



Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

A Place to Call Home?

A Review into the Quality of Life and Care
of Older People living in Care Homes
in Wales

An independent voice and
champion for older people



The Older People's Commissioner for Wales

The Older People's Commissioner for Wales is an independent voice and champion for older people across Wales. The Commissioner and her team work to ensure that older people have a voice that is heard, that they have choice and control, that they don't feel isolated or discriminated against and that they receive the support and services that they need.

The Commissioner and her team work to ensure that Wales is a good place to grow older, not just for some but for everyone.

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Foreword

When older people move into a care home, all they are doing in effect is moving from one home to another. The word 'home' should mean something special, a place that we hope will be filled with friendship, love and laughter.

Regardless of where we live when we are older, or how frail we are, we will all want to feel respected and valued and be able to do the things that matter to us. We all want, regardless of our age or frailty, or where we call home, to have the very best quality of life. This is why I chose to focus my Review on the quality of life and care of older people in the place they should be able to call home.



At our best, and I have personally seen much of our best, we are ambitious, bold, challenging of ourselves, creative and innovative. At our best, our care homes in Wales, our care staff and our services, give people the best quality of life they could have. However, many of the older people and families that I have supported and those who have contacted me as part of my Review have shared with me examples of care that not only fall below the standard of care that people have a right to expect, but are also unacceptable.

My Review has been the biggest inquiry ever undertaken in Wales into the quality of life and care of older people in care homes and the lives they live. Led by me, with the support of an advisory board of experts in the field of residential and nursing care, as well as older people and carers, it combined a national questionnaire, to which over 2,000 people responded, and extensive written and oral evidence from 93 organisations. I also met and heard directly from care home owners and managers. At its heart, however, were visits to 100 care homes across Wales to meet with residents, their families and staff to ensure I was able to deliver what I promised my Review would do: give a voice back to older people, their families and those who care for and care about them.

The findings of my Review make for hard reading, but in failing to acknowledge the changes required we undermine the good care there is and prevent ourselves from achieving what we are capable of in Wales. My Review makes very clear the impact of failing to get it right upon the people living in care homes and the price that is paid when failures occur, which, for too many, is simply too high.

A simple concept needs to be reclaimed across residential care: that it is not just about being safe or having basic physical needs met, essential as these are, it is also about having the best quality of life, in whatever way that is defined by an individual older person. Within the current social care system, there is no formal way to recognise or reinforce crucial values such as compassion, friendship and kindness, self-determination, choice and control. Yet these values are key to quality of life and

must now be placed at the heart of the residential and nursing care sector.

I recognise that there are many changes to our health and social care services underway, both at a strategic and local level in Wales, through legislation, modernisation programmes and collaborative approaches. Whilst I strongly welcome this progress, a key question I have asked throughout my Review is a simple one: are the changes underway sufficient to deliver the change that older people want and have a right to see? In determining the areas where further action is required, I have been conscious of current constraints without losing the ambition that we should have in Wales. I have linked my action back to the current and developing policy agenda in Wales, in particular to the Social Services National Outcomes Framework.

My Review is about people and the lives they lead, the value we place on those lives and the value we place, as a nation, on older people. We should be ambitious as a nation on behalf of older people, not just because we are in public service, or because the people I am representing through this Review are some of the most vulnerable people in our society, but because of who older people are. They are not a group apart, they are our family and friends, the people who raised us and taught us, the people we care about and who care about us. They still have much to contribute and should be seen as important members of our communities.

My Review follows shortly after the adoption and launch, by the Welsh Government, of the Declaration of the Rights of Older People in Wales, which reminds us all of our duties towards older people. Through my Review I want to set a new benchmark in respect of the duty of care owed to older people. In doing this, a strong and clear signal is sent: that older people living in care homes in Wales are valued.

I would like to thank all of the older people who have responded to my calls for evidence and helped to shape the outcome of this Review. I would also like to thank my amazing team of Social Care Rapporteurs. Together they have helped me to keep my promise to give a voice back to older people living in care homes in Wales.

All of us who work within public service in Wales have both a responsibility and a real opportunity, through our collective effort, to make good practice standard practice. Based on the good practice that I have seen through my Review, the passion and dedication of so many public service staff and care home providers and the opportunities afforded to us by new legislation, I have no doubt that this is achievable.



Sarah Rochira
Older People's Commissioner for Wales

Key Findings

This section presents the key findings of my Review in respect of four key areas related to the quality of life of older people living in care homes in Wales.

- Day-to-Day Life
- Health and Wellbeing
- People and Leadership
- Commissioning, Regulation and Inspection

These key findings draw together the evidence from my questionnaire, Social Care Rapporteurs' visits to 100 care homes and written and oral evidence submitted to me through the Review.

Day-to-Day Life

Social Participation

- There is a lack of social stimulation within care homes that can lead to older people withdrawing, both physically and emotionally, which has a significant impact on their health, wellbeing and quality of life.
- Residents often do not have choice and control over the activities that they are able to participate in and are not supported to do the things that they want to do when they want to do them.
- There is a lack of awareness amongst care staff about the specific communication needs of people living with dementia and/or sensory loss, as well as the needs of Welsh language speakers, which can significantly reduce opportunities for social participation.

Meaningful Occupation

- Only a small number of care homes enable residents to participate in meaningful occupation, activities that are essential to reinforce an individual's identity, such as making tea, baking, gardening, setting the table, keeping pets, taking part in religious services and helping others.
- In many cases, risk-aversion and a misunderstanding of health and safety regulations act as barriers and prevent opportunities for meaningful occupation.

Personal Hygiene, Cleanliness and Comfort

- While residents' basic hygiene needs are generally being met, the approach to personal care is often task-based and not delivered in a person-centred way that enables an individual to have choice and control.

- The personal hygiene needs of residents with high acuity needs, such as those living with dementia or a physical disability, are sometimes not met, with care staff reporting that they found it difficult or lacked the training to provide personal care in these circumstances.
- There are significant variations in the ways in which residents are assisted in using the toilet. Some care homes take a tasked-based approach, which can have a detrimental impact both on an individual's independence and their dignity, while others respond to residents' needs in a respectful and dignified way, assisting them to use the toilet as and when they require.
- Incontinence pads are often used inappropriately, with residents being told to use them, despite the fact they are continent and able to use the toilet. Pads are also not changed regularly. This causes significant discomfort and has a disabling impact on mobility and independence, stripping people of their dignity entirely in some cases.

Personal Appearance

- Residents are generally supported to choose which clothes and accessories they wear in order to maintain their personal appearance. This is essential to reinforce an individual's identity and ensure that they feel comfortable, relaxed and at home.

The Dining Experience

- Mealtimes are often a 'clinical operation', seen only as a feeding activity, a task to be completed, which means there is very limited positive interaction between staff and residents and a lack of a positive dining experience.
- Residents often have little choice about what to eat, and when and where to eat, which can lead to residents having no control over a fundamental aspect of their daily lives.
- There is a lack of positive communication and interaction between residents and care staff, which is essential to ensure that residents' choices and preferences are taken on board and they are encouraged to eat.
- In many cases the dining experience does not reflect the needs of the individual or enhance quality of life, instead it is structured to be functional and convenient for the care home.

Care Home Environment

- Many care homes have a functional, institutional and clinical feel, with a design and layout that is often unsuitable, rather than being homely, comfortable and welcoming.

- Care homes are often not dementia friendly, lacking in helpful features such as pictorial signage or destination points, which can result in increased confusion, anxiety and agitation among residents living with dementia.
- There is a lack of consideration of the needs of residents with sensory loss, with a lack of assistive equipment, such as visual alarms, hearing loops, stairwell lighting, handrails and clearly marked ramps, essential to allow residents to move around the care home as safely and as independently as possible.

Factors Influencing Day-to-Day Life

- Care homes are often characterised by institutional regimes, where a task-based approach to delivering care concentrates on schedules, processes and checklists, rather than the needs of an individual.
- There are clear variations in the quality of care provided, even within individual care homes, which means that older people are often not receiving the level of care they have a right to expect.
- Older people and their families can have low expectations about quality of life in a care home.
- Older people did not expect anything more than an adequate quality of life in a care home.
- The role of independent advocacy and its importance is neither fully understood nor recognised and there are significant variations in the availability of and access to advocacy services. There is little evidence that independent advocacy services are being actively promoted within care homes.
- The ability of third sector organisations to deliver independent advocacy services is often affected by unstable and unreliable funding.

Health and Wellbeing

Prevention and Reablement

- Inadequate staff resources and training can lead to risk averse cultures developing that can result in inactivity and immobility amongst residents. Similarly, restrictive applications of health and safety regulations can prevent an individual moving freely around the care home. Immobility can actually contribute to a fall, which is inevitably more damaging to an older person's physical and emotional wellbeing.
- Access to preventative healthcare and reablement services, such as Physiotherapy, Occupational Therapy, Speech and Language Therapy and Podiatry, is severely limited within care homes. Where such services are

available, often people are waiting too long to access them, a delay that means it is often not possible to reverse the physical damage or decline that has already occurred.

- The culture of care homes is often built upon a dependency model, where it is assumed that people need to be ‘looked after’. This approach often fails to prevent physical decline and does not allow people to sustain or regain their independence.

GPs

- There are significant variations in how older people living in care homes are able to access GP services, with particular issues around appointment processes and out of hours services.
- There is often a reliance on telephone diagnoses from GPs, which can lead to medications being prescribed incorrectly and potentially dangerous polypharmacy.
- There are often delays in the transfer of medical records, which impact upon the ability of GPs to assess an older person’s health needs when they move into a care home. This is a particular issue when an older person is discharged from a hospital in one Health Board area to a care home in another.

Sensory Loss

- Older people are not routinely assessed for sensory loss upon entry into a care home and there is also a lack of on-going assessment for sensory loss for older people living in care homes. This can result in many older people living with an undiagnosed sensory loss, leading to difficulties in communication that can often be misinterpreted as dementia and lead to a failure to meet an individual’s care needs.
- There is limited awareness in care homes about sensory loss and its impact, which means that a large number of older people could be missing out on essential assistance and support.
- There are issues around the basic maintenance of sensory aids and care staff are often unaware of how to support individuals to use them. This can mean long delays and avoidable visits to hospital to carry out basic maintenance.

Diet

- There are significant variations in the quality of food provided to residents in care homes, from meals that included fresh produce and lots of fruit and vegetables to meals with a ‘ready meal’ appearance.

- There is a limited understanding within care homes about the dietary needs of older people, in particular the importance of meeting an individual's specific dietary needs, and a 'one size fits all' approach to residents' diets is often adopted.
- There is a lack of support to assist and encourage older people to eat, something particularly important for people living with dementia and/or sensory loss. This is often due to care staff being unaware that an individual requires assistance and can result in older people struggling to feed themselves, which has a detrimental impact on their health and wellbeing and can lead to malnutrition in some cases.

Oral Hygiene

- Many care home residents rarely or never have access to a dentist, which results in a significant deterioration of people's oral health.
- Care staff rarely receive training on oral hygiene and are therefore unable to maintain the oral health needs of older people effectively or are unaware of how to identify a problem that needs to be referred to a dentist.

People and Leadership

Care Staff

- Working with emotionally vulnerable, cognitively impaired and frail older people is emotionally, mentally and physically challenging and demanding. Many care staff are generally kind and committed and are trying their best to deliver high standards of care in a pressured environment with limited resources and support.
- Care work currently has a particularly low social status, reflected by low pay, long working hours, poor working conditions and a lack of opportunities for professional development and career progression.
- Registration and regulation of care staff would be an effective way of driving up the status, identity and value placed on delivering residential and nursing care for older people.
- Many care homes are understaffed, sometimes chronically, which can significantly increase the pressure placed on care staff and can result in them having less time to interact with residents as they become more task-orientated to ensure that their essential core duties are undertaken.
- The recruitment and retention of high quality care staff is vital to older people's quality of life. Many of the best care homes are those with high morale among care staff and low staff turnover.

- Current basic mandatory training for care staff, which consists only of manual handling, fire safety and health and safety training, does not sufficiently prepare individuals to understand the needs of older people and provide the appropriate support. Furthermore, a significant number of care staff (estimated to be 40% of the workforce) are delivering care without even this most basic of training.
- Values based training, which includes themes such as dignity and respect, attitudes and empathy and equality and human rights, is essential to ensure that care staff not only fully understand the needs of older people living in residential care, but can also understand what it feels like to be an older person receiving such care. This is essential to be able to provide truly person-centred care and not simply follow a task-based approach.

Nursing Staff

- There is often disparity between the standards of nursing in the NHS and the standards found in nursing care homes. This can be due to a number of factors, including limited clinical supervision, a lack of peer support in nursing homes and a lack of opportunities for professional development.
- It is more difficult to recruit nurses to work in nursing care homes due to a lower standard of pay and conditions, more isolated working environments and a general negative perception of nursing care homes.
- There can be confusion about roles and responsibilities for clinical treatment and care between the NHS and nursing care homes due to assumptions that nurses working in nursing care homes can ‘do everything’. This means that the NHS often does not provide support in a proactive way.

Care Home Managers

- Effective leadership is a common factor amongst good care homes and strengthening management and leadership skills delivers better outcomes. A Care Home Manager plays a key role in modelling person centred care on a daily basis and is essential to improve the quality of interactions between residents and care staff to ensure that a task-based approach is not used in the delivery of care.
- The breadth of a Care Home Manager’s role, as well as competing priorities and demanding workloads, can result in a lack of time to drive the cultural change often required within care homes.
- There is a clear need for effective and on-going support for Care Home Managers, both in the form of additional training and specialist and peer support, due to the increasing demands and expectations that are now placed on this role.

- The role of a Care Home Manager can be too much for one individual to balance and a more equitable balance between the Care Home Manager and the responsible individual (e.g. care home owner) can deliver better outcomes for older people.

Workforce Planning

- Workforce planning is challenging due to a lack of demographic projections about future demand for, and acuity levels within, care homes. It is therefore not possible to quantify the 'right' number of care staff needed in the future.
- The unregulated nature of the care home workforce in Wales, which means that data is not held on the number of care home staff in Wales, can also lead to difficulties around effective workforce planning.
- In relation to nursing staff, workforce planning is not effective as it is based only on the needs of Health Boards and does not consider the needs of residential care. This can cause particular issues around the recruitment of qualified and competent nurses to work in EMI (Elderly Mentally Infirm) settings.
- There are issues around the recruitment of qualified and competent Care Home Managers and there is a lack of effective planning for current and future needs.

Commissioning, Inspection and Regulation

Commissioning

- The statutory focus of commissioning processes has been on contractual frameworks and service specifications rather than the quality of life of older people living in care homes.
- There is a lack of shared intelligence and joint working in contract monitoring to ensure that older people are safe, well cared for and enjoy a good quality of life.
- Commissioners are often experts in procurement but are often not experts in social care and do not fully understand the increasingly complex needs of older people.

National Minimum Standards

- The National Minimum Standards¹ (The Standards) are reinforcing a culture of tick box compliance, rather than creating an enabling culture where older people are supported to have the best quality of life.
- The Standards are insufficient to meet the needs of the emotionally vulnerable and frail older people now living in care homes.

- The Standards do not explicitly outline how to provide enabling care and support to older people with sensory loss and/or cognitive impairment and dementia.

Availability of Care Homes

- The residential and nursing care market in Wales is volatile and fragile. There are a number of barriers that can discourage providers from entering the market in Wales.
- A lack of registered Care Home Managers and a shortage of appropriately skilled nursing staff are risk factors to both the quality of care being provided and the ability for a provider to continue provision.
- The choices available to older people are often restricted by a lack of capacity in some areas, which can result in older people having to move away from their family and communities or live in a care setting that is not entirely appropriate for their needs or life.
- There is no overview at a strategic level to ensure sufficient and appropriate care home places for older people in Wales, both now and in the future.

Self-funders

- The current lack of knowledge about the number of self-funders in Wales living in care homes has an impact on the quality of life of older people as it is not clear what support and advice individuals are receiving and the extent to which or how the quality of care that self-funders receive is monitored.
- Residents who are self-funders and their families are fearful about raising concerns and complaints with a provider because of the perceived risk that they may be asked to leave the residential home and would not know how to manage such a situation without support.
- The health and care needs of self-funders are not sufficiently monitored and are therefore often not recognised and acted upon by visiting Local Authority and Health Board staff because they only monitor the individuals who are funded by their bodies.
- Local Authorities and Health Boards are unable to fully plan for the future needs of the older population and required provision of residential and nursing care if they are unaware of the total number of self-funders living in care homes, or how many self-funders are likely to live in care homes in the future.

Regulation and Inspection

- Quality of life is not formally recognised by the system in the way that it implements regulation and inspection at present and there is too great a reliance simply on formal inspection.
- The current inspection approach adopted in respect of nursing homes means that there is currently not a system-wide approach to ensuring effective scrutiny of the delivery of healthcare within residential and nursing care settings.
- The potential for the regulation and inspection system to be strengthened through the use of Community Health Councils and Lay Assessors to monitor healthcare and wider quality of life within care homes has not yet been fully explored.

Key Conclusions and Required Change

My key conclusions, which are drawn from the key findings of my Review, as well as my own casework and on-going engagement with national and local government across Wales, provide a high level assessment of those areas where change is required. This change is underpinned by clear outcomes to ensure that Wales, in taking forward the action contained within this report, stays focused on the overall aim of my Review: that quality of life sits at the heart of residential and nursing care in Wales.

