

Health care in care homes

A special review of the
provision of health care to
those in care homes

1. Introduction

The findings in this report were gathered as part of our previous approach to ‘special reviews’. The initial data was collected between February and April 2010, with the intention of publishing a national report following the inspections in November 2010. Due to the widely reported reallocation of resources and focus to deliver to the government’s timetable for registration, the timing for the inspections, analysis of the data and information for this review was rescheduled for early 2011.

Since 2010, the Department of Health has agreed that CQC should not carry out periodic reviews of primary care trusts or local authority adult social care departments. New arrangements are being developed under which the identification of under-performance by local councils, and improvement activity, is led by the sector itself. This change has had a significant impact on the way the data has been collected, analysed and reported, given that we are no longer assessing and reporting on the commissioning behaviours of the PCT and local authority, as this was to have been an integral component of this review.

The PCTs are still the legal entities responsible for commissioning. Although there have been some structural changes to their configuration, the findings of this report will be of interest to the PCT clusters and the community health service providers that have replaced the individual PCTs that were analysed in this review.

We have reviewed the data and information we collected in early 2011 again, and consider that the most effective way to ensure that we can use the results is to help shape the forthcoming thematic inspections on dignity and nutrition, which will be undertaken across 500 care homes with nursing provision from the summer of 2012. We will also map the findings about meeting the health care needs of people with a learning disability in this sample to the results we will have available for our national report on the thematic inspection of 150 services for people with learning disability, mental health and challenging behaviour. That report will be published in spring 2012.

2. Aim of the review

We consulted with our key stakeholders on undertaking this topic as part of our programme of ‘special reviews and studies’ for 2009/10.¹ Our proposal for this review was in the context of a number of other policy and strategy reviews concerned with the health care needs of people in care at that time, including *Death by Indifference*² and *Ageism and age discrimination in primary and community health care in the United Kingdom*.³

The aim of this review was to look at how well the health care needs of people living in care homes were met, based on commissioning and provider behaviours. The scope for the review set out to consider practice not just in individual care homes, but to focus attention on the rights of people in care homes to access NHS services that met their needs. This included GP services and pathways for continence care, NHS support for care homes to ensure quality of health care through direct provision of district nursing services, and training for care home staff.

3. Methodology

The methodology for the special review was based on a plan to take an in-depth review of this subject and to look at how the services were commissioned as well as provided. This approach was determined at a time when CQC still exercised powers to assess PCTs and local authorities as commissioners.

The sample type of residents receiving health care included both older adults in care homes and younger adults with learning disabilities in care homes. In definitional terms, the sample of care homes was made when these services were still being regulated under the Care Standards Act (2009) against the national minimum standards (see Table 1 and 2 below). CQC has regulated these services under the Health and Social Care Act 2008 from October 2010, and since we collected the data from inspections after these services were registered under this legislation, we have mapped the results to the outcomes set out in the *Guidance about compliance*.⁵

The full description of the methods used can be found on the CQC website⁴.

It should be noted that the sample size for the PCTs, both as commissioners and providers, local authorities and the care homes involved in the survey and inspections are too small for any of the results to be interpreted into national findings. The care home sample represents around 0.45% of the whole care market and must therefore be treated with caution (see Table 1 and 2 below).

They are however, of significant use for shaping the approach to our current methods for delivering themed inspections and may be of use to the current PCT clusters, community health service providers and newly emerging clinical commissioning groups, Health and Well Being Boards and their purposeful effort to deliver the joint strategic needs assessment for their communities.

As mentioned, we will use the results to formulate and shape the themed inspections covering dignity and nutrition in 500 care homes.

4. Results of the review

The results presented here are based on an analysis from the actual inspections of the 81 care homes in our sample. We interviewed or observed care being delivered to 386 residents in these 81 care homes during January and February 2011. The details of these are shown in Table 1.

Table 1

Group interviewed	Care setting and number	Number of people interviewed/care observed
Older adults (65+)	Homes with nursing (27)	144
Older adults (65+)	Homes without nursing (27)	153
Adults with learning disabilities (18-64)	All care homes (27)	89
Total	81	386

Table 2 provides more detail about the staff interviewed in each of the care homes and the case files that were reviewed.

