of ‘responsive’ care on a service level were: the ability to make changes quickly, such as buying in new crockery if existing crockery is difficult to use or organising a carer to come earlier if the resident wishes to get up earlier.

Although all agreed with the description of ‘responsive’, the element which respondents identified as most important was: *‘people receive care, treatment and support that is personalised, putting them at the centre of identifying needs, choices and preferences’.* Some took issue with *‘there are range of ways in which people can feedback their experience of the care they receive and raise any issues or concerns they may have’* because they felt

their relative would be unable to feedback on their care, and that therefore the feedback of the relatives should be given more weight.

Interestingly, this sample was better able to conceptualise the ‘well-led’ domain than previous research done with other service users. ‘Well-led’ care was perceived as communication between staff: efficient handovers; regular staff meetings; and a low turnover of staff. It was also grounded in the facility’s recruitment and management policies; the home should be employing staff with the relevant skills, qualifications and attitudes; and it should be creating good working conditions for staff, i.e. not overworking staff. Finally, well-led care was the visibility of management (the presence of the manager(s) on site).

2.4 Information requirements

The decision-making process for choosing a nursing home varied across respondents; however few felt that they had had much choice in the matter:

- Several felt that they had to make the decision ‘in a hurry’ because they were being pressured out of hospital or respite care;
- Availability was also an issue as many homes did not have spare rooms;
- The social worker (and, in one case, the insurance company) made strong recommendations;
- A few respondents’ choice was guided / restricted by religious / cultural needs.

However, for almost all respondents the deciding factor in choice of nursing home was ‘how it looked’ when they visited. The ‘atmosphere’ / ‘feel’ of the home held great sway with respondents.

The key information which respondents wished to know / ask was: are the staff friendly? Can family drop in 24 / 7? Does the home meet all the personal and medical needs of residents?

3. RESIDENTIAL CARE SUMMARY

3.1 Method and sample

4 triads (3 respondents, 1.5 hours duration) were completed w/c 5th May with carers of those using residential care services.

- 2 x triads with older people using residential care;
- 2 x triads with people with learning disabilities using residential care.
- A mix of male and female carers was achieved.

3.2 Care standards experienced

A range of care standards were experienced from inadequate through to outstanding.

Like nursing care, an ‘outstanding’ standard of care was characterised by the attitude and personal qualities of the staff, i.e. staff who ‘went the extra mile’. It was also characterised by the facility meeting the requirements of the individual (without prompting from relatives) both in terms of personal care (mincing food for a patient who was not able to swallow) and also liaising with outside services (arranging medical appointments). For one respondent (who had a daughter with extreme learning difficulties), having one allocated carer who knows her daughter’s needs well constituted ‘outstanding’ care, given the fact that her daughter would not be able to explain.

A ‘good’ standard of care was characterised by cleanliness of both environment and patients (‘they keep her clean and tidy’). Good care was also perceived as the behaviour of the carers, who were expected to be patient, friendly and caring. Other aspects of good care were the provision of entertainment and good quality of food. For patients with learning disabilities, the entertainment had to be appropriate to the individual – ‘she doesn’t read but loves music’.

Aspects of care which were perceived as requiring improvement were lack of response to the patient's needs, e.g. one respondents had to mention her mum's swollen ankles several times before carers arranged an appointment with the GP. For respondents with learning difficulties, there were some issues around dignity which required improvement. One example of this was not locking the patient's bedroom door when she is getting changed so she is able run out down the corridor without any clothes.

Only one respondent had experienced 'inadequate' care, although other respondents had identified aspects of their care which they thought 'inadequate'. 'Inadequate' care was characterised as both essential tasks not being completed and the attitude of staff. Essential tasks were considered: helping patient eat / drink; failing to keep patients clean; and failing to follow up on falls. An inadequate attitude in staff was perceived as treating care as 'just a job' and 'just going through the motions' and talking to patients in a certain manner, e.g. 'it's not time to go to toilet yet'.

3.3 Definition of good care

Like nursing care, general public priorities for the 'safe' domain in residential care were perceived to be in the environment. 'Safe' care was categorised as:

- Sufficient security to prevent residents wandering out and strangers wandering in;
- Alarm pulls to allow residents to call for help in an emergency;
- Clear floors (no tripping hazards);
- Bars on the sides of the beds to prevent residents rolling out.

Although all agreed with the description of 'safe', the elements from which respondents identified as particularly relevant to their needs were: *'people are safe because the service protects them from bullying, harassment, avoidable harm and potential abuse'* (this standard was given most priority); *'the control and prevention of infection is managed well'*; and *'there are always sufficient and competent staff on duty'*.

Respondents characterised the ‘effective’ domain in a very similar way to the nursing care sample, with the slight differences in emphasis. ‘Effective’ care was seen as not just doing a task, but ensuring that it had been done. For example, not only distribution and record keeping of medicines, but also having at least two nurses to distribute to ensure that the medicine is taken (this was especially important for residents with learning disabilities). Another example is, not only feeding / watering residents, but ensuring that they have eaten / drank. ‘Effective’ care is also checking that staff have the relevant training and qualifications for the job.

Although all agreed with the description of ‘effective’, the most important element for respondents was: *‘staff have the right competencies, knowledge, qualifications, skills, experience, attitudes and behaviours to enable them to provide support and meet people’s needs effectively.’* Other elements identified as important were: *‘specialist or adaptive equipment is made available’*; *‘people, who lack the capacity to make certain decisions, are supported by staff to understand their needs’* (this was particularly resonant with those caring for people with learning disabilities); and *‘people, especially those with complex needs, are protected from the risk of poor nutrition, dehydration, swallowing problems and other medical conditions’*.