The overall conclusion of my Review is clear: Too many older people living in care homes have an unacceptable quality of life and the view of what constitutes 'acceptable' needs to shift significantly.

Our best care homes are empowering, enabling, flexible, welcoming and friendly, communities in their own right but also still part of the wider communities in which they are located. The older people who live in these homes have the very best quality of life that they could. In our best care homes, older people are safe, can regain their independence, have a sense of identity and belonging, and are supported to live better lives. This care is a tribute to the many dedicated care home staff across Wales, as well as others who work within our social care system.

However, this is not the case for all care homes. Too many simply focus on the functional aspects of care, with a reliance on a task-based approach, rather than delivering care that is person-centred. Too many care homes are focused on an unchallenged dependency model that prevents older people from maintaining their health, wellbeing and independence for as long as possible. For too many older people their lives in care homes can be without love or friendship and people can be lonely and sad.

Too often, there is an acceptance by organisations and the 'system' of an overall level of care that is simply not good enough. Much of what is now considered to be acceptable should be considered unacceptable in 21st century Wales and falls below the standard that older people have a right to expect. Care delivered without abuse or neglect is not the same as good care.

Through undertaking my Review I have drawn the seven conclusions below. Underneath each conclusion I make clear the change that needs to take place and the outcomes that must be delivered. The actions required, including lead responsibilities and time scales, are contained in the Requirements for Action section on page 98.

1. Too many older people living in care homes quickly become institutionalised. Their personal identity and individuality rapidly diminishes and they have a lack of choice and control over their lives.

When older people move into a care home, too often they quickly lose access to the things that matter to them that give their lives value and meaning and are an integral part of their identity and wellbeing, such as people, places and everyday activities. Older people are often not supported to do the things that matter to them but instead have to fit into the institutional regime often found in care homes, losing choice and control over their lives.

This is due, in part, to a risk-averse culture, but is also indicative of a system in which the dignity and respect of older people is not sufficiently protected and older people are not seen as individuals with rights. This is exacerbated by de-humanising language too frequently used, such as ‘toileting’, ‘feeding’, ‘bed number’ or ‘unit’ that further strips older people of their individuality, their dignity and the concept of the care home as their home. For too many, a daily culture of inactivity and a task-based approach to delivering care, centred around the functional aspects of day-to-day life such as getting up, eating, formalised activity hours and going to bed, leads to institutionalisation and a loss of value, meaning and purpose to life.

The change I expect to see:

Older people are supported to make the transition into their new home, are seen and treated as individuals, have choice and control over their lives, enabling them to do the things that matter to them, and are treated at all times with dignity and respect.

Evidence of this will include:

Older people receive information, advice and practical and emotional support in order for them to settle into their new home, beginning as soon as a decision to move into a care home is made (Action 1.1 & 1.2).

Older people’s physical, emotional and communication needs are fully understood, as are the issues that matter most to them, and these are reflected in the services, support and care that they receive (Action 1.1).

Older people have real control over and choice in their day-to-day lives and are able to do the things that matter to them, including staying in touch with friends and family and their local community (Action 1.1).

Older people are aware of their rights and entitlements and what to expect from the home (Action 1.2).

Older people are clear about how they can raise concerns and receive support to do so (Action 1.2).

Older people are supported to maintain their continence and independent use of the toilet and have their privacy, dignity and respect accorded to them at all times (Action 1.1, 1.3, 1.5).

Mealtimes are a social and dignified experience with older people offered real choice and variety, both in respect of what they eat and when they eat (Action 1.1, 1.4).

Older people are treated with dignity and respect and language that dehumanises them is not used and is recognised as a form of abuse (Action 1.1, 1.3, 1.4, 1.5, 4.6).

Older people living in care homes that are closing, as well as older people that are at risk of or are experiencing physical, emotional, sexual or financial abuse, have access to independent or non-instructed advocacy (Action 1.6).

2. Too often, care homes are seen as places of irreversible decline and too many older people are unable to access specialist services and support that would help them to have the best quality of life.

Older people want to maintain their physical and mental health for as long as possible. However, formal health promotion is absent from many care homes. Too many older people are not being offered preventative screening or interventions, such as falls prevention, mental health support, speech and language therapy, occupational therapy, physiotherapy and wider re-ablement, which would enable them to sustain or regain their independence, mobility and overall quality of life. This is a particular issue when older people move into care homes after periods of ill health or following hospital admissions.

The lack of this specialist support, which would be more readily available if they were still living in their own home, can hasten frailty and decline, both physical and mental.

The change I expect to see:

Older people living in care homes, through access to health promotion, preventative care and reablement services, are supported to sustain their health, mobility and independence for as long as possible.

Evidence of this will include:

Older people benefit from a national and systematic approach to health promotion that enables them to sustain and improve their physical health and mental wellbeing (Action 2.1).

Older people receive full support, following a period of significant ill health, for example, following a fall, or stroke, to enable them to maximise their independence and quality of life (Action 2.2).

Older people's risk of falling is minimised, without their rights to choice and control over their own lives and their ability to do the things that matter to them being undermined (Action 2.3).

The environment of all care homes, internally and externally, is accessible and dementia and sensory loss supportive (Action 2.4).

3. The emotional frailty and emotional needs of older people living in care homes are not fully understood or recognised by the system and emotional neglect is not recognised as a form of abuse.

Older people living in care homes need to feel safe, reassured and that they are cared for and cared about. The current focus on task-based care, together with the absence of a values-based approach, can lead to care and compassion, simple kindness and friendship, too often being missing from older people's lives in care homes. Their emotional and communication needs are often misunderstood and neglected, with the needs of older people with dementia frequently poorly understood. As a consequence, they are too frequently labelled as 'challenging' or 'difficult', which places them at risk of unacceptable treatment and the inappropriate use of antipsychotics. The absence of emotional care is not recognised as emotional neglect, which, in turn, is not recognised as a form of abuse.

The change I expect to see:

Older people in care homes receive the care and support they need to sustain their emotional and mental wellbeing and anti-psychotic drugs are not inappropriately used. Residents feel safe, valued, respected, cared for and cared about, and care is compassionate and kind, responding to the whole person.

Evidence of this will include:

All staff working in care homes understand the physical and emotional needs of older people living with dementia and assumptions about capacity are no longer made (Actions 3.1 & 3.2).

Older people are supported to retain their existing friendships and have meaningful social contact, both within and outside the care home. Care homes are more open to interactions with the wider community (Action 3.3).

Older people are able to continue to practice their faith and maintain important cultural links and practices (Action 3.3).

The mental health and wellbeing needs of older people are understood, identified and reflected in the care provided within care homes. Older people benefit from specialist support that enables them to maximise their quality of life (Action 3.4, 3.5).

Older people are not prescribed antipsychotic drugs inappropriately or as an alternative to non-pharmaceutical methods of support and NICE best practice

guidance is complied with (Actions 3.4 & 3.5).

Emotional neglect of older people is recognised as a form of abuse and appropriate action is taken to address this should it occur (Action 3.6).

4. Some of the most basic health care needs of older people living in care homes are not properly recognised or responded to.

Too many older people living in care homes do not have access to the basic functional screening and primary healthcare that would have been available to them while living in their own home, such as regular access to GP services, eye health, sight and hearing tests, podiatry services, oral health advice, medication reviews and specialist nursing care.

Older people are unable to access services to which they are entitled, undermining their health and wellbeing. As a result of this, their ability to do the things that matter to them and communicate effectively can be significantly compromised.

The change I expect to see:

Older people living in care homes clearly understand their entitlements to primary and specialist healthcare and their healthcare needs are fully met.

Evidence of this will include:

There is a consistent approach across Wales to the provision of accessible primary and specialist health care services for older people living in care homes and older people's healthcare needs are met (Actions 4.1, 4.2 & 4.5).

Older people in nursing care homes have access to specialist nursing services, such as diabetic care, tissue viability, pain management and palliative care (Action 4.1, 4.2).

Older people are supported to maintain their sight and hearing, through regular eye health, sight and hearing checks (Actions 4.1, 4.2 & 4.3).

Older people are able to, or supported to, maintain their oral health and retain their teeth (Actions 4.1, 4.2 & 4.3).

Older people have full access to dietetic support to prevent or eliminate malnourishment and to support the management of health conditions (Actions 4.1, 4.2 & 4.3).

Care staff understand the health needs of older people and when and how to access primary care and specialist services (Action 4.3, 5.4).

Older people receive appropriate medication and the risks associated with polypharmacy are understood and managed (Action 4.4).

Older people are able to challenge, or have challenged on their behalf, failures in meeting their entitlements (Action 4.5).

5. The vital importance of the role and contribution of the care home workforce is not sufficiently recognised. There is insufficient investment in the sector and a lack of support for the care home workforce.

Care staff and Care Home Managers play a fundamental role in ensuring that older people living in care homes have the best quality of life and should be seen as a national asset to be invested in.

However, despite working in highly challenging and difficult circumstances, they currently receive low pay, often have poor terms and conditions, work long hours, lack training and work in a sector that is rarely seen as having a valuable status.

There is insufficient support available to care staff to ensure that they have the skills, knowledge and competencies required to deliver both basic and high quality care and there are limited opportunities for continued professional development and career progression.

Despite the high acuity levels of many older people living in care homes, there is no standard approach to staffing levels and required competencies and, for many care home providers, support is only available to them once the quality of their services has declined to an unacceptable level.

The change I expect to see:

There are sufficient numbers of care staff with the right skills and competencies to meet the physical and emotional needs of older people living in care homes.

Evidence of this will include:

Care homes have permanent managers who are able to create an enabling and respectful care culture and support care staff to enable older people to experience the best possible quality of life (Action 5.1).

Older people are cared for by care staff and managers who are trained to understand and meet their physical and emotional needs, including the needs of people with dementia and sensory loss, and who have the competencies needed to provide dignified and compassionate care (Action 5.2).

Older people receive compassionate and dignified care that responds to them as an individual (Action 5.3, 5.4, 5.5).

Care homes that want and need to improve the quality of life and care of older people have access to specialist advice, resources and support that leads to improved care and reduced risk (Action 5.6).

Older people are safeguarded from those who should not work within the sector (Action 5.7).

The true value of delivering care is recognised and understood (Action 5.8).

6. Commissioning, inspection and regulation systems are inconsistent, lack integration, openness and transparency, and do not formally recognise the importance of quality of life.

At present, there is an inconsistent and geographically variable focus on quality of life within commissioning, which is too often seen as a functional task-based process. Although there is action being taken at a local level in Wales to better recognise quality of life and the Welsh Government has published a new Social Services National Outcomes Framework, this has yet to translate into a consistent and systematic approach to the commissioning, regulation and inspection of care that has quality of life at its heart and is reflected in the way that commissioning, regulation and inspection are implemented.

There are competing and inconsistent demands upon providers, both in relation to standards and reporting, as well as an inconsistent approach to joined-up working, information sharing and the use of information to better evaluate quality of life and care.

Within nursing care homes there is also a lack of independent inspection from a healthcare perspective and there is currently not sufficient scrutiny of access to healthcare within residential care settings.

There is a lack of information that can be meaningfully used by older people, their families and those who care for and support them, to judge the quality of life, care and safety in individual care homes. There is also a lack of information in the public domain from commissioners and providers about the quality of care they provide or are accountable for.

Too many older people struggle to raise concerns and feel that their concerns are acted upon in an unsatisfactory way. There is also, too often, a lack of any evaluation of the quality of care outside of formal inspections.

The change I expect to see:

Quality of life sits in a consistent way at the heart of regulation, provision and commissioning, inspection and reporting. Providers, commissioners and the inspectorate have a thorough and accurate understanding of the day-to-day lives of older people living in care homes and this information is shared effectively to promote on-going improvements and reduce the risk of poor care. There is greater public reporting on the quality of care homes within Wales and older people have access to meaningful information in respect of the quality of care provided within individual care homes. There are effective ways in which the views of residents and

their families are sought and used to support continuous improvement.

Evidence of this change:

Quality of life sits consistently at the heart of the delivery, regulation, commissioning and inspection of residential and nursing care homes (Action 6.1).

Commissioners, providers and inspectors have a thorough understanding of the day-to-day quality of life of older people living in care homes (Action 6.2, 6.3).

Older people's views about their care and quality of life are captured and shared on a regular basis and used to drive continuous improvement (Action 6.2, 6.3).

The quality of life and healthcare of older people living in nursing homes is assessed in an effective way with clear and joined up annual reporting (Action 6.4, 6.5, 6.6).

Older people have access to relevant and meaningful information about the quality of life and care provided by or within individual care homes and there is greater openness and transparency in respect of the quality of care homes across Wales and the care they provide (Action 6.7, 6.8, 6.9, 6.10).

Older people are placed in care homes that can meet their needs by commissioners who understand the complexities of delivering care and are able to challenge providers about unacceptable care of older people (Action 6.11).

7. A current lack of forward planning means that the needs of older people in care homes will not be met in the future.

There is not a clear national understanding of what the future need for residential and nursing care will be, nor an understanding of how acuity levels within care homes are likely to further change as a result of wider changes in the model of health and social care within Wales and the potential for further development of other models that combine housing and care, such as extra care, has not been fully explored.

This means that there is a lack of effective forward planning for, and action to ensure, the future supply of appropriate, high quality care home places in Wales with the appropriate numbers of specialist staff required, in particular in respect of nursing care.

There are already parts of Wales that are unable to meet current demand, in particular in respect of care of older people with high levels of dementia and nursing care needs.

The change I expect to see:

There are sufficient numbers of care homes in Wales, or alternatives to traditional care homes, in the places that older people need them to be, that are able to provide high quality care that meets the needs of older people.

Evidence of this change:

Forward planning ensures there is a sufficient number of care homes, of the right type and in the right places, for older people (Action 7.1).

Forward planning and incentivised recruitment and career support ensures that there are a sufficient number of specialist nurses, including mental health nurses, to deliver high quality nursing care and quality of life outcomes for older people in nursing homes across Wales (Action 7.2, 7.3).

Impact of not delivering the change required

If we fail to deliver the change I have outlined in my report, we fail older people. We fail those who need us, expect us and require us, through our collective leadership, to act on their behalf. If we fail, the price will not be paid by those of us in public service, it will be paid by some of the most vulnerable people in society and the price that they will pay will be too high.

Within my Requirements for Action (Page 98) I make clear what the impact of this failure will be upon older people. This should drive all of us in public service to do everything that needs to be done to support, protect and stand up for those who are most vulnerable and ensure that older people living in care homes in Wales have the very best possible quality of life.

Why I Carried out my Review

In 2013, I published my priorities as Commissioner, based on extensive engagement with older people across Wales, in effect their priorities. In my Framework for Action, I clearly signalled that I expected to see significant improvements in the quality of, availability of and access to, health and social care. Specifically, that quality of life sits at the heart of residential and nursing care, that people with dementia and other groups of older people needing specific support have their needs met and that older people have voice, choice and control over how they receive services, care and support.

Whilst residential care is not an option for everyone, and increasingly need not be as a result of significant work within Wales to support people in their own homes, for many older people it continues to be a key way in which they receive the care and support they need and, in years to come, will be particularly important for our frailest and most vulnerable older people.

The majority of older people living in a care home will have moved there as a result of complex health conditions, disability or frailty, which meant that they could no longer live safely in their own homes. Many of these people, just a few years ago, would have been cared for in community hospitals or long-term care of the elderly wards.

This means that the 23,000 care home residents in Wales² are amongst the most vulnerable people in society, often as a result of significant levels of cognitive impairment, sensory loss and emotional frailty, as well as physical ill-health, which, too often, can leave them without an effective voice and powerless.

For example, 80% of older people living in residential care will have a form of dementia³ or cognitive impairment. Similarly, it is estimated that 70% of people aged over 70 have some form of sensory loss, a figure that rises significantly among people aged 80 and over^{4,5}.

Older people in care homes, however, must not be categorised by their health conditions or be seen as a homogenous group. Older people living in care homes are diverse, with individual needs and wishes. The diversity of older people, which covers the breadth of race, gender, language, disability, sexual orientation, trans status and religion or belief, must be recognised and the care they receive must be sensitive to their individual needs.

I travel the length and breadth of Wales meeting with many older people living in care homes, as well as care staff, and I have seen for myself the impact that high quality care, which meets people's individual needs, can have on their lives. I have spoken frequently about the many excellent examples of health and social care in Wales and the many dedicated staff in both the public and private sector.

However, I have also received an increasing amount of correspondence about the quality of life and care of older people in care homes across Wales and I have had to provide individual support to older people and their families who have found themselves in the most distressing and unacceptable of circumstances to ensure that they are safe and well cared for.

As a result, I have spoken publicly many times about what I consider to be unacceptable variations in the quality of life and care of older people in care homes. I have been clear that we fail to keep too many older people safe and free from harm, that too many older people are not treated in a compassionate and dignified way and that, for some, their quality of life is unacceptable.

I recognise that much work has been undertaken and is taking place within Wales to address specific aspects of social care. The National Assembly for Wales' Health and Social Care Committee's Residential Care Inquiry, for example, examined how effective the residential care sector was at meeting older people's needs, with a focus on the process by which older people enter residential care. Similarly, the Social Services and Wellbeing (Wales) Act 2014 aims to transform the way that social services are delivered in Wales. Furthermore, forthcoming legislation in the form of the Regulation and Inspection Bill offers a real opportunity for quality of life to become a key part of regulation and inspection processes. There is also work underway across Wales, in some places significant, at a local level, both within Local Authorities and Health Boards and by care home providers, to address a wide range of aspects of residential and nursing care.