Table 2

Care setting	Number of staff interviewed	Number of case files checked
Homes with nursing (27)	93	109
Homes without nursing (27)	90	99
Homes for people with learning disabilities (27)	76	80
Total	259	288

In each of these inspections, we included an expert by experience to work alongside the CQC inspector and a CQC pharmacy inspector who together made up the inspection team. All the experts by experience were given training to support the inspection programme in order to maximise their input into the process.

We did not inspect any of the community health services that were in the original sample set, but we have referred to their services where we have details from the care home inspections. We make no reference or commentary to commissioning activity.

We have captured information about the care homes' engagement with primary medical services and this is reported here. GP practices will not be registered with CQC until April 2013 and are therefore outside the scope of regulated activity. However, primary care out-of-hours services will come into regulation in April 2012, and so we have mapped the findings about primary medical services to the relevant outcome areas.

CQC undertook the inspections for this special review under a different set of powers to our routine compliance work. Where the inspection process identified practices that were not compliant with the essential standards of safety and quality, we subsequently followed up these concerns using our formal entry and inspection powers. Under these powers, we are able to set out the requirements for providers to take necessary action to become compliant.

Since we undertook these special review inspections we have continued to monitor the compliance of all care providers, including all the care homes in the original sample.

While we have provided an analysis of the key findings for this report from the data that we have collected, there is other data from this review that we have not included, but are making available on our website as part of open access to information requirements. This can be found at the review's webpage:

www.cqc.org.uk/organisations-we-regulate/special-reviews-and-inspection-programmes/thematic-reviews/health-care-nee.

5. Key outcomes from the review

In order to maximise the learning from this review and ensure that we shape the forthcoming dignity and nutrition inspections of care homes, we have analysed and mapped the data against the most relevant themes in the *Guidance about compliance*.

These are:

- Involvement and information
- Personalised care, treatment and support
- Safeguarding and safety
- Suitability of staffing

Involvement and information

The key findings under this outcome were:

- The majority of homes (86%) had a policy on consent issues, but there was variability in whether key subject areas such as non-verbal communication were included in these policies.
- Most homes included in the review (77%) provided staff with training on the sharing of personal information. However, interviews with residents suggested that although most (74%) felt that their information was kept private, many (42%) did not feel that staff asked them for their permission before sharing information more widely.
- Half of homes (54%) did not provide residents with information about which health care services are included in the home's basic fees in their care contract and agreement.
- Where referrals to health care professionals were undertaken, the majority (91%) were felt to be appropriate.
- The review found some variability between care homes in the services provided by GPs and who pays for these services: 33% of homes said that GPs did not provide

post-admission assessments for residents, 53% said they were provided and paid for by the PCT and 7% said that they were provided but paid for by the care home.

- Managers at 44% of care homes indicated that GPs undertake scheduled surgeries or visits in the care home.

Personalised care, treatment and support

The key findings under this outcome were:

- In the majority of homes (present in 77% of case files inspected) there was evidence that care planning took into account the views of the person. However, some homes did not adequately demonstrate person-focused care planning, and in many homes the views of the person's relatives and carers were not taken into account or not documented in care plans.
- Information from interviews with residents indicated that most (85%) felt that staff often or occasionally talked with them about their health care needs; however just over half of residents (55%) interviewed were aware that they had a care plan in place that set out their needs.
- 25% of residents with continence needs felt that they did not have a choice of male or female staff to help them use the toilet.
- 30% of nursing homes included in the review did not have a 'Do Not Attempt Resuscitation' (DNAR) policy in place (in settings where having a DNAR policy was appropriate and required). Where DNAR policies were in place, most staff (76% of staff in nursing homes) were aware of the policy, although very few (37% of staff in nursing homes) had received formal training in the policy.
- Over half of homes (59%) indicated that they offered residents the option to self-administer their medicines, although only a small number of case files (4%) seen during the review contained evidence of self-administration of medicines.
- Most homes (85% of nursing homes and 78% of residential homes) included in the review provided residents with information on continence care, although interviews with residents suggested that about a third (38%) did not feel that they were offered choices about how their continence needs are managed.
- The majority of homes (96%) included in the review identified changes in the health care needs of residents through informal or responsive monitoring, such as responding to issues they or their carers raise. Furthermore most (94%) identify changes through the formal monitoring that comes from regular staff meetings and regular diagnostic monitoring.