Respondents’ priority for the ‘caring’ domain was the manner in which carers behaved towards residents. *“Carers should be speaking to them with respect like they are human beings and not treating them like children”*. This standard was perceived as directly related to the personal qualities of the carer (rather than qualifications or input from management). A good standard of care in this domain was also seen as meeting the personal needs of patients, i.e. keeping them clean.

Like the nursing care sample, the language used in the description of ‘caring’ struck a chord with respondents, who felt that it reflected their view of the care residential homes should provide. Although all strongly agreed with the description, the elements which were given particular priority were: *‘care is individual and centred on each person’*; and *‘staff communicate effectively with every person using the service, no matter how complex their needs. They develop trusting relationships, and understand and respect confidentiality’*.

‘Responsive’ care was seen on an individual level; essentially, it was seen as responding to patients’ personal, medical and social needs. For example, carers recognising and following up on a physical / mental change in a resident (and instigating medical help / treatment if necessary). Interestingly, ‘responsive’ care was also characterised by carers interacting with patients on a basis other than that of their immediate needs, such as a ‘friendly word’ rather than just dispensing medicines / food.

Although all agreed with the description of ‘responsive’, the elements from which patients identified as particularly relevant to their needs were: *‘people receive the care, treatment and support that is personalised, putting them at the centre of identifying their needs, choices and preferences’; ‘people are protected from the risks of social isolation and loneliness’; and ‘staff work in partnership with other health and social care providers to make sure people’s needs are met’.*

Like the nursing care sample, the residential care sample had a clearer sense of the ‘well-led’ domain than other service users previously researched. ‘Well-led’ care was characterised as strong management and communication within the organisation. Management should ensure that both the carers are delivering a good standard of care, but also that they are not ‘bogged down’ with paperwork, but free to spend time with the patients.

Although all agreed with the description of ‘well-led’, respondents perceived the most important element to be: *‘staff report that they are motivated and supported by the way the service is managed and led and that they are happy in their job’.*

It is interesting to note that respondents perceived CQC’s definition of good care to be the ‘ideal’, and as such almost ‘unattainable’ (this was felt particularly in relation to the caring domain) – ‘the utopia care home!’

3.4 Information requirements

There was a sense that respondents in this sample had had (slightly) more choice when choosing a facility, in comparison to the nursing home sample. More individuals mentioned visiting facilities, and visiting a greater number of facilities (or even visiting facilities more than once for some). However choice was still restricted by:

- Availability (of beds);
- Locality (of the facility to where the family lives);
- Funding, i.e. some had to choose a specific provider because they are linked to the council's funding;
- Time pressure, e.g. one respondent was under time pressure due to her mum being evicted from her sheltered housing because she wandered at night.

Like nursing care, the atmosphere on visiting the home was the most influential factor in choice. Respondents also felt it would be useful to talk to other families about their experience of the facility. Questions likely to be asked were: are staff nice? Are residents happy? What is the ratio of staff to residents? What are the visiting times?

4. INSPECTION REPORTS (old style)

4.1 Rating inspection reports

Respondents' rating did not necessarily agree with CQC's rating.

Example 1 (which was rated as 'met all standards' by CQC) was rated as 'good' overall, although the lack of registered manager was thought to 'require improvement'.

Example 2 (which was rated as 'requires improvements – a lot' by CQC) was unanimously rated as 'inadequate'. Although there were several elements of care which drove this rating, the most important was *'people are not always fully protected against the risk of abuse'* (which was thought to be unacceptable).

Example 3 (which was rated as ‘requires improvements – one’ by CQC) was given a range of ratings from ‘inadequate’ through to ‘outstanding’. It was rated ‘inadequate’ due to the fact that *‘not everybody received the medication they needed on time’*, which was perceived to be crucial.

Like the previous research, more guidance about CQC’s interpretation of the inspection findings will be required. However, this sample were more engaged with the summaries than others, and perceived the information as useful (in terms of choice of care home).

Respondents felt that they would be unlikely to use a facility which had been rated inadequate, despite the fact they felt better able to judge it by their own visit.

4.2 Report structure, content and language

Whilst some felt that inspection reports could be used as a ‘starter’ when choosing a care home (and one respondent had used them in this way in the past), many felt that the reports did not contain the relevant information so were of little use.

The current language of the reports did not interest respondents: it did not give them the information they wanted to know, i.e. it did not seem to be focussed on the patient (and their needs). Respondents felt that the reports need to have more focus on how the facility is meeting the individual needs of residents and treating them with kindness and respect. *“This does not tell me that they are looking after people”.* They also felt that a more granular approach was necessary, e.g. *‘residents were fed three times a day...’*

There was a sense that CQC did not or was not able to inspect and regulate care homes sufficiently, given the vulnerability of the residents. Some were suspicious of the phrase ‘met the standard’ – ‘what and whose standard’? There were also several queries regarding CQC’s inspection procedure. Some felt that they would be better able to judge a facility by visiting and talking to staff / residents.

Like community health and home care services, respondents felt that CQC's inspection reports were valuable, but did not feel they were for patients to use. The language and format of the reports did not aid them in finding the information and they needed.

With regards to a summary of inspection reports, the sample identified the following as important elements:

- Residents are kept physically safe;
- Residents' personal needs are met, i.e. food, cleanliness etc.;
- Residents medical needs are met, i.e. medicine, treatment etc.;
- Residents are not subject to physical or mental abuse;
- Residents are treated with kindness and respect by carers;
- Staff have the relevant qualifications, skills and attitudes.