However, despite this work, I wanted, and required, a higher level of assurance that the action being taken would ultimately translate to safer, high quality care for older people living in care homes and that having the best quality of life would become the outcome that sits at the heart of residential and nursing care across Wales.

It is for the reasons outlined above that I took the decision to undertake a Review into the quality of life and care of older people living in care homes in Wales, using my powers under Section 3 of the Commissioner for Older People (Wales) Act 2006.

Focusing on and Defining Quality of Life

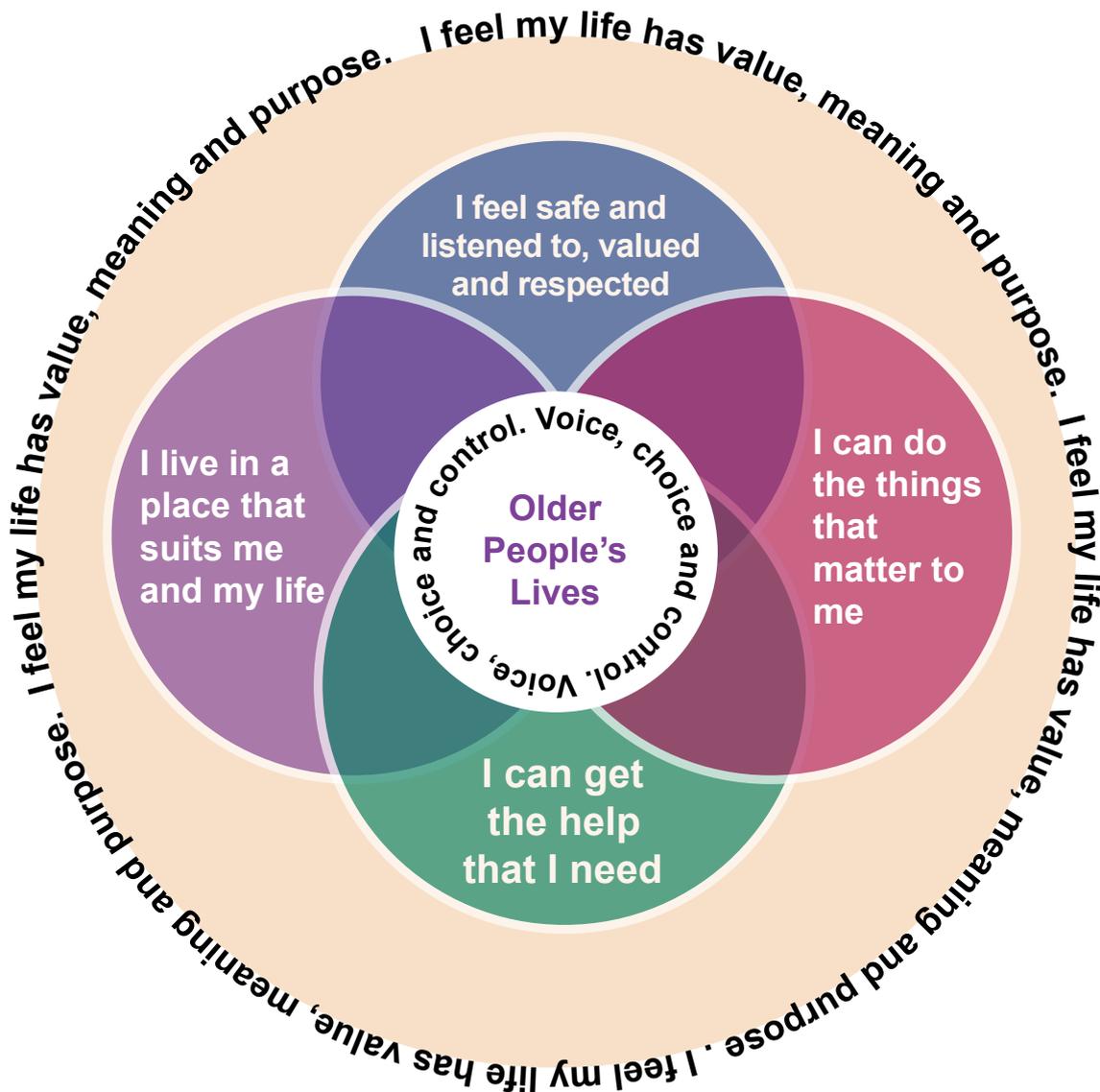
My extensive engagement with older people and care staff in care homes has made it clear to me that life is precious and life is for living, regardless of your age or how frail you may be. It is not sufficient for older people to be just safe and physically well cared for in care homes, essential as these are. Despite the importance of quality of life, through my engagement with older people, it became clear to me that this was systematically missing from our residential and nursing care sector.

Our quality of life as we grow older is hugely important to all of us and should be formally recognised and sit at the heart of the residential and nursing care sector in Wales to ensure that older people living in care homes have lives that have value, meaning and purpose. It is for this reason that my Review focuses on quality of life.

Older people have told me that their lives have value, meaning and purpose when they:

- Feel safe and are listened to, valued and respected
- Are able to do the things that matter to them
- Are able to get the help they need, when they need it, in the way they want it
- Live in a place which suits them and their lives

Figure 1. Quality of Life Model



Older people are very clear that they want to have a strong voice and meaningful control over their lives, both in their day-to-day life and how they are supported and cared for. The extent to which they do will have a direct impact on their quality of life and, in many cases, increase the positive impact of services.

How I Carried out my Review

In order for my Review to achieve its aims, I drew together a number of different approaches, including an extensive literature review, a questionnaire for older people, their families and carers, focus groups, written and oral evidence and visits to care homes to observe and understand the day-to-day lives of older people. To support me in these visits, I recruited a team of 43 Social Care Rapporteurs from a wide range of backgrounds and selected an observation tool that considers a range of quality of life factors such as control over daily life, personal safety and social participation and aligns with my own quality of life model.

Commencing in October 2013, the process for my Review comprised five phases:

Phase 1: (October 2013 – January 2014)

- Review team undertakes comprehensive review of research literature about residential and nursing care.
- Adoption of ASCOT, the Adult Social Care Outcomes Toolkit (Appendix 6), as the framework against which to consider quality of life factors for older people living in care homes.
- Development of a detailed questionnaire for older people, their families and the general public to share their experiences of residential and nursing care. The questionnaire considered factors such as physical and psychological health, social relationships, and the care home environment.
- Formal launch of the Review process, with extensive media coverage across Wales.
- Wide distribution of the questionnaire to every care home in Wales, third sector organisations, older people's groups, 50+ forums and Assembly Members to reach as many older people and their families as possible across Wales. Alongside this, the Review team undertook work with the media, particularly local newspapers, to promote the Review and call for evidence.
- Review team receives over 2,000 questionnaire responses.
- Review team gathers written evidence from the bodies subject to the Review (Appendix 3), with a particular focus on current systems in place and action underway to promote the quality of life of older people living in care homes.
- Review team also gathers extensive written evidence from a wide range of organisations that represent and work on behalf of older people, including professional bodies, third sector organisations and recognised experts in the delivery of residential and nursing care.

- Review team receives a total of 53 written submissions (Appendix 4).
- Review team recruits and trains 43 Social Care Rapporteurs (Appendix 2) to prepare them for visits to care homes during Phase 2.

Phase 2: (January 2014 – May 2014)

- Review team selects 100 care homes at random for visits by Rapporteurs. The selection process ensures that the care homes represent the diverse cultural and demographic context of Wales.
- Rapporteurs make unannounced visits to 100 care homes across Wales, seven days a week, to observe older people and to hear directly from them about their experiences and expectations.
- Review team undertakes a series of engagement events and focus groups across Wales to capture the views and experiences of the families of older people living in residential and nursing care, those providing independent advocacy and representatives of groups whose voices are seldom heard.
- Review team gathers oral evidence at roundtable discussion sessions with organisations that represent and work on behalf of older people, including professional bodies, third sector organisations and recognised experts in the delivery of residential and nursing care.
- Review team undertakes an analysis of the extensive evidence received.

Phase 3: (May 2014 – September 2014)

- Review team undertakes evidence and scrutiny sessions with bodies subject to the Review to discuss and consider the written evidence provided in greater detail and to obtain further information about their understanding of the day-to-day realities of living in residential and nursing care, the change required to improve quality of life and whether current action (planned or underway) is sufficient to deliver this change.
- Review team undertakes a second round of evidence and scrutiny sessions with bodies subject to the Review in order to cross-reference against evidence gathered from the Review questionnaires and care home visits.
- Review team analyses oral evidence from a total of 82 bodies gathered during roundtable discussion sessions and formal evidence / scrutiny sessions (Appendix 5).
- Writing of Review report and development of Requirements for Action.

Phase 4: (November 2014)

- Review report published.
- Requirements for Action issued to public bodies subject to the Review that state what must be improved, changed or implemented to ensure that quality of life sits at the heart of residential and nursing care across Wales.

Phase 5: (February 2015)

- Deadline for responses to Requirements for Action. The public bodies to whom Requirements for Action are directed must demonstrate what action they will take to comply with them.
- Publication of a register detailing Requirements for Action and what action will be taken by public bodies.
- Agreed action is implemented and mechanisms agreed and adopted to provide assurance that this action has delivered the intended outcomes.

Day-to-Day Life

Literature Review

It is clear that the choice and control that an individual has over their daily life is fundamental to a good quality of life.

This is reflected in the volume of literature that explores aspects of day-to-day life in care homes. The National Development Team for Inclusion (NDTi) and the Centre for Policy on Ageing has identified 7 key domains⁶ over which older people value having choice and control, one of which is the need for a meaningful daily life.

“Older people need to have their views and experiences taken into account on an on-going basis to have real choice and control in decisions that affect them.”⁷

Tom Owen, collaborating with the Joseph Rowntree Foundation, Age UK, City University and Dementia UK, conducted research for the My Home Life (MHL) study, ‘Promoting Quality of Life in Care Homes’. The study identified that the principles of voice, choice and control correspond with the three MHL ‘personalisation themes’, designed to promote a more relationship-centred approach within care homes:

- Maintaining identity: ‘See who I am!’
- Sharing decision-making: ‘Involve me!’
- Creating community: ‘Connect with me!’⁸

Owen’s findings go on to report that care home residents need to be “seen as individuals and given a ‘voice’ to express who they are and what they want (maintaining identity)”. In addition, there needs to be “more than one way of doing things (choice), especially in situations of collective living”, and older people need “to have ‘control’ over what is the right option for them (sharing decision-making)”⁹.

Relationship-centred care is central to Nolan et al’s work on the Senses Framework. The conceptual phase, together with practical work from a related project ‘Dignity on the Ward’¹⁰, identified the Senses Framework as a potential framework for practice. These studies suggest that in the best care environments all participants experience a sense of:

- Security – to feel safe
- Belonging – to feel part of things
- Continuity – to experience links and connection
- Purpose – to have a goal(s) to aspire to
- Achievement – to make progress towards these goals
- Significance – to feel that you matter as a person¹¹

“Where there is a community that supports older people, relatives and staff, a greater connection is developed through which choice and control can be realised. This finding is not new; it reflects a strong body of knowledge surrounding relationship-centred care.”¹²

The Commissioner’s own research has found that access to advocacy is key to older people exercising voice, choice and control at all stages of decision-making, from deciding to enter, whilst living in residential care, or when moving from it, and is particularly important as a safeguard for those in a position of vulnerability¹³. However, research has found that there is a lack of access to and awareness of advocacy and information for residents and their families^{14,15}, especially during the process of choosing and entering residential care¹⁶, and without this support it may not be possible for older people to have real voice and choice over their day-to-day lives.

Voice and choice is not only fundamental to promoting the bigger, overarching themes above, it also plays a crucial role in almost every day-to-day decision. For example, a large number of studies indicate that social participation and daily activity are key: “meaningful activity, recreational opportunities, expressive arts or one-to-one activities can make a significant contribution to the overall living environment in care homes”¹⁷. The urge to engage in purposeful and meaningful activity is a basic human drive and this in-built motivation does not diminish or disappear as people age¹⁸.

However, social participation and meaningful occupation are often seen as one and the same. Whilst both can mean some form of general activity, the real difference is in the outcome as experienced by the resident. Social participation is about enabling someone to feel part of the community and engaging with fellow residents. It is vital in encouraging residents to become a part of community life and “turning boredom, lethargy, sleeping and staring into space into positive social interactions”¹⁹. The result of this approach can mean that a resident is more closely connected to and involved in the community life of their home.

However, meaningful occupation focuses more on the concept of wellbeing through specific purpose, which is often aligned to what an individual did previously, such as a former carpenter having opportunities to undertake woodwork.

Research suggests that meaningful occupation engenders a sense of purpose, as well as self-worth, and can help to develop and maintain independence by promoting choice and control in the daily life of residents.

The College of Occupational Therapists has taken a very practical approach to person-centred care to ensure that people are able to continue to live active lives, which enables them to maintain their independence and do the things that matter to them²⁰.

“The traditional service-led approach has often meant that people have not received the right help at the right time ... However, occupational therapists have always

taken a client-centred approach, which is consistent with the principles and practice of personalisation.”²¹

Choice is vital to improving and maintaining quality of life. The NICE Quality Standard, Mental Wellbeing of Older People in Care Homes, states that [older people] “should be encouraged to take an active role in choosing and defining [daily] activities that are meaningful to them”²². It is therefore crucial that older people in care homes have the opportunity and are encouraged to take part in activity in all its forms, “including activities of daily living, that helps to maintain or improve their health and mental wellbeing”²³.

Choice around personal cleanliness is fundamental to maintaining a good day-to-day quality of life. Having the option to determine the timing and frequency of baths and showers, for example, is crucial. However, the physical act of washing is only one aspect of personal cleanliness; the psychological impact on daily life also needs to be considered. Research has shown that “having a clean and respectable appearance and pleasant environment is key to maintaining the self-esteem of older people”²⁴. In addition, “hygiene and cleanliness is seen as a key indicator of standards within a [care] home”²⁵.

Improving the mealtime experience of adults living in residential care can also be a major factor and a facilitator in improving the care, general health and wellbeing, as well as the quality of life, of older people²⁶.

The physical layout and design of a care home impacts on the daily life of residents. In general, care homes and hospitals are designed to “fulfil an institutional purpose, a purpose which does not enrich life for persons with physical disabilities, memory, perceptual or behavioural challenges”²⁷. However, a care home can be so much more.

A wide range of research draws attention to the importance of building design that encourages and promotes a welcoming and homely space “which allows for privacy when necessary, as well as their [a resident’s] overall desire to have a home that supports relaxed behaviour, common in a domestic setting”²⁸.

It is vital that a positive culture of care underpins an individual’s day-to-day life. A recent Joseph Rowntree Foundation report, ‘Learning for care homes from alternative residential care settings’, highlights the importance of developing a positive culture for caring. The report argues that “a positive organisational culture has the potential to impact on the lives of residents, families and staff”²⁹.

Key areas identified in the report stress the importance of person-centred and relationship-based care. Fundamental to these approaches is the placement of the individual and their families at the centre of care planning. This approach focuses on individuals’ strengths and interests rather than on assessing what they can’t do³⁰.

However, there are other factors to consider. “Studies that have examined the impact of residential services emphasised that features of a positive culture are

complex and depend on...organisational structures, management arrangements, the physical environment, skilled staff and teamwork, and positive staff and resident relationships”³¹.

A key element in improving cultures of care is the need to eliminate a process and/or task-driven approach in which residents have things done to or for them rather than with them. “The prevalent model in care emphasises the debilitating effects of old age where staff take on the role of custodians who ‘do things to’ residents. This devalues staff as much as residents. A more positive model is one which emphasises personal growth for residents and staff with a shared commitment to ideas, values, goals and management practices by residents, staff and relatives”³².

A positive culture also means that all residents, their families and staff members are provided the opportunity to be involved in decision-making processes that affect them. A culture of open communication and information sharing needs to be encouraged enabling all stakeholders to be involved in decision-making processes. Quality improvement is more likely to be successful in homes with a culture that promotes innovation and staff empowerment³³.

Although the literature identifies the importance of person-centred and relationship-centred care as fundamental to improving cultures of care, it is also important to note the emphasis on knowing the resident and understanding his or her needs and preferences. Studies stress the importance of an individual’s right to privacy and guidelines published over the past 20 years have emphasised the importance of valuing privacy, dignity, choice, rights, independence and fulfilment.

Residents should be able to maintain their privacy at all times, and staff should respect this. This includes privacy of their personal care, confidentiality of any information owned by or kept about the resident and privacy of their personal space³⁴.

Treating residents with dignity and respect is a vital part of residential care and must be ensured in order to maintain a positive culture within a care home and enhance good quality of life. It is also worth emphasising that staff need to be treated with dignity and respect if they are to deliver dignified care to residents^{35,36}.

Review Findings

Social Participation

The majority of Rapporteurs reported that many residents spent their time sat in chairs placed around the edge of the lounge, an arrangement that is not conducive to conversation and interaction. In many cases, the TV was left on with no subtitles and no-one watching, its volume making conversation difficult, if not impossible. A number of Rapporteurs also reported that residents were sat in poorly lit surroundings for a significant amount of time until care staff noticed and turned lights on.