Safeguarding and safety

The key findings under this outcome were:

- The review looked at whether systems were in place to support residents who lack the mental capacity to make decisions. We found that just over half (59%) of homes that care for people who lack capacity had best interest decisions in place for all these people.

- The majority of homes (93%) indicated that they ‘always’ recorded medicines errors and had arrangements in place to learn from errors relating to prescribing, monitoring, dispensing or administering medicines.
- The majority of care homes (85%) had a policy on homely medicines¹ in place.
- 40% of the homes had residents that were receiving anti-coagulation therapy, and in the majority of cases (84%) the anti-coagulation record was in place. However less than a third (31%) of these homes were aware of the National Patient Safety Agency safety alert regarding anti-coagulation therapy.
- 35% of homes indicated that getting medicines to residents on time was ‘sometimes’ a problem, while three homes (4%) indicated that this was often a problem.
- 49% of all homes recorded the actual time of administration of medicines.
- 43% of homes did not have a policy in place covering the decision to administer medicines to be ‘taken as prescribed’.

Suitability of staffing

The key findings under this outcome were:

- Training in a variety of topic areas was provided in care homes. This was both general and specialist, with some variation in the subject areas covered. When looking specifically at nursing and residential homes, most homes (93%) provided training about dementia, but only half (52%) provided staff with training about stroke.
- Staff interviews provided evidence of training attendance during the past 12 months in a range of areas. Across all care homes, medicines was the health care area with the highest attendance in the past 12 months (59% of all staff interviewed), while a much smaller proportion of staff (36%) had attended training about continence care in the last 12 months.
- Staff confidence in relation to the health care needs of residents varied across homes. In three-quarters (75%) of homes, all staff interviewed said that they definitely feel confident that they “understand the health care needs of people living in the care home and what they need to do to help meet these”. However, in the remaining homes some or all staff interviewed indicated that they only felt confident to some extent or did not feel confident at all.
- While tools and guidance were available to staff for processes and procedures in care homes, there was some evidence to show these were not always used by staff. For example, where inspectors found DNAR decisions in case files, less than half (42%) had been made in line with the home’s DNAR policy.

¹ Homely remedy protocols are not prescriptions but protocols to enable administration of general sales list and pharmacy only listed medicines in settings, for example, care homes, children’s homes and some educational institutions. The protocol should clarify what medicinal product may be administered and for what indication it may be administered, the dose, frequency and time limitation before referral to a GP. An example of a homely remedy could be paracetamol for a headache. (NMC, 2010)

6. Future work

This review was one of the last that was planned using a methodology for reviews of services that are no longer a part of the CQC regulatory framework.

Since 2009 we have listened to our key stakeholders and have now moved to unannounced annualised inspections of providers. A part of that programme is to carry out themed inspections of services as part of our annual cycle of activity. Since this change in approach, we have carried out thematic announced inspections looking at care and welfare and safety and safeguarding across 150 learning disability, mental health and challenging behaviour services, and dignity and nutrition inspections of 100 older people's services in acute hospitals.

The limited findings from this old style review will provide material that will help us to shape and improve the new methods we are using to deliver unannounced thematic inspections, in particular, developing key lines of enquiry to identify non-compliance. We will be drawing extensively from these findings to help us with the next thematic inspections of dignity and nutrition in care homes.

References

1. Care Quality Commission, *Reviews in 2009/10: Assessing and rating health and adult social care organisations*, 2009.
2. Mencap, *Death By Indifference*. 2007.
3. Centre for Policy on Ageing, *Ageism and age discrimination in primary and community health care in the United Kingdom: A review from the literature*, 2009.
4. www.cqc.org.uk/public/reports-surveys-and-reviews/reviews-and-studies/meeting-health-care-needs-people-care-homes
5. Care Quality Commission, *Guidance about compliance: Essential standards of quality and safety*, 2010.

© Care Quality Commission 2012

Published March 2012

This document may be reproduced in whole or in part in any format or medium for non-commercial purposes, provided that it is reproduced accurately and not used in a derogatory manner or in a misleading context. The source should be acknowledged, by showing the document title and © Care Quality Commission 2012.

How to contact us

Phone: 03000 616161

Email: enquiries@cqc.org.uk

We have also produced an easy read version of this guide, which can be found at www.cqc.org.uk. Please contact us if you would like a summary of this document in other formats or languages.