For residents who were bed-bound, many were 'left alone' for long periods of time, with interactions limited to task-based care, such as the administering of medicines, and no opportunities for social participation.

The lack of social stimulation within care homes has a significant impact on the wellbeing and quality of life of older people. This can often lead to older people withdrawing, both physically and emotionally, which further restricts potential opportunities for social participation.

Rapporteurs described residents as being withdrawn, seeming 'bored' and 'listless'. Many residents spent much of their time dozing or sleeping, with some choosing to remain in their rooms.

“People were left all day every day without any form of social stimulation, nothing to do whatsoever, day after day...” Family Member (Questionnaire Response)

“A really good home is where residents are motivated to do things and not just sit in a chair in front of the telly all day.” Chartered Society of Physiotherapists (Oral Evidence)

Many Rapporteurs also commented on the lack of interaction between staff and residents, with little conversation about anything other than the care task in hand or asking a resident quickly if they were 'OK'.

In only a small number of the care homes visited, Rapporteurs reported that where care staff interacted with residents in a more meaningful way, such as by reminiscing with them and talking about their lives, older people knew that they mattered and felt valued and part of a community within a homely environment.

Staff told Rapporteurs that they did want to engage more with residents but felt that they did not have the time or simply lacked ideas on how to do so and therefore continued to focus on checklists rather than residents' quality of life.

Good Practice: Dementia Care Matters – Being a Star Programme³⁷

This eight day training programme aims to improve self-awareness among care staff, giving them the practical skills to deliver truly person-centred care for people living with dementia.

The programme allows staff to develop emotional intelligence and develop specialist skills to enhance the quality of life of residents.

The course concentrates on the following key messages and objectives:

- We don't do person-centred care, we need to be person-centred.
- Experiencing the person's journey through dementia. (Cont...)

- Interpreting feelings behind words.
- Noticing controlling care. Feel it, see it, hear it.
- Growing in confidence and changing the moment. Skills in ‘The Butterfly Approach’.
- Mealtimes with meaning. Well-being is the key to life.
- Appreciating what is behind behaviours.
- Relationships matter and closeness is what counts in ‘later stage’ dementia care.

The evaluation of the programme found that the workshops appear to have had a positive impact on practice, with an increase in positive social interactions observed and an appropriate decline in neutral and restrictive care. This approach appears to offer significantly more potential to change practice and cultures than traditional approaches to training.

The importance of meaningful interaction between care staff and residents is often not recognised due to a clinical approach to care delivery that does not recognise the need of the whole person. This can lead to an ‘us and them’ culture that can result in care staff perceiving residents only as a series of care needs and tasks, rather than individuals who they can enable to lead a life that is as active as possible.

In many instances, Rapporteurs reported that residents simply sat doing nothing. Many residents, particularly those with high acuity needs, sensory loss or those with dementia, were entirely reliant on care staff to engage, interact and participate.

“Frank lives in a care home in North Wales and communicates in British Sign Language but his paid carers are unable to communicate with him. This means that the only time he is able to communicate with others is when his family travels from Birmingham to visit him.” **Action on Hearing Loss (Written Evidence)**

Evidence from the Commissioner’s roundtable discussion with organisations working with people living with sensory loss clearly showed a lack of awareness amongst care staff about the specific communication needs of people living with sensory loss and the impact this can have on social participation.

“[A resident said] I don’t know what is going on, I can’t hear anyone very well and I need guidance with the craft as my sight is very poor.” **Deafblind Cymru (Oral Evidence)**

Rapporteurs also reported that many residents whose first language was Welsh were unable to communicate in their language of choice due to the lack of Welsh-speaking care staff. This is particularly important for residents with dementia, who are often no longer able to communicate in English as their dementia progresses. Residents reported that it was important for them to be able to communicate in Welsh and that they were frustrated that they were unable to do so. Evidence from Gwynedd Council, which has a proportionally high number of Welsh speakers, supported this, stating that the language in which people converse has a direct impact on their quality of life and care.

The lack of awareness about the specific communication needs of individuals can lead to frustration, confusion and distress for residents; being unable to communicate with care staff and fellow residents can lead to a decline in an individual's physical and emotional wellbeing.

Rapporteurs found that many care homes employed a dedicated activities coordinator, who was responsible for ensuring that activities were available for residents.

Rapporteurs identified a small number of exemplary care homes where the activities coordinator played a vital role in ensuring that all residents were engaged with other residents and care home staff and that opportunities for residents to participate and enjoy doing the things that matter to them were readily available.

“The home has a wonderful activities coordinator who does lots of activities with the residents. My father is a quiet sort of man who doesn't always want to join in, but she is always cheerful and encouraging.” Family Member (Questionnaire Response)

“One activities coordinator literally took the activities to people's rooms to ensure that those who were bed-bound could participate socially in some way.” Social Care Rapporteur

Good Practice: Care Home, Caerphilly

At a Caerphilly care home, the activities coordinator works to deliver both spontaneous and programmed activities with a range of people with dementia in a group and on a 1:1 basis. Her interventions have encouraged previously non-verbal residents to talk, reduced agitation and welcomed families back into the heart of the care home with regular tea parties, film afternoons and fundraising activities.

In many care homes, the introduction of activities coordinators has had a positive impact on the quality of life of residents, although there is great variation in implementation and outcomes of this role. With the right skills and resources, the

activities coordinators are an invaluable resource to challenge accepted practices and embed new and innovative ways of thinking around engaging and stimulating older people, regardless of their physical and cognitive abilities.

Rapporteurs observed that where the role works most effectively, it is because the coordinator has been supported by the Care Home Manager to ensure that all care staff engage both in planned and spontaneous activities in order that all residents are enabled to live an active life in the place they call home.

However, in the majority of the homes visited, opportunities to take part in meaningful activities were severely limited. In many cases there was a lack of flexibility that meant that residents could only participate in the planned and structured programme of activities and were not supported to do the things that they wanted to do when they wanted to do them.

Furthermore, even when books, newspapers, magazines, games and IT were present, a lack of staff time and encouragement to enable residents to use them meant that resources often went unused.

In the exemplar care homes visited, the care homes in which residents seemed to have the best quality of life, it was clear that the Dementia Care Matters model of care, which is people-centred rather than systems-based, was used to ensure that staff were engaging and participating meaningfully with residents. Staff were able to encourage conversation by knowing about a person and their life before moving into a care home and by referring to the things they enjoy, as well as their likes and dislikes. Furthermore, relationships between staff and residents were based on genuine friendship, empathy and understanding.

A significant number of Rapporteurs reported that residents would like more outings and activities outside of the home. While some of the homes visited organised regular trips and outings, such as trips to the beach, shopping trips and trips to the theatre, these opportunities were often limited due to a lack of staff availability, access to transport or cost implications.

Many residents also told Rapporteurs that it was the care home's decision as to whether they were allowed or not allowed to leave the home, meaning that some did not have a choice to participate in activities outside of the care home environment.

Rapporteurs reported that some care homes engaged with the wider community, as well as groups and organisations, on a regular basis to enable residents to enjoy activities and experiences that would not usually be available within the home. Examples included local schools visiting to perform for and interact with residents, animal charities visiting with dogs and cats, and faith leaders holding religious services.

However, these kinds of opportunities were significantly lacking in the majority of care homes visited, where the care home was not open to interactions with the wider community.



Care homes that enable residents to interact with the wider community are able to enhance the lives of residents through initiating and maintaining links with individuals, groups and organisations. Without this, residents do not feel connected to their communities and are unable to develop relationships with individuals beyond family members and care staff.

Meaningful Occupation

The role of meaningful occupation in reinforcing an individual's self-esteem and identity, and the positive impact this can have on their quality of life is frequently underestimated. Being enabled to make a contribution through meaningful occupation allows individuals to feel valued, have a sense of continuity, be reassured by a familiar role or task and know that they continue to matter.

Only a small number of care homes visited enabled residents to participate in meaningful occupation, activities that are essential to maintain an individual's identity, such as making tea, baking, gardening, setting the table, keeping pets, taking part in religious services and helping others.

“Allowing my sister to access the kitchen so that she could clean up, wash dishes and make scones made all the difference.” Family Member (Questionnaire Response)

“Attending a church service in the home meant that my Mam could actually experience rare moments of peace and calm.” Family Member (Questionnaire Response)

One Rapporteur gave an example of a home in the Vale of Glamorgan where residents were supported to use their skills to maintain the care home's garden. They were involved in the garden's design and were able to choose the plants and flowers that they wanted. Residents also grew vegetables that were used as part of the care home's menu. Residents also looked after chickens, selling eggs to care staff to raise money for their activities.

Another positive example identified by a Rapporteur during a visit to a home in Rhondda Cynon Taf was the use of volunteer befrienders, recruited from the community, to visit and share skills with residents and support them to do the things they like and enjoy, such as arts and crafts, woodwork and baking.

Providing residents with a choice to do the things that they want to do can help them to build relationships and give them a sense of achievement, as well as supporting them to be more active and engaged. Specifically for residents living with dementia, meaningful occupation is vital as it provides an important link to the past and enables them to contribute and feel valued within the care home, reducing levels of confusion, anxiety and agitation.

In the care homes visited where meaningful occupation was enabled, Rapporteurs reported that residents were often more physically active, more engaged and less likely to report boredom and loneliness.

“My Mum has been given small jobs in the kitchen, preparing vegetables on the odd occasion. It’s wonderful to see the enjoyment and feeling of self-worth Mum has gained from this small act of kindness by the staff.” Family Member (Questionnaire Response)

However, the majority of care homes visited did not provide opportunities for meaningful occupation to residents. In many cases, barriers, that could often be easily overcome, were put in place that prevented access to areas of the home where meaningful occupation would take place, such as the kitchen, laundry room and the garden. For example, residents were often prevented from undertaking simple tasks for themselves or others, such as making a cup of tea, which ultimately impacts upon an individual’s independence. This was often informed by an attitude of risk-aversion and a misunderstanding of health and safety regulations.

Enabling care homes will actively look for ways to overcome perceived risks and health and safety barriers to support residents to do the things that matter to them, an essential element in an individual’s quality of life.

“Undertaking a simple risk assessment has allowed one care home in Cardiff to take residents ice-skating each year as this is what they said they want to do.” Age Cymru (Oral Evidence)

Good Practice: My Home Life Cymru

Gwynfor was able to talk with the independent advocate and said that he had been forgotten about and that no-one cared about his wishes. It transpired that Gwynfor was a keen gardener but had no access to the garden outside. The advocate advised the care home manager on how she could conduct a risk assessment to ensure Gwynfor’s safety and allow him to begin to go outside. This resulted in a change in Gwynfor’s behaviour as over time he became less agitated and was able to enjoy spending time outside. Gwynfor told the advocate that it was the first time that anyone had really listened to him in many years.

Personal Hygiene, Cleanliness and Comfort

Personal care is an integral part of an individual’s day-to-day life and the ways in which this is delivered has a direct impact on their dignity and wellbeing.

The majority of Rapporteurs found that the residents they observed were clean and that help and support was provided by care staff to residents who were unable to maintain their own personal hygiene. Residents reported that care staff were sensitive to their needs and they greatly valued the support they received.

Rapporteurs did comment, however, that it was often not possible for residents to have a bath or shower when they wanted to due to rota systems being in place as a result of a lack of facilities and/or staffing levels.

“Perhaps baths are not offered often enough, but this is I think through shortness of staff.” Family member (Questionnaire Response)

“I’ve never had a shower in my life, but I can’t have a bath as there’s not one here. So my carer uses a flannel to wash me.” Resident (Care Home Visit)

While basic hygiene needs are generally being met in a sensitive way, the approach to personal care is often task-based and not delivered in a person-centred way that enables an individual to have choice and control, an essential part of their quality of life.

In addition, a number of Rapporteurs commented that personal hygiene needs were sometimes not met for some residents with high needs, such as those living with dementia or a physical disability, with care staff reporting that they found it difficult to provide personal care in these circumstances.

Without the necessary training for care staff, older people will be unable to receive the personal care that they require in a sensitive and supportive way that meets their needs.

There were variations in the ways in which residents in the homes visited were assisted in using the toilet. Some homes saw using the toilet as a structured task that took place at specific times during the day, which resulted in residents being lined up and told when to use the toilet. This tasked-based approach to continence management can have a detrimental impact both on an individual’s independence and their dignity.

Other homes, however, responded to residents’ needs in a respectful and dignified way, assisting them to use the toilet as and when they required.

Rapporteurs found that incontinence pads were widely used in the homes visited and that some residents were told to use these despite the fact that they were continent and able to use the toilet, albeit with assistance.

“Carers told my husband to go in his pad (in front of me). This is something that he would never have wanted. I used to take him [to the toilet] all the time while looking after him at home.” Family Member (Questionnaire Response)

Evidence from the Commissioner’s questionnaire also showed that incontinence pads were not changed regularly, with residents often left in discomfort for hours.

“Visiting in the afternoons I often had to ask staff to change my mother’s pad as she was ‘leaking’. The difficulty getting her from her room to downstairs meant that she did not get her pad changed before lunch nor even immediately after. The result was always embarrassing, distressing and humiliating to her.”

Family Member (Questionnaire Response)

The inappropriate use of incontinence pads can cause severe discomfort and have a disabling impact on people’s health, particularly around mobility and independence, stripping them of their dignity entirely in some cases.

Personal Appearance

Rapporteurs found that the majority of residents were supported to maintain their personal appearance and this aspect of their identity. Clothes were generally clean, pressed and in a state of good repair. However, issues around residents’ clothing were identified during visits, such as clothes going missing while in the laundry.

“A frequent complaint is that clothes go missing after having been sent to the wash and no explanation is given. I appreciate that it is difficult to wash everyone’s clothes separately, but my relative takes pride in having nice underwear etc. and I do not feel it is right for her to suffer the indignity of wearing other people’s clothes.” Family Member (Questionnaire Response)

Some homes visited have systems in place, through personalised laundry baskets, for example, to ensure that clothing is not misplaced or mixed up and that residents are always able to wear their own clothes and have a choice about what to wear.

Some homes visited also supported residents to dress in clothes associated with their earlier lives, something particularly important for people living with dementia who often find comfort in particular, familiar clothing. An example of this was at a home in north Wales, where a resident with dementia was supported to wear clothing that reflected his time in the Navy.

Other good practice observed by Rapporteurs included hairdressers and beauticians regularly visiting homes and female residents being supported to use their handbags, wear their favourite jewellery items and choose their favourite perfume.

An individual being able to express themselves through their appearance, such as choice over the clothes and accessories they wear, enables them to feel comfortable, relaxed and at home. Furthermore, it reinforces their personal identity and has a positive impact on their quality of life, providing a connection to their past, particularly important for residents living with dementia.

The Dining Experience

Mealtimes are a key part of an individual's day and their experience during these times has an impact on their health and their quality of life. Mealtimes should therefore be more than a task-based feeding activity. They should be social occasions where residents are fully engaged and are able to enjoy the dining experience.

Rapporteurs described that this was rarely the case and that meal times were often a 'clinical operation', with staff wearing plastic aprons and gloves. While hygiene was understood as a factor, this functional appearance reinforced the notion of meal times as a task-based feeding activity and did not provide a dining experience, which is an important aspect of maintaining quality of life.

When mealtimes are seen as 'feeding', merely as a task to be completed, there is a lack of positive interaction between care staff and residents. This can lead to an 'us and them' culture developing, which can lead to an institutional feel within many care homes.

Rapporteurs observed that communication between staff and residents, as well as communication between residents themselves, was either non-existent or solely based on the task in hand. A number of Rapporteurs reported that residents sat in silence at the table, with the only staff interaction being the placing of food on the table or occasionally offering a drink.

Rapporteurs also observed that many older people sat alone at lunch for over 30 minutes, with no social interaction before uneaten meals were cleared away.

Good communication between staff and residents during mealtimes is essential. Without this, the needs of residents will not be met, their choices and preferences will not be taken on board and they will not be encouraged to eat. Furthermore, without support and encouragement from care staff during mealtimes, residents are at risk of losing their physical ability to feed themselves, essential to allow them to exercise choice about how they eat their food and vital to support their independence.

The majority of Rapporteurs observed that there was some choice in the meals available and that residents were involved in meal planning in some of the homes visited, something confirmed by a number of questionnaire responses from family members.

“Residents have a good choice of food.” Family Member (Questionnaire Response)

“They are also willing to provide a favourite meal if anyone asks.” Family Member (Questionnaire Response)

However, this choice was often limited to only two options and daily menus were often not visible or accessible by residents. There was also little evidence that best practice was being used around providing pictorial representations of the meals on the menu or that sample meals were plated up and shown to residents for them to understand what was available. While kitchen staff worked with residents to plan menus in a small number of the homes visited, this was not the case for the vast majority.

“Residents are often given a plate of something, without being asked what they would like. I have seen hot plastic cups of tea being thrust into residents’ hands when they have limited dexterity. No choice is offered, even though there may be a choice on the board (two choices) of a mix and match available from one meal option. Tea time meal mainly consists of a sandwich.” Family Member (Questionnaire Response)

Outside of formal dining times, Rapporteurs reported that there were significant variations in the availability of food and drink throughout the day and that interactions between care staff and residents were often limited, with a lack of meaningful engagement, physical support and encouragement.

“The residents were not even offered a choice of biscuit. Likewise they weren’t able to add their own sugar or milk to their tea and coffee. This may be for very good reasons, but very disempowering.” Social Care Rapporteur

“The trolley is rolled up and if no one asks for a drink, they don’t get it. These are people with dementia that need to be encouraged to eat and drink.” Family Member (Questionnaire Response)

A lack of choice about what to eat, and when and where to eat, can lead to residents having no control over a fundamental aspect of their daily lives. This results in a dining experience that does not reflect the needs of an individual but rather the needs of the system.

Good Practice: My Home Life Cymru

When a resident who has dementia arrived in the dining room for lunch a care worker asked, “Elsie have you come to join us for a meal, where would you like to sit?” The resident sat in her usual chair and was introduced to the other diners by the staff member, even though she knew them all and sat with them every day. The chef came out and presented all the diners with plated meals of what was available; all condiments were on the table including gravy. The care worker asked each resident, “where would you like your gravy?” None of the residents wore an apron or protective clothing, and after the meal no one’s clothing was stained.

Good Practice: Care Home, Cardiff

There is a great emphasis on treating people with dignity and respect. Menus were chosen through a “Come Dine With Me” experience, where residents and family members sampled a range of foods on offer and chose their favourites for the menu. The kitchen staff will always make alternatives if someone does not want what they have chosen and the chef always checks people are happy with their food. When soft foods are served, moulds, piping and other innovative techniques are used to ensure that the food is beautifully presented and offers a range of textures, so it looks and tastes as close to non-pureed food as possible.

Care Home Environment

Many Rapporteurs commented that the homes they visited often had a functional, institutional and clinical feel, rather than being homely, comfortable and welcoming, which can have a detrimental impact upon residents’ quality of life.

Rapporteurs also reported that the majority of the homes visited were old buildings that had been adapted for use as a care home. Whilst Rapporteurs reported that many homes were well decorated and that many residents’ rooms were personalised, the design and layout was often unsuitable, particularly for people with sensory loss and/or dementia. In some cases, residents who were neither related or in an intimate relationship were found to be sharing rooms, something which is no longer acceptable in other parts of the UK.

Evidence from the College of Occupational Therapists stated that the physical structure of buildings and use of some older properties as care homes can act to reduce mobility:

“For example, in one situation where nursing residents were moved from the ground floor to the 1st floor in order to open up more nursing home beds. This move left residents with no access to a communal living room or suitable bathing facilities on the 1st floor. The lift in this section of the home was too small for use with any nursing residents with specialist seating.”

Evidence from Action on Hearing Loss Cymru also stated that a lack of assistive equipment such as visual alarms, hearing loops and other adaptations, is affecting people’s independence, privacy and dignity. For example, bedroom doors may be kept open as a result of a lack of flashing doorbells in care homes, which can lead to older people with hearing loss losing their right to privacy.

In a number of cases Rapporteurs observed that the homes they visited were poorly lit, with no consideration of the importance of lighting, particularly for residents with deteriorating eyesight and sight loss, had a lack of hand rails and clearly marked

ramps, which impeded residents' ability to easily and safely move around the home environment without support.

A number of Rapporteurs reported that the care home environment was not designed to meet the needs of older people. Notice boards, for example, which provide essential information for residents, such as information about activities, advocacy services and other local information, were often hard to reach or difficult to see.

A number of questionnaire responses from family members also highlighted a lack of private space available in the care home, such as seating areas separate to lounge areas, that could be used instead of a resident's room to allow them to spend time with their loved ones.

Many of the homes visited were not dementia friendly, with a lack of pictorial signage, destination points and sensory areas, such as memory walls or rummage boxes.

“Memory walls or areas are becoming more common and one home had memory boxes where people could handle items like coins or look at pictures. But they often seem to be an afterthought, hidden away rather than an integral part of the design of a building.” Social Care Rapporteur

Dementia friendly care home environments, where features such as pictorial signage or destination points are used, are lacking, even in EMI and nursing care environments. This can result in increased confusion, anxiety and agitation among residents living with dementia.

Good Practice: RNIB Cymru

RNIB Cymru has produced a new guide called 'Homes for people with sight loss and dementia: A guide to designing and providing safe and accessible environments'³⁸.

The guide offers clear and simple guidance on how to design, refurbish and maintain accommodation in a way that will best support people with sight loss and dementia.

The guide was developed in conjunction with housing associations, care providers, academic experts, access consultants, people with dementia and organisations that support people with dementia.

The effective use of design can reduce the impact of sight loss and dementia, maximise independence and safety and reduce falls and other safety risks.

The impact that specific aspects of the built environment can have on older people has also been identified by some care homes.

“My residential manager came to me and said our bathrooms are boring. I’ve got residential dementia clients that I need to encourage to take a bath and I want to make them interested to reduce the challenge... So she got little shelving, matching towels, little LED candles and fairies, all where they would be looking up at the wall when they were in the bath and just made it so pretty - a different place. But she didn’t stop there she spread it through the whole home and you walk into any bathroom now and it’s alive.” Care Home Manager (Oral Evidence)

A well designed care home environment can be enabling and therapeutic, supporting residents in their daily lives. Conversely, a poorly designed care home that lacks the necessary adaptations can have a significant impact on residents, particularly those with sensory loss and dementia, disabling their ability to live as independently as possible and increasing the risk of falls and accidents.

Factors Influencing Day-to-Day Life

In gathering evidence about the day-to-day life of older people living in care homes, a number of broad themes were identified that impact upon an individual’s quality of life.

Institutional Regime

The majority of Rapporteurs reported that the care homes visited were characterised as institutional regimes, a cross between a hospital and a hotel. It often seemed that systems in place within the care home took priority over the needs of residents.

Rapporteurs observed that there was a task-based approach to delivering care that concentrated on schedules, processes and checklists, rather than the needs of an individual, particularly around personal care and eating.

Written and oral evidence from Age Cymru, Alzheimer’s Society, British Geriatric Society, British Association of Social Workers, the Royal College of Nursing and the Neath Port Talbot Social Care Academy supported this view, stating that an institutional culture of task-based care had a detrimental impact on their quality of life.

“Well my priority is safeguarding people from cultures of care, that is my main priority... many staff don’t understand how a poor attitude, an institutional culture can really affect the person who they’re caring for.” Neath Port Talbot Social Care Academy (Oral Evidence)

In care homes where an institutional regime exists, the focus is on ‘the system’ and not on meeting the needs of an individual or creating a homely environment. This leads to a culture of task-based care where positive relationships between residents and care staff are less likely to develop. This can result in older people having a lack

of choice and control over their lives and losing their sense of identity, which has a detrimental impact on their quality of life.

Variations in care

Evidence from the Commissioner's questionnaire and Rapporteurs identified significant variations in the quality of care provided, even within individual care homes.

A small number of family members and Rapporteurs identified exemplary care being provided to residents, which was delivered in a sensitive and compassionate way. One Rapporteur, for example, observed care staff using a hoist to move a resident from her chair to her wheelchair. They explained each step of the process clearly and in detail and also provided reassurance both verbally and by holding her hand throughout.

“Mum can't wait to come back after we've taken her out after lunch. That shows how much she loves living here.” Family Member (Questionnaire Response)

“The staff are all very attentive and caring towards my mother. They make everyone feel like they belong there and are their own little community.” Family Member (Questionnaire Response)

The majority of Rapporteurs, however, observed care that was 'neutral', where there was little meaningful interaction between staff and residents. This type of care was characterised by a lack of good communication or physical contact and a task-based approach.

“Staff are doing their jobs and ticking the boxes, but little imagination or personalisation is going on.” Social Care Rapporteur

Evidence from family members identified some concerns over the quality of care provided, while a small number of Rapporteurs also witnessed inappropriate and controlling care, where residents were patronised, ignored, spoken over or called derogatory names. When this type of care was delivered it was with a poor attitude and no awareness or sensitivity to the individual they were assisting. This was particularly evident in the case of residents with high needs and those living with dementia and/or sensory loss. Rapporteurs observed carers continually using their mobile phones, only interacting with other carers and displaying little interest in the residents.

“I feel like my grandfather is talked down to. I very much think he is 'still in there' despite not being able to talk. He is a bright man and I wish he was treated like it.” Family Member (Questionnaire Response)

“Most staff are pretty good, but one or two can be pretty patronising – some care staff seem to think that they should treat older people as if they were children.” Family Member (Questionnaire Response)

Everyone has the right to be safe, well cared for and have the best quality of life, regardless of their needs or where they are receiving care. Unacceptable variations in care and disparity between care homes, mean that older people are often not receiving the level of care they have a right to expect, care that should be truly person-centred and delivers the best quality of life.

Low expectations

Evidence from professional bodies and the third sector highlighted that older people and their families can have low expectations about quality of life in care homes. This can be driven by a range of factors such as the fact that moving into a care home is often not seen as a positive choice, but rather as a last resort, and a media portrayal of care homes that concentrates on failures and poor care.

“There is a big difference between being safe and having a good quality of life.” Age Cymru (Written Evidence)

It was also suggested that low expectations can result from a culture of learned helplessness in which older people are the passive recipients of task-based care that does not acknowledge nor value them.

“People’s expectations become reduced because ‘how can we keep fighting it?’.” College of Occupational Therapy (Oral Evidence)

This was supported by evidence from the Commissioner’s questionnaire, which highlighted that residents and their families can have low expectations about quality of life in a care home.

“For me she is safe, but life for her is sad. At least she is not abused.” Family Member (Questionnaire Response)

“I’ve only been here for three months. There’s not much to do, but you get used to it.” Resident (Questionnaire Response)

“There’s nothing to do, but I’m happy.” Resident (Questionnaire Response)

Many responses showed that people did not expect anything more than an adequate quality of life in a care home, something that was reflected in observations made by many Rapporteurs during their visits. They identified a culture of acceptance in which older people simply ‘made do’.

Advocacy

“Lots of people here can’t talk for themselves. They don’t have a good quality of life, but aren’t in a position to do anything about it.” Social Care Rapporteur

“You are powerless.” Resident (Questionnaire Response)

Rapporteurs found little evidence of independent advocacy services being actively promoted within the care homes they visited. It was clear that the role of advocacy and its benefits were not widely understood and that there were significant variations in the availability of and access to advocacy services.

Evidence from Age Cymru stated that the availability of independent advocacy may be limited as some care staff may feel undermined by the presence of independent advocates and do not understand their distinct role.

“Many staff in care homes consider that they advocate for residents on a day-to-day basis and do not recognise the value of independent advocacy.” Age Cymru (Oral Evidence)

Where advocacy services were available, it was clear that they were having a positive impact on the lives of older people.

“I find independent advocates have helped us a lot. We had, actually, a person coming and going of their own time, talking to the families and residents. And the feedback to us and the support, I think, improved the quality of the staff and the culture as well. I think they are very, very important people to be available in any care home... And they’re supporting us, they’re not against us. Anything, any problem we have, we are very open with them but I think that is very important. I think their presence is very, very important in any care home...” Care Home Manager (Oral Evidence)

Evidence taken during the roundtable discussion on advocacy highlighted that independent advocacy is critical in improving the quality of life and care of older people by ensuring that their voices are heard and that their rights are upheld. However, the evidence demonstrated that the value of independent advocacy was not sufficiently understood or even recognised by many care homes, Local Authorities and Health Boards.

Written evidence from Local Authorities and Health Boards also indicated that there are often limited opportunities for older people’s voices to be heard outside of formal complaints procedures, reinforcing the need for independent advocacy services.

During the roundtable discussion, many examples of excellent independent advocacy services across Wales were highlighted. Despite this, however, the ability of third sector organisations to deliver services is hampered by unstable

and unreliable funding sources and a lack of understanding of the value that their presence can bring.

The roundtable discussion on advocacy raised concerns that, as a result of funding from the Big Lottery's AdvantAGE programme coming to an end, the future availability of independent advocacy is at significant risk.

“Our funding finishes at the end of October, but really we have got to stop taking referrals in July or August because we can't leave people high and dry.”
Age Connects Wales (Oral Evidence)

Evidence from the British Association of Social Workers indicated that independent advocates have an essential role as they can focus entirely on the needs of an older person, unlike those who may have traditionally provided advocacy.

“Whilst social workers should be expected to advocate on behalf of their clients, this can often be extremely difficult in practice due to the potential conflict with their employers... Families and friends often have their own views and perspectives on a situation, so it is dangerous to assume that these are the same as the older people.” **British Association of Social Workers (Oral Evidence)**

Care homes are older people's homes, places where they should be able to have a strong voice and choice and control about the life they want to live. Older people should therefore be fully involved in any decisions that will affect their lives and it is clear that in these situations an independent advocate is often best placed to provide support and speak out on a person's behalf.

Health and Wellbeing

Literature Review

Many older people who live in care homes have high levels of healthcare needs³⁹. Reports have suggested that around three-quarters of care home residents have a disability and that 57% of women and 48% of men needed help with one or more 'self-care' tasks⁴⁰.

A recent cohort study of the health status of residents in UK care homes observed that the average number of diagnoses per participant (6.2) and the prevalence of stroke, dementia, Parkinson's disease and osteoporosis were higher than those previously reported for similarly aged UK residents who did not live in care homes. The findings confirm the hypothesis that "multi-morbidity is a defining feature of the care home population, and implies a requirement for expertise in geriatric medicine that may be beyond that of some GPs"⁴¹.

Furthermore, this study found that while there might be an increased need to access services due to "cognitive impairment, behaviour disturbance or malnourishment, residents had contact with the NHS on average once per month"⁴².

Physical health is fundamental to quality of life and as research suggests, older people have substantial and complex healthcare needs requiring a full range of healthcare services. However, a great deal of evidence suggests that care home residents are not always receiving the healthcare services they should. In some instances, residents are paying for services that should be provided under the NHS⁴³.

Dementia is perhaps the most prolific health issue to affect older people in residential care with an estimated 80% of care home residents living with dementia in the UK⁴⁴. One in 14 people over 65 years of age and one in six people over 80 years of age has a form of dementia. It is estimated that by 2021 there will be over 1million people with dementia in the UK⁴⁵. Diagnosis rates in Wales are just 38.8 per cent, which means there are still around 28,000 people in Wales who are living with dementia and have not been diagnosed⁴⁶.

Dementia can mask a range of other health issues. According to recent research, physical comorbidity is very common in people with dementia and leads to "excess disability and reduced quality of life"⁴⁷. Epilepsy, delirium, falls, oral disease, malnutrition, frailty, incontinence, sleep disorders and visual dysfunction are found to occur more frequently in people living with dementia⁴⁸. However, physical comorbidity is often treatable.

Older people living in care homes are three times more likely to fall than if they lived in their own homes but, in many cases, taking the right action can help to prevent people from falling. Whilst preventing falls should be a priority, services need to achieve this while allowing residents to be as independent as possible⁴⁹. NICE

recommends initiatives such as strength and balance training for older people, as well as regular exercise, to enable them to avoid falling as much as possible⁵⁰.

The Social Care Institute for Excellence (SCIE) recognises that reablement leads to improved health and wellbeing of older people living in care homes and also reduces the expenditure required for on-going support⁵¹. By enabling older people to do things for themselves in care homes, as opposed to doing things for them, their independence is not only increased but their individual outcomes also improve. SCIE has stated that people that have accessed reablement services welcome the emphasis on helping them to gain independence and better functioning⁵².

Sensory loss is particularly prevalent among older people: estimates suggest that 1 in 9 people over the age of 60 and 1 in 3 people over the age of 85 are living with sight loss⁵³. According to research by the Welsh Local Government Association (WLGA), there will be an 11.25% increase in the prevalence of sight loss in the next 10 years, correlating to an ageing population and a growing incidence in key underlying causes of sight loss such as obesity and diabetes⁵⁴.

1 in 6 people are estimated to be affected by hearing loss in Wales. The majority of those with hearing loss are older people and the prevalence increases with age: 71.1% of those over the age of 70 are living with hearing loss⁵⁵. According to the Medical Research Council (MRC) there will be a 14% increase in prevalence every 10 years⁵⁶, again correlating to an ageing population. The World Health Organisation estimates that by 2030 adult onset hearing loss will be in the top 10 disease burdens in the UK, above diabetes⁵⁷.

It is estimated that 18,850 people in Wales are currently affected by both visual and hearing impairments. 62% of the deafblind population is aged over 70⁵⁸.

The links between dementia and sensory loss are well evidenced. According to RNIB, at least 2.5% of people will have both dementia and sight loss by the age of 75⁵⁹. As the population ages, the number of people with both dementia and sight loss will increase⁶⁰.

In care homes, studies indicate a higher proportion of residents may have both conditions. People with mild hearing loss have nearly twice the chance of developing dementia compared to people with normal hearing. The risk increases threefold for those with moderate and fivefold for severe hearing loss. People with advanced dementia will often have sensory loss as a result of age related eye conditions and / or damage to the brain due to the disease⁶¹.

The literature highlights that food and diet is a contributing factor that impacts upon residents' quality of life⁶², health and well-being, with malnutrition or 'under-nutrition' acknowledged as a particular problem in long term care institutions^{63, 64, 65}.

One in three older people are affected by malnutrition upon entry into residential care homes⁶⁶ and if their diets are not properly managed, the clinical consequences can include: impaired immune response, reduced muscle strength, impaired wound

healing, impaired psycho-social functioning and impaired recovery from illness and surgery⁶⁷.

NICE has stated that the healthcare cost of managing malnourished individuals is twice that of non-malnourished individuals due to a higher use of healthcare resources. It has placed effective intervention on malnutrition as the third highest in top clinical guidelines to produce savings. Malnourished residents will have greater healthcare needs in the care home, have a higher admission rate to hospital and, during those admissions, will spend longer in hospital⁶⁸.

The British Dental Association has highlighted that there are high levels of unmet dental need in care home residents, with many only receiving dental care when they develop a problem. Residents of care homes are more likely than older people living in their own home to suffer from mobility as well as cognitive impairments which both tend to have negative impacts on oral health. Poor oral health in older people has wide ranging health implications, from the more obvious impacts of pain and discomfort in and around the mouth and jaw, to the follow-on effects that difficulties in chewing can have on nutrition and general health⁶⁹.

Policy is very clear that NHS services should be provided on the basis of need. In spite of this, there is evidence of variations in the provision and funding of key elements of NHS services for care home residents. These variations can result in unfair access and even discrimination⁷⁰.

The availability of and access to high quality healthcare is a basic human right⁷¹ and research suggests that localities should therefore focus attention on re-establishing multidisciplinary and multi-agency healthcare support for older people in long-term care⁷².

The National Assembly for Wales' 'Inquiry into Residential Care for Older People'⁷³ recognises this and highlights the need to improve the safeguarding and protection of older people in residential care through improvements to ensure access to good healthcare. Access is also a priority in the work of My Home Life Cymru, which states that primary care organisations should review their provision to ensure that residents have access under the NHS to all services⁷⁴.

The literature highlights the importance of partnership working to develop new initiatives that give residents, their families and carers greater voice and control with regard to accessing healthcare⁷⁵. Healthcare services for older people living in care homes should ideally incorporate multidisciplinary, multi-agency specialist teams.

Teamwork is also an important element in the availability and provision of healthcare and is a consideration picked up by the Promoting Excellence in All Care Homes study (PEACH). This research indicates the importance and clear health benefits of effective leadership and supervision within the care home in fostering good teamwork⁷⁶.

There are, of course, many examples of good practice in care homes that show that care and support can be delivered effectively to improve quality of life for residents⁷⁷. However, all too often, these practices are fragmented and patchy.

Despite being a basic entitlement, many older people are routinely denied the benefits of primary, secondary and community health services.

Review Findings

Prevention

Care homes need not be seen as places of immediate decline, where preventative and reabling interventions are assumed to have little value. Whilst the prevention and reablement agendas have been identified as essential to reduce pressure on primary health care services, it seems their importance is not yet recognised in care homes.

“To maintain health and wellbeing, residents require physical, mental and social stimulation. Yet some care homes are very task orientated. Basic care needs such as washing and dressing, feeding and toileting, can take a considerable time for residents with complex care needs, leaving little time for other activities.” **College of Occupational Therapists (Oral Evidence)**

Evidence from the Chartered Society of Physiotherapists stated that if people are more physically active, an essential element of the prevention agenda, then they will be at less risk of falling and money could potentially be saved from the use of wheelchairs and emergency admissions to hospital.

“A problem reported to us by community physiotherapists is that they perceive clients to be too inactive throughout the day. Furthermore, many of the activities offered are seated and do not present a challenge to posture and balance.” **Chartered Society of Physiotherapists (Oral Evidence)**

Their evidence also highlighted the dangers of immobility for the whole body system, stating that being seated all day means that individuals can lose capacity in all body systems. These secondary complications can often lead to an increased use of medication and preventable hospital admissions.

This was reflected in evidence from the College of Occupational Therapists that stated that activity is not an added bonus of care but an essential requirement to enable residents to actively participate in daily life. They also stated that when a person is left for long periods without movement or stimulation, a number of detrimental physical and psychological changes occur. Physically, muscles waste, the heart atrophies, blood pressure rises and the risk of pressure sores increases. Psychologically, listlessness and boredom, depression and lethargy, and confusion and disorientation can occur, alongside a loss of confidence and skills. This can create a life and environment that is full of negative impact.

Good Practice: North Wales Care Home Falls Multi Factorial Risk Assessment and Care Plan

Public Health Wales' North Wales Falls Prevention Project has developed a care tool for care homes to use to implement NICE guidance on Falls (2013)⁷⁸. This is a collaborative project, consisting of key stakeholders including Care Forum Wales, CSSIW and District Nurses.

The Care Tool is a package of support that includes:

- Guidance for completion
- Multifactorial Risk assessment
- Summary Care Plan
- Record of referrals and follow up
- Record of unmet needs
- Review recording
- Support documents - footwear suitability / nutrition prompt / culprit medication

This has been further supported by on-going partnership work, training and support to care homes to enable them to implement falls prevention within current processes, for example pre-arrival assessment, care planning, and falls review to assess the culprit.

Good Practice: College of Occupational Therapists – Living Well through Activity in Care Homes Toolkit 2013⁷⁹

This resource has been designed for care home staff to enable residents to live a more active life.

The toolkit provides a range of suggestions for changing traditional approaches to task based care through outlining approaches that care staff could implement from a 5 minute chat with a resident, to assistance in the kitchen and gentle exercise.

The benefits of residents living more active lives in care homes are also outlined in terms of an improved sense of physical and emotional wellbeing, a sense of belonging, as well as increased talking, smiling and laughter.

Evidence from the College of Occupational Therapists stated that equipment and furniture in use at a care home can make a huge difference to an individual's health and mobility. Access to profiling beds, correct seating and appropriate cushions can all enable older people to have reduced pain and greater mobility. A person's individual requirements must be considered as a 'one size fits all' model is not effective.

“...Limited or no access to appropriate and safe seating within nursing homes can result in residents being restricted to bed for months (sometimes years). This is not necessarily because they can’t sit out of bed, but because their needs have not been assessed and appropriate seating has therefore not been provided.” College of Occupational Therapists (Written Evidence)

Rapporteurs regularly reported that residents were often sat in identical chairs that ‘looked uncomfortable’ and were propped up by cushions. This can cause hips to become misaligned, which can lead to muscle wastage, immobility and pain. Rapporteurs also reported that care staff seemed unaware of bad posture or poor seating and the impact that this can have in reducing a resident’s mobility and causing pain.

Evidence from the Chartered Society of Physiotherapists stated that a lack of staff resources can lead to risk-averse cultures developing within care homes, which can result in inactivity and immobility amongst residents.

“A lack of resources leads to risk aversion. Care staff use wheelchairs and hoists rather than give people time to walk to dinner, walk to the garden, etc.” Chartered Society of Physiotherapists (Oral Evidence)

Rapporteurs often observed a restrictive application of health and safety that overruled an individual’s right to move freely around the care home. Rather than keeping an individual safe, the resulting immobility can actually contribute to a fall, which is inevitably more damaging to an older person’s physical and emotional wellbeing. It is essential that any risk assessment conducted in a care home balances an individual’s right to autonomy against the potential risk to themselves and others if this right is upheld.

Reablement

Evidence from the Chartered Society of Physiotherapists stated that reablement services within care homes are lacking. They stated that often people are waiting too long for vital reablement services and that this delay means that it is often not possible to reverse physical damage or decline that has occurred. Providing reablement services as soon as they are required provides the best possible opportunities for regaining independence and delivers better health and wellbeing outcomes for older people living in care homes.

Evidence from a senior manager at HC-One also highlighted that reablement services for older people in care homes are less accessible than similar services for other vulnerable groups.

“I saw a resident was having problems with food and swallowing and I said ‘right, let’s get Speech and Language Therapy (SALT) in to sort this out’. The

managers looked at me and said ‘they don’t tend to come into our settings’. And I said ‘why not?’. I was used to somebody within a week to look at something, give a review, help and support. Everyone I spoke to was saying ‘No, older residents don’t tend to get that support’. I don’t know if that’s across the board, but it did worry me that we can’t get the support that they were entitled to as quickly as younger adults can. It wasn’t just SALT, I’m using that as an example, it just hit me in the face because the lady who was choking was obviously going to lose weight and be malnourished and we could have done something very quickly.” **HC-One (Oral Evidence)**

Evidence from the British Geriatric Society also highlighted the difficulties in accessing specific therapies such as physiotherapy and speech and language therapy. They suggested that this is the result of reablement services not being seen as important within care home settings.

This was reflected in questionnaire responses from residents and their families, who highlighted that access to specialist healthcare and other therapies is often limited.

“Basics are covered but the home needs to be more open and proactive contacting professionals for support.” Family Member (Questionnaire Response)

“I have had to ask over 4 weeks for a chiropodist to attend to the long nails on mum’s feet. In the end, I sought out the chiropodist and asked that she cut mum’s nails, which she did very shortly afterwards.” Family Member (Questionnaire Response)

In the questionnaire responses from residents, all residents stated that they never have access to a physiotherapist. The majority also stated that they never have access to a speech and language therapist and that they never or rarely have access to a podiatrist. This means that the majority of older people in care homes are unable to access specialist healthcare that could have a positive impact on their health, wellbeing and quality of life.

Evidence from Age Alliance Wales highlighted particular issues around access to reablement services for stroke survivors.

“It is well known that Wales has a chronic shortage of therapy services available to stroke survivors. This includes Physiotherapy, Occupational Therapy, Speech and Language Therapy, psychological, cognitive and emotional therapy, dietary and nutritional therapy. Access to these specialist therapies can become more restricted for stroke survivors living in care homes. As a consequence, continuing rehabilitation can be compromised. Best practice from other parts of the UK demonstrates that outcomes are significantly improved for stroke survivors in residential care when care staff

work closely with multi-disciplinary stroke teams. Stroke survivors living in residential care are not systematically offered the best chances of recovery.”
Age Alliance Wales (Written Evidence)

Occupational Therapy, Physiotherapy and seating equipment all play a vital role in maintaining the mobility of older people living in care homes, but the evidence clearly shows that this support is often not easily accessible and older people’s independence is not being maintained. The culture of care homes is often built upon a dependency model, where it is assumed that people need to be ‘looked after’, which often fails to prevent physical decline or allow people to regain their independence.

GPs

Evidence from care home managers showed that where good relationships are developed with GPs, this has a positive impact and delivers better outcomes for residents as there will be regular visits that allow a GP to review their patients’ overall health, undertake medication reviews and review care plans.

“I’ve got a really good GP. We sit down and discuss [residents’] weight, diet, mental health, psychological state and that’s great.” **Care Home Manager (Oral Evidence)**

However, the fact that in some care homes one practice will deliver care for all residents, whereas in other care homes residents will receive care from multiple practices means that there can be issues around developing and maintaining positive relationships between GPs and care homes.

Written and oral evidence from bodies representing health professionals, as well as evidence from care home managers, also stated that there are significant variations in how older people living in care homes are able to access GP services, particularly around appointment processes.

Evidence from care home managers stated that it was often difficult to get an appointment with a GP, due to the inflexibility of the GP’s appointment booking system.

“‘Why didn’t you ring before ten?’ We get that all the time, ‘why don’t you ring before ten?’. Because they were perfectly alright before ten. All people don’t get ill before ten o’clock only.” **Care Home Manager (Oral Evidence)**

This inflexibility can lead to delays in obtaining a proper diagnosis and support, which is essential as, without timely access to basic and easily administered health care, a simple condition could quickly escalate.

Similar issues were identified in evidence from the British Medical Association, the Royal College of GPs and Shropdoc in terms of out-of-hours GP services. They highlighted how these services have been under-resourced for a number of years and are spread too thinly, something that has a significant impact on older people living in care homes who are more reliant on this provision. They stated that care home staff may phone the 'out of hours' service for advice at night, but without a link to their daytime practice, care plans may be overlooked, which can lead to unnecessary hospital admissions. This is particularly an issue with agency staff working in care homes.

Care Home Managers also stated that difficulties in obtaining a proper diagnosis can often lead to medication being prescribed over the phone, which could put residents at risk.

“We are not a nursing home, I do not have nurses on the premises. On the phone, I mean, we could only say what the symptoms we see are and we might be wrong, he might give the wrong diagnosis.” Care Home Manager (Oral Evidence)

Evidence from the Royal College of Physicians, Royal College of GPs, the Royal Pharmaceutical Society and the British Geriatrics Society stated that older people are at risk of potentially dangerous interactions between multiple medications due to medication error. This clearly demonstrates the importance of medications being properly prescribed and the need for regular medication reviews.

Evidence from 1000 Lives Plus stated that being improperly prescribed medication is a particular issue for people living with dementia who experience behavioural and psychological symptoms of dementia (BPSD). They stated that antipsychotics are overprescribed for the treatment of BPSD and that they are often used ahead of non-drug therapies, contrary to NICE/SCIE guidance, often leading to severe side effects. They also highlighted that antipsychotics can be discontinued in 70% of people with BPSD without worsening symptoms.

“The reduced use of antipsychotic medications in care homes needs to be a top priority for Health Boards, particularly given the evidence from local pilot testing and audits of the effective implementation of the 1000 Lives Dementia Care Improvement Target 3, but there is a problem at the moment in the spread of this good practice, it is not spreading wide enough or fast enough, particularly in terms of the continued use of inappropriate anti-psychotic medications for older people, who have entered a care home following a stay in hospital.” 1000 Lives Improvement Service (Written Evidence)

Evidence from Aneurin Bevan University Health Board stated that mental health in-reach services in Torfaen provide advice and guidance to residential and nursing care home staff to improve the quality of care being provided for those living with

dementia and prevent the use of anti-psychotic medication wherever possible. They stated that potential savings may be made with mental health in-reach services:

“There has been a definite reduction in admissions to our Mental Health Assessment Unit from care homes. The consequence of this would have a probable effect on patients receiving continuing healthcare as they are treated early and there is a reduction of transfer to a higher dependency/category of care. There is also a resulting possibility of reducing an increase in morbidity and mortality by keeping the person in a familiar environment.” Aneurin Bevan University Health Board (Written Evidence)

Good Practice: Abertawe Bro Morgannwg University Health Board – Mental Health in-reach service

Abertawe Bro Morgannwg University Health Board is delivering a residential care mental health in-reach service in Bridgend.

A multi-disciplinary team works with older people in care homes to support care staff and ensure on-going mental health assessments and the appropriate use of medication. The service also provides training to care staff and managers on dementia care.

The team uses a monitoring system and referral co-ordinator to allocate the frequency of visits and to ensure a crisis point is not reached before mental health specialists are sought.

Access to specialist mental health care has improved as a result of this proactive and preventative approach. Mental health admissions have fallen by 50% since 2009 and its Continuing Health Care budget has been contained, with a simultaneous decrease in the use of long stay beds⁸⁰.

The Royal College of General Practitioners also stated that there are difficulties around the transfer of medical records. This impacts upon the ability of GPs to deliver the enhanced service contract for care homes, which includes the need to assess an older person within a fortnight so that their health needs are understood by their GP and action can be taken if required. This delay can be up to six weeks if someone is discharged from a hospital in one Health Board area to a care home in another.

“Information exchange between existing and new GPs (residents frequently change their doctor when they move into a care home) must take place on the day that the person moves into the care home – this is frequently not the case and can lead to medical mismanagement.” Royal College of Physicians (Written Evidence)

Whilst demographics have shifted and models of care have changed over the years, with older people now receiving care in care homes rather than long-term care of the elderly hospital wards, it is clear that the role of the GP must adapt to ensure that older people are able to access the services they need.

Evidence from the British Geriatrics Society also stated that as care systems change, GPs would benefit from additional support, which could be delivered through community geriatricians, to ensure that the increasingly complex needs of older people living in care homes are met.

Sensory Loss

One in five people in Wales have a form of sensory loss, a figure that increases dramatically with age – 70% of 70 year olds have a form of sensory loss, for example, rising to 80% for 80 year olds and 90% for 90 year olds⁸¹.

Sensory loss can have a significant impact on older people's quality of life, particularly within care homes, and can lead to loneliness, isolation and depression.

Evidence from Action on Hearing Loss, Deafblind Cymru and RNIB Cymru, taken at the Sensory Loss roundtable, identified that older people are not routinely screened for sensory loss upon entry into care homes. Their evidence also showed that there is a lack of regular/ongoing screening for sensory loss for older people living in care homes.

This lack of testing/screening can result in many older people living with an undiagnosed sensory loss, which can often be misinterpreted as dementia and lead to a failure to meet an individual's care and communication needs.

Action on Hearing Loss gave an example of a care home in which 13 out of 25 residents were already diagnosed with hearing loss. However, after screening all residents, a further 11 were identified as having hearing loss.

“It is without dispute that there are thousands of people living in residential care in Wales who are unable to hear but have not been diagnosed with hearing loss. This means that they are missing out on the support that is available for them to hear better.” [Action on Hearing Loss Cymru \(Written Evidence\)](#)

Evidence provided by RNIB Cymru and Optometry Wales highlighted that where sight tests were undertaken in care homes, they were often carried out by large optometric companies that do not tailor these tests to meet the needs of older people. They are therefore not testing for conditions that can cause sight loss, such as glaucoma or Age-related Macular Degeneration, and also often fail to identify pre-existing conditions.

It is essential that sight tests are regularly undertaken and that sight loss is properly diagnosed and managed as evidence from RNIB Cymru identified that sight loss can have a direct impact on an individual's mobility and safety. They stated that sight loss can restrict an individual's ability to move around the home freely, which can not only result in a decline of an individual's overall physical health, but also increase the risk of falls or other injuries.

The roundtable discussion highlighted that there is a general lack of awareness in care homes about sensory loss and its impact. This was confirmed by Rapporteurs who reported that many care home managers stated that sensory loss did not affect any of their residents. Given the prevalence of sensory loss amongst older people, this is almost certainly not the case and means that a large number of older people could be missing out on essential assistance and support.

Good Practice: Action on Hearing Loss / Age Cymru

In 2013, a bilingual booklet, 'Quality of life for residents with hearing loss', was distributed to all care homes in Wales. The booklet discusses the issues faced within care homes around hearing loss, how these can have an impact on quality of life and how members of staff can better support residents to enjoy a good quality of life. It contains information about how to identify hearing loss, how to support residents with hearing loss and how to support people living with hearing aids.

Evidence gathered from family members and through the sensory loss roundtable discussion highlighted issues around basic maintenance of glasses and hearing aids as well as a lack of awareness from care staff on how to support individuals to use them.

“There was no consideration of my father's poor sight, and his profound deafness. His hearing aids were often off or batteries were flat.” Family Member (Questionnaire Response)

“Residential Care providers tell us that they struggle to train their staff to maintain hearing aids due to high staff turnover. This means that residents are usually poorly supported if their hearing aids need cleaning or a change of batteries. This can mean long delays until a long and often unnecessary trip to the hospital audiology department for what is a simple maintenance task.” Action on Hearing Loss Cymru (Written Evidence)

Good Practice: Action on Hearing Loss

During 2013/14, Action on Hearing Loss worked with eight residential care homes across Swansea, Bridgend, and Neath Port Talbot. Their aim was to improve dignity in care for older people through delivering training and information to front-line care staff and managers to increase their awareness of hearing loss.

158 care home staff were trained in total covering the following areas:

- How to identify hearing loss, the impact of hearing loss, and what interventions or actions to take to address this.
- How to support people with hearing aids, cleaning and maintenance. Tips and advice on how to communicate effectively with people with hearing loss.
- Adjustments and assistive products that are available.
- Local services, groups and organisations.

The training resulted in a greater awareness and understanding of the equipment available to help with hearing loss and tinnitus and how this equipment can help with effective communication on a daily basis.

Care staff were also trained on how to use specialised assistive equipment, such as the Sonido, which is a personal listening device that can significantly improve communication between staff and residents and can help individuals with the isolation that so many of them feel when they are unable to communicate.

Danny, a blind gentleman and very hard of hearing, experienced the difference that the Sonido can make. Using the device he could instantly hear the trainer and his carer and could have a conversation in Welsh, something that he hadn't done for years.

Diet

In the majority of survey responses, residents disagreed or strongly disagreed with the statement 'the food and drink available is of a good quality'.

“After the cook leaves at 1.30, the only thing available is sandwiches and biscuits, not a lot of choice for tea and supper. No fruit, no salad. Food is very repetitive. Sandwiches are often freezing cold.” Resident (Questionnaire Response)

Rapporteurs generally reported that the food they observed being eaten during mealtimes was 'acceptable', but significant variations were observed in the quality of the food provided in the care homes visited. While a number of Rapporteurs

described fresh produce and lots of fruit and vegetables being provided as part of meals, others described a 'ready meal' appearance to the food provided. On occasion, serious concerns were raised about the unacceptable quality of the food available and the fact that it would not meet older people's dietary needs.

Oral evidence was taken from the Unified Menu Planning Project, a project designed to improve the nutritional standard of meals provided in care homes and to educate care home managers, care staff and cooks/chefs about how to reduce malnutrition. Members of the project's steering group, from Public Health Wales, Torfaen County Borough Council and Aneurin Bevan University Health Board, stated that there is a lack of understanding within care homes about the dietary needs of older people, particularly the importance of meeting an individual's specific dietary needs.

“My friend has a problem with swallowing some foods and it has taken some time for the home to adapt to the food that she can eat. This is improving but slowly. She tends to get a lot of mashed potato.” Friend (Questionnaire Response)

They highlighted that a resident who is overweight and has diabetes would need a healthy eating approach, with a controlled intake of sugars, whereas a resident who is at risk of malnutrition would need a fortified diet. However, they stated that this individualised approach was not common and that care homes often adopted a 'one size fits all' approach. An example given was of a care home that was told to increase the fats and sugars in one resident's diet but decided to do this for all residents. Another example given was of a care home where all residents were found to be on a 'soft' diet, where foods are mashed, pureed or simmered in liquid, which would not have met the individual needs of all residents.

The roundtable discussion also highlighted the myth that because a person is in a care home they lose their appetite and require smaller portions of food. Portion sizes should be based on an individual's choice and need, not based on a 'one size fits all' approach.

During the roundtable session a lack of support to assist older people to eat was identified, something often due to care staff being unaware that an individual would require assistance.

“Food is poor at times, dry which is hard for him to eat. There is limited help and I go in and feed him and others.” Family Member (Questionnaire Response)

“Mealtimes can be a trying time when sitting too far away from the tray on an easy chair and trying to balance the chair and being left to fend for oneself. Due to her disabilities my mam is unable to gain access to food and water unless they are within her reach and I have found sandwiches left on the windowsill.” Family Member (Questionnaire Response)

This was also observed by Rapporteurs, who saw residents playing with their food and plates being taken away without food having been eaten. Rapporteurs also commented on the fact that some bed-bound residents were given trays that were placed too high for them to eat from comfortably resulting in them struggling to feed themselves.

Dementia Care Matters also identified that it is vitally important to assist older people living with dementia to eat, but more than that to also encourage them to eat, both directly through care staff and indirectly by providing readily available snacks and food that is easy to eat.

Alzheimer's Society state that finger foods are a good solution for people with dementia who may have difficulties with co-ordination or struggle to use cutlery as they are prepared in a way that makes them easy to pick up and eat with the hands.

Evidence from RNIB Cymru and Action on Hearing Loss identified that eating can also be difficult for people with sensory loss, particularly those with dual sensory loss. If a person's hearing and sight loss is severe, it is essential that they know that the food is there and are supported to eat it.

Evidence from the nutrition roundtable stated that food supplements are often thought of as a 'safety blanket' in care homes, which can contribute to a culture where the importance of diet and encouraging and assisting people to eat is not recognised.

Evidence from Prescribing Support Dieticians also stated that in some cases food supplements are being wrongly used instead of meals, as a more convenient and cheaper option for care homes.

It is estimated that 16-29% of older people living in care homes in Wales are malnourished⁸², something that has a significant impact on their health and wellbeing.

Whilst a number of existing health issues can cause malnutrition amongst older people, in many cases it could be easily prevented by ensuring that older people are supported and encouraged to eat a diet that they enjoy.

Action to ensure that the dietary needs of individuals are met and that malnutrition is prevented wherever possible is essential to maintain the health, wellbeing and quality of life of older people living in care homes. Effective intervention on malnutrition is identified by NICE⁸³ as essential to reduce preventable healthcare costs and the number one clinical intervention to prevent admissions to hospitals.

Whilst there is some good practice underway in Wales around food, nutrition and malnutrition, this is often limited and demand for support often outstrips supply.

Good Practice: Aneurin Bevan University Health Board

Aneurin Bevan University Health Board has a dedicated Community Nutrition Support Team that works with local care homes to educate and advise care staff on food and nutrition.

Using the 'food first advice', they have provided useful and practical information about fortifying foods, having nourishing drinks and snacks between meals, increasing calorie and protein intake, preventing weight loss and promoting weight gain, and how to eat well with a small appetite.

The Community Nutrition Support Team noted that in the care homes where this training had been delivered and staff were trained about nutrition, the fortifying of food was fully understood, food record charts were more widely used, and there were a greater number of activities to encourage residents to eat.

Oral Hygiene

Oral evidence from the Welsh Government's Senior Dental Officer stated that there is often a perception that the vast majority of older people will have dentures, something that was true for 90% of the population in 1987. However, advances in dental services, improved oral health products and public health promotion have resulted in this figure dropping significantly to an estimated 50%.

The Senior Dental Officer stated that as original or restored teeth may require a more complex level of care compared to dentures, many older people are dependent on others for their oral hygiene as their ability to use a toothbrush has diminished.

Good Practice

Hywel Dda Community Dental Service offers a certified oral health training package to all nursing and care homes within the health board area. The programme, 'Reason to Smile', offers practical advice and support on good oral hygiene, such as what toothbrushes and toothpaste to use, how to use them and how to identify specific issues such as mouth ulcers. A telephone advice line is also available to help care staff to access additional support.

Evidence from Cardiff University's Nursing and Residential Care Home Oral Health and Access to Dental Care Survey (2008)⁸⁴ confirmed this, stating that oral hygiene within a care home is often dependent on the ability of care staff to administer oral care. They highlighted that care staff in one in three care homes are assisting residents with oral hygiene, despite having received no training for this. Furthermore, the follow up Wales Care Home Dental Survey (2010 -11)⁸⁵ stated that "care home residents are more in need of regular dental checks to assist in supervision of any

disease in their mouths. Given lower reported levels of regular dental checks, this presents a challenge to both care homes and dental services”.

Evidence from residents and family members also identified concerns about oral hygiene, with the majority of survey responses stating that residents rarely or never have access to a dentist.

“There is absolutely no regular check service from dentists.” Resident (Questionnaire Response)

“There is a problem with providing regular and good dental cover.” Resident (Questionnaire Response)

A number of responses also highlighted that a lack of access to dentistry services had resulted in oral health deteriorating significantly.

“My mother’s teeth were left to rot in her mouth.” Family Member (Questionnaire Response)

“Since I’ve been here, all my teeth have fallen out. I am so ashamed to speak or smile.” Resident (Questionnaire Response)

In addition to issues identified around oral hygiene, evidence also showed that access to dentistry services is also an area of concern.

To address this concern, the Welsh Government’s National Oral Health Plan 2013-18⁸⁶, part of its Together for Health programme, gives a commitment to equitable access to dentistry for all, particularly ensuring services for the most vulnerable.

Despite this commitment, the plan acknowledges that access to NHS dental care is limited in some parts of Wales and that some care homes have reported difficulties in obtaining routine and emergency dental care.

Written evidence provided by the British Dental Association stated that the Community Dental Service would be well-placed to deliver dentistry services within care homes, but is under extreme pressure as high street dentists are no longer able to provide a domiciliary service.

However, the Senior Dental Officer stated that the Welsh Government plans to develop a strategic programme for delivering effective mouthcare for residents in care homes across Wales to address the concerns raised by family members and residents about the lack of access to dental care and support for daily oral health care, which will help to ensure more consistent and effective mouthcare for older people in care homes across Wales.

People and Leadership

Literature Review

Whilst social care staff face a range of pressures in carrying out their day-to-day roles, they are largely doing the best they can under extreme pressure[s]. As Kitwood has asserted, “poor care is not deliberate”. However, it is noted that a greater culture of support is needed to improve matters. This is explicitly acknowledged in a recent PANICOA report⁸⁷, which suggests that although staff are “typically hardworking and committed to delivering respectful care” that promotes independence, this was often undermined by workload pressure.

The report also states that stress and burnout were “not uncommon”, driven by recruitment and retention problems, and that staff managed these pressures by focusing on “meeting urgent physical needs at the cost of providing more relationship-centred care”, and providing “reactive care,” undertaken as a series of unrelated tasks.

The report concludes that the “good treatment of staff will be likely to result in the good treatment of those for whom they care”, particularly fair reward systems, a culture of trust and openness and management of workload pressures⁸⁸.

To further improve matters, the PANICOA report calls on UK governments to ensure regulators set and monitor standards for minimum staffing levels that care homes would be required to meet. It also said councils must work with providers to agree practicable staff to resident ratios “sufficient to ensure the safe and respectful care of older people at all times”, and to use this as the basis for a “fair and accurate fee structure”⁸⁹.

Minimum standards in Wales require that staffing numbers and the skill mix of qualified/unqualified staff are appropriate to the assessed needs of the service users, as well as the size, layout and purpose of the home, at all times⁹⁰ and with reference to qualifications, Minimum Standards call for at least 50% of care staff to hold NVQ level 2 in care or a similar qualification recognised by the Care Council for Wales, or a higher level qualification in care⁹¹.

For some specific job roles and settings, workers are required by the Welsh Government to register with the Care Council for Wales. The current mandatory qualification for Care Home Managers in adult care homes is a Level 5 Diploma in Leadership for Health and Social Care Services (Adults’ Residential Management) Wales and Northern Ireland⁹².

Whilst Minimum Standards and mandatory qualifications are necessary, Dementia Care Matters (DCM), which works to change care home cultures and environments, asserts that “competencies and qualifications are no match for emotional intelligence”⁹³. DCM also recognises the value of leadership, emphasising that

“emotional support for staff trying their very best has to be at the core of services aiming to be person centred”⁹⁴.

Staff support may also address the problem of staff turnover and retention. There is a continuing concern over an on-going shortfall of social care staff “of about 8%, with a turnover of about 30% in the first 2 years of employment”⁹⁵. This shortfall suggests an “unmet delivery of care to meet peoples’ needs and the high turnover suggests that recruitment practices are not finding and keeping staff with the right values to sustain them in their jobs. Both of these factors have an influence on quality. Staff turnover also costs money in recruitment and agency staff costs to fill the gaps”⁹⁶.

In 2012, the Royal College of Nursing conducted a poll of 600 nurses working in care homes in which more than a third (38%) of respondents said they thought the homes were understaffed, with a lack of full-time registered nurses. Almost half (48%) of respondents said that care homes were accepting residents to fill empty beds, despite fears about levels of care⁹⁷.

The combination of low levels of morale and extreme pressure at work has a detrimental impact on the workforce. This is critical, because morale is directly linked to the quality of the output that a workforce delivers⁹⁸. If the challenges that care homes face remain overlooked year on year, it is likely that the morale of its workforce will continue to deteriorate. This has worrying implications for the quality of care staff can deliver and could result in a further reduction of the workforce as more staff leave, further compounding existing problems⁹⁹ and, in turn, having a detrimental impact on the quality of life and care of residents whose life can be marked by constant change and disruption.

Review Findings

Care Staff

“A care home is as good as its staff.” Resident (Questionnaire Response)

Care staff play an essential role in whether or not residents have a good quality of life. The pressures faced by care staff in fulfilling this role, however, should not be underestimated as working with emotionally vulnerable, cognitively impaired and frail older people, often for very low pay, is emotionally, mentally and physically challenging and demanding.

Comments from the questionnaire clearly showed that relatives and residents understood that care staff were working in a pressured environment and that, in many cases, they were doing ‘their best’ with limited resources.

Rapporteurs also reported that care staff were generally kind and committed, trying their best to deliver high standards of care, often in difficult circumstances. It was clear that the best care homes were those where care staff felt valued and supported.

To ensure that care homes are the best that they can be, the residential care workforce must be seen as a professional national asset and must be valued and supported so they have resources available to deliver truly person-centred care.

It is clear, however, that this is not the case: care work currently has a particularly low social status, reflected by low pay, long working hours, poor working conditions and a lack of opportunities for professional development and career progression. Similarly, a care home can be an isolating environment and a place with limited access to peer support.

This can lead to care staff having low morale and becoming demotivated, which can lead to poor staff retention and a culture of ‘neutral care’ delivered in a task-based way with a lack of compassion and focus on an individual’s needs.

Evidence from the Care Council for Wales (CCW) stated that registration and regulation of care staff would be an effective way of driving up the status, identity and value placed on delivering residential care for older people. They clearly stated that “it is not a matter of whether regulation should be introduced, but how” and are currently undertaking work to determine how this system might work.

Staff Capacity

“Staffing is an issue. We are already stretched. If one or two people go off sick, it’s very difficult to cope.” Care Home Manager (Oral Evidence)

“When I visited, the staff were doing their best, but they were in short supply.” Family Member (Questionnaire Response)

Rapporteurs reported that Care Home Managers and care staff regularly stated that they were understaffed, sometimes ‘chronically’. This was particularly evident at weekends: it was rare to find a senior manager on the premises and staffing levels were reported to be below normal service levels.

When the Commissioner’s team contacted the care homes on the morning of a visit, a number of homes requested that the Rapporteurs visit at another time because their staffing levels were low or the manager was unavailable.

“We could do with an extra pair of hands.” Care Home Manager (Care Home Visit)

“I’d love to see people get out more, but we just don’t have the staff.” Care Home Manager (Care Home Visit)

Understaffing in care homes can significantly increase the pressure placed on care staff, which can result in them having less time to interact with residents as they become more task-orientated to ensure that their essential core duties are undertaken. This lack of person-centred care can have a significant impact on an

older person's quality of life as care is often delivered with limited time and with a lack of compassion.

Written and oral evidence from care home providers, Care and Social Services Inspectorate Wales (CSSIW), Local Authority Commissioners and the Royal College of Nursing (RCN) identified that low staffing levels are often the result of difficulties in the recruitment and retention of care staff. A number of reasons were stated for this, including poor levels of pay, low morale, long working hours that can include 12 hour shifts as part of a 60-70 hour week and the role of a care worker not being seen as a desirable and viable professional career option. This is a particular issue in rural areas and areas where the need for Welsh language speakers is high, as the number of potential care workers with the right skills can be especially limited.

The recruitment and retention of high quality care staff can play a vital role in older people's quality of life; Rapporteurs observed that the best care homes were those with high morale among care staff and low staff turnover, where many of the staff had worked for decades.

**“If you haven't got a happy and good staff team, then you haven't got a home.”
Care Home Manager (Oral Evidence)**

Care home providers also identified the importance of career progression to attract people to the care sector, particularly for younger people at the start of their careers:

“We are, in lots of ways, at a loss in not being able to recruit carers at sixteen. In England you can do that, in Wales they have to be eighteen. If you can bring them on an apprenticeship scheme and train them from the start, chances are they will stay. But also you're developing the workforce of the future. Within that they have to have some sort of development.” Barchester Healthcare (Oral Evidence)

Evidence from CCW stated that due to a shortage of staff, many care staff are employed without a reference in place. This means that the National Minimum Standard 22 (Recruitment Outcome), which states that 'service users are supported and protected by the home's recruitment policy and practices', is not being met in many cases.

Similarly, in order to meet legal requirements around staffing numbers, many care homes regularly use agency staff to provide the support required. Agency staff may find it more difficult to build relationships with residents due to their irregular and inconsistent working patterns.

“In order to get the right levels of staffing, we tend to end up with agency staff and it's a huge impact, people who don't know the home, they don't know the residents... Their systems are different. So you have residents who

see different faces constantly, if you are using agency every day they don't have relationship building, people don't understand their needs. But for safety's sake we have to do it, we have to have nurses on duty." **HC-One (Oral Evidence)**

The impact that staffing issues can have on older people's quality of life was clearly outlined in evidence from the RCN, which stated that:

"Poor staffing leads to poor care. Overwork and chronic understaffing are key contributing factors to the development of a culture of learned helplessness. So, when things go wrong in patient care, failings have become the norm, so they [staff] are far less-likely to recognise when a problem with care occurs." **Royal College of Nursing (Oral Evidence)**

Training

During their oral evidence session, CCW outlined the mandatory training that individuals must undertake before they can deliver care in a care home setting. This basic training consists only of manual handling, fire safety and health and safety training and does not sufficiently prepare individuals to understand the needs of older people and provide the appropriate support.

It is also particularly concerning that, according to evidence from CCW, only an estimated 60% of care staff have completed this mandatory training, which means that a significant number of care staff across Wales are delivering care without even the most basic of training. This also means that the National Minimum Standard 21 (Staff Qualifications Outcome), which states that 'service users are in safe hands at all times' is currently not being met in a significant number of cases, potentially putting older people at increased risk of injury or harm.

"They had no training. I asked and the only training they had received was health and safety, and manual handling, they had no idea of how to meet a resident's needs, particularly people with dementia." **Family Member (Questionnaire Response)**

"There are a lot of good carers but they lack better training." **Family Member (Questionnaire Response)**

Evidence from Age Cymru stated that the basic training currently provided is not sufficient and that 'mandatory dementia awareness, equality and human rights and basic values training should be provided to all residential care staff. This should include dignity and respect principles, attitudes and values, empathy, equality and human rights awareness and challenging negative stereotypes'.

Evidence from Alzheimer’s Society reflected this, stating that staff need knowledge, both about the impact of dementia on the resident and also around practical components of care, to deliver high quality care to residents living with dementia. They stated that dementia training should be holistic and cover a range of aspects of care provision in both practical and personalised areas, such as providing care that promotes dignity and respect and communicating effectively with a person with dementia, essential to be able to understand their wishes and needs.

This values-based training would ensure that care staff not only fully understand the needs of older people living in residential care, but can also understand what it feels like to be an older person receiving such care. This empathy is essential to be able to provide person centred care and not simply follow a task-based approach.

Good Practice: Neath Port Talbot Social Care Academy – Care For Your Future

Neath Port Talbot Social Care Academy has been developed to support the sector in the recruitment of quality social care staff.

The Care for Your Future course sits within the ‘Social Care Academy’ and its programme starts with ‘Delivering Dignity’ which focuses on the question ‘how can we be sure that every person is supported through an ethos of dignity and respect each and every day of their lives?’.

The Academy is open to people who are able to attend a six month programme of workshops on a two weekly basis and equally attend as a volunteer for four hours per week in a care setting, where they will be guided by a mentor who has previously completed this training and has a full understanding of delivering compassionate care.

One carer who had completed the training stated:

“Today I’ve realised that for the last twelve years I’ve just provided what you call token care. I’ve given people good food and I’ve put them to bed in a clean bed, but not with compassion and not ever realising how do they feel at this moment.”

Good Practice: Care Forum Wales – Driving Dignity in Wales Toolkit

This toolkit has been developed with the help of Practitioners and Managers working in social care in Wales. It contains a selection of material they believe may be useful when carrying out induction, running refresher CPD seminars or just in general staff training.

The toolkit is built around four principles that should underpin service delivery:

Principle 1: Promote autonomy, personal identity and empowerment

Principle 2: Engender respect

(Cont...)

Principle 3: Communicate effectively

Principle 4: Ensure privacy

The toolkit has eighteen parts and includes a wide range of information for care staff about what dignity means to older people, meeting people's personal preferences, the principles of person centred care and the impact of language.

The toolkit brings together best practice from across Wales to ensure that dignity in care is promoted.

In addition to values based training and up-skilling, further practical training for care staff can also deliver better outcomes for older people.

Evidence from Shropdoc, for example, stated that training staff to undertake simple health assessments, such as temperature, pulse, blood pressure and glucose levels, would enable more detailed health information to be provided during initial contact with GPs, resulting in more accurate diagnoses.

However, evidence from Care Home Managers and independent providers stated that limited staff time and workforce pressures often restricted access to training opportunities for care staff. Furthermore, wider support to access training opportunities is limited. This means that staff are often not able to learn and develop new skills that could enhance the quality of life of older people living in residential care.

Nursing Staff

Oral evidence from the RCN stated that there was disparity between the standards of nursing in the NHS and the standards found in nursing homes. They identified a number of reasons for this, including limited clinical supervision, a lack of peer support in nursing homes and a lack of opportunities for professional development, as well as nurses often having to make decisions on their own as they have no one to discuss issues with. These factors can be a particular issue in smaller nursing homes.

The RCN also stated that it is more difficult to recruit nurses to work in nursing homes due to a lower standard of pay and conditions, more isolated working environments and a general negative perception of nursing homes.

This can often result in newly qualified nurses being recruited to nursing homes who may have limited experience in working with older people and may require additional support and training. Retaining these nurses can also be difficult as many will move to a nursing role within the NHS.

Their evidence stated that Health Boards do not have a primary care strategy for nurses working in the residential care sector, which means that workforce planning

for Wales is based on the needs of the NHS and has failed to consider the needs of Welsh citizens living in residential care.

Whilst nurses working in nursing homes have a wide range of care skills, there will always be instances when older people will need timely access to specialist healthcare. The Commissioner received evidence from the RCN, Care Home Managers and independent providers that demonstrated there can be confusion about roles and responsibilities for medical treatment and care between the NHS and nursing care homes.

Evidence received from Care Home Managers stated that there are assumptions that nurses working in nursing homes can 'do everything', which means that the NHS often does not provide support in a proactive way.

“She [NHS professional] said ‘what sort of nursing home are you that you can’t do a male catheterisation?’. But with an EMI psychiatric nursing home you don’t very often find a gentleman with advanced dementia with a catheter. The nurse felt ‘that big’.” Care Home Manager (Oral Evidence)

Evidence taken during the roundtable discussion on health also highlighted the historical attitude towards nurses working in care homes:

“When I joined the Health Board in 2008 or 2009, there was an appalling attitude to nursing homes. It was very negative, they were somehow below us and I was quite shocked at that because I’m from primary care, I’m a General Practitioner... I think we’ve come on leaps and bounds, I think there’s an awful lot of respect for our colleagues in the independent sector. They’re not NHS nurses but they’re still nurses... I think there is a long way to go yet, I still think that our opinions of care homes lacks a lot so I think there is still some work to do.” Abertawe Bro Morgannwg University Health Board (Oral Evidence)

It is clear that on-going support to nurses working in care homes, whether from their peers or from the wider health system, is vital, not only to ensure that they have the skills and experience necessary to carry out their role effectively, but also to ensure that older people are receiving the care they need.

This is something that was acknowledged by Health Boards across Wales during the roundtable discussion on health:

“There are some great examples of secondary care being provided in nursing homes that prevents people from coming into secondary care type services. We’ve got a range of those, so a question of Health Boards is, given that this is happening and it’s producing great results, why aren’t you doing that everywhere? (Cont...)

...So the reflection of our board is that there's great practice in parts of our board, but why aren't they consistently and reliably doing this everywhere because it saves us money, it saves us time?" **Abertawe Bro Morgannwg University Health Board (Oral Evidence)**

Good practice: Betsi Cadwaladr University Health Board - Residential Care Liaison Nurse Project

The aim of this project is to take a proactive approach to maintaining the health of residents living in a residential care home, thus enabling them to stay in their home environment, preventing hospital admissions and being transferred to a nursing care home.

A trained nurse with the District Nursing team will coordinate and support the 29 registered residential care homes within the Health Board area. Initially a 12 month pilot project is planned where the liaison nurse will develop the role within one home over a four to six month period with a view of extending it to three homes within the year.

The team's initiative will be to support the care homes by assisting them in identifying training and development needs and assisting them in enhancing their practise.

Care Home Managers

"A manager who is caring and has a friendly manner with staff and relatives can make all the difference in a care home..." **Alzheimer's Society (Oral Evidence)**

"Some of the best care homes I saw had an ethos that came straight from the manager. An ethos that is shared with the staff and means that the focus was delivering care in people's own home and this should be done respectfully and unobtrusively wherever possible." **Social Care Rapporteur**

Written evidence from Age Cymru stated that effective leadership is a common factor amongst good care homes and that strengthening management and leadership skills in care homes delivers better outcomes.

This was supported by evidence from Dementia Care Matters who stated that the manager plays a key role in modelling person-centred care on a daily basis, essential to improve the quality of interactions between residents and care staff, and ensure that a task-based approach is not used in the delivery of care.

"In all dementia care homes that really provide a new culture in dementia care, this rests with a manager who knows how to lead, rather than just manage. Improving a dementia care home requires a significant amount of drive and

commitment to enable culture change. Maintaining the momentum of culture change can be particularly challenging. Task orientation is deeply ingrained. Achieving real outcomes for older people means that care homes need inspiring leaders.” **Dementia Care Matters (Written Evidence)**

It is clear that Care Home Managers who strive to deliver the best quality of life for residents have recognised the limits of a task-based approach to care delivery. For example, during their roundtable discussion, Care Home Managers spoke about cultivating a family spirit in their homes, as well as the need for emotional energy and passion ‘in bucket-loads’ to maintain a positive care environment and drive cultural change.

“I’ve invested a massive amount of emotion in my home and that’s what rubs off, if you’ve got that depth of feeling about the people you’re looking after and loving, then the staff to take that on board, it cements huge relationships between the people you’re looking after. And the people I’m looking after are all of the people in my building, there’s 51 residents, there’s 53 care assistants and I guarantee one thing if they [care staff] don’t like it, they won’t stay.” **Care Home Manager (Oral Evidence)**

Whilst the Care Home Managers who gave evidence were committed to delivering the best care and quality of life for older people, they were clear that the breadth of their role, competing priorities and demanding workloads resulted in a lack of time to drive the cultural change required within their care homes.

This was reflected in evidence from Age Cymru who stated that it is the manager who will demand high standards and drive a positive culture in a care home. However, the complexity of a manager’s role, which often combines the role of lead clinician, operations manager, finance manager and marketing director, can affect their ability to do this.

“A manager should lead by example and free up time, away from their own tasks, to spend quality time with the staff and people who are at the care home...show everyone that they matter.” **Rhondda Cynon Taf County Borough Council (Written Evidence)**

Support for Care Home Managers

“Many [Care Home Managers] are isolated – they don’t have opportunities to discuss issues with people in similar roles. Access to learning is limited.” **Care Council for Wales (Oral Evidence)**

Care Home Managers must hold certain qualifications in order to register with the Care Council for Wales, which ensures that they are professionally qualified to

undertake their role. However, Care Home Managers clearly identified the need for and value of effective and on-going support, both in the form of additional training and specialist support.

“I think there’s a paucity of higher level support, certainly of education. You’re a manager or you’re a nurse, that’s it, you don’t need any further [training]... Well you do, you need loads. Well I personally do.” Care Home Manager (Oral Evidence)

“I think that we’re very stand-alone aren’t we and kind of forgotten maybe because not a lot of people know what to do to make a good home.” Care Home Manager (Oral Evidence)

In their evidence, CCW highlighted a number of reasons why care home managers may feel that they need additional support.

The main reason they stated was that the role of a Care Home Manager has significantly changed over recent years as the needs of older people living in residential care have become more complex. The definition and status of a Care Home Manager has not kept up with the increasing demands and expectations that are now placed on this role. CCW recognise that this ‘lag’ needs to be addressed and initiatives are being explored that will ensure that Care Home Managers are equipped to become ‘leaders of practice’, such as continuing personal development delivered through post-qualification training. CCW stated that the development of a career pathway and Continuing Professional Education and Learning (CPEL) Framework¹⁰⁰ will provide an opportunity to contribute to the professionalisation of the care home workforce, drive up standards of care and provide care home managers with the knowledge and skills that they need.

Furthermore, CCW stated that the component parts of the Care Home Manager role are “too much for one individual to balance”. There needs to be a more equitable balance between the care home manager, who should be a leader of practice and responsible for the delivery of high quality care, and the responsible individual (e.g. care home owner) who should carry corporate responsibility for the way the home is run.

Evidence from Embrace Group, an independent provider, described more successful care homes as those that delegated responsibility across staff with different skill sets. In these homes the manager will work closely with a deputy to continuously deliver high quality care and culture even in their absence.

In their evidence, CCW highlighted that training opportunities for Care Home Managers are limited, outlining a number of reasons why this is currently the case. They stated that financial and time pressures have resulted in difficulties around releasing and funding care managers to receive training. They also stated that there is a lack of parity in the investment into health care and social care, with between

£70k and £100k of public funding used to train a nurse and only £5k used to train a social care manager. Furthermore, they highlighted that the proposed changes to funding arrangements in Wales are likely to reduce access to funding for training opportunities for people aged 24 and over, which could have a negative impact upon the professional development of care home managers.

It is essential that learning provision is made available that is of high quality, regulated, flexible, sustainable and cost-effective in order to deliver the Social Services and Wellbeing Outcomes Framework in care homes.

Good Practice: Aneurin Bevan University Health Board (ABUHB) - Clinical Lead Forum

ABUHB has developed a clinical lead forum to bring together Care Home Managers with other key organisations, such as CSSIW and Care Forum Wales, on a regular basis.

The forum provides an opportunity to consider and discuss various topics including contract compliance and monitoring, Deprivation of Liberty Safeguards, Protection of Vulnerable Adults and the development and sharing of good practice.

These forums are greatly appreciated by both the Care Home Managers and ABUHB as they enable reliable on-going communications.

Workforce Planning

Evidence from CSSIW stated that workforce planning is challenging due to a lack of demographic projections about future need therefore it is not possible to quantify the 'right' number of care staff as this will vary depending on the support needs of individuals living in residential or nursing care homes.

“One of the things we battle with as an inspectorate is staffing sufficiency. There are no set number ratios and that is both a good thing and a bad thing. The bad thing is it is very hard for us to hold people to account for the number of staff that they’ve got on duty. On the other hand, you need to be flexible in terms of people’s increased dependency.” CSSIW (Oral Evidence)

Evidence from the Care Council for Wales stated that the unregulated nature of the care home workforce in Wales, which means that data is not held on the number of care home staff in Wales, can also lead to difficulties around effective workforce planning.

Evidence from the RCN identified that, in relation to nursing staff in particular, there is a lack of effective workforce planning. They stated that this planning is based on the needs of Health Boards and the hospitals they run and does not consider the needs of residential care.

Evidence from Carmarthenshire County Council and Rhondda Cynon Taf County Borough Council also stated that they have significant issues around the recruitment of nurses, particularly in recruiting Registered Mental Health Nurses and nurses to work in EMI care homes.

Issues around recruiting EMI nurses were also highlighted in evidence from Caerphilly County Borough Council.

“The EMI capacity, particularly in nursing capacity, is a real problem for us. Not so much on a residential EMI capacity, we’re doing okay on that. But it’s proving very difficult to persuade providers to go and provide those EMI nursing facilities. It is not an attractive market for them to move into. So those capacity issues, I can only see continuing, to be honest.” **Caerphilly County Borough Council (Oral Evidence)**

Local Authorities have also stated that the recruitment and retention of Registered Mental Health Nurses, alongside the higher cost of specialist nursing care in EMI settings, is a significant barrier to providers entering and sustaining this type of provision, especially in rural areas.

The Care Council for Wales also identified that a number of Care Home Managers are not registered and, although succession planning has improved, there are still gaps in the number of registered managers that are needed for the future.

“Whereas there is some evidence of succession planning in that there were more services with more than one person qualified and registered as a manager than in 2012, there still needs to be careful succession planning for the service.” **Care Council for Wales (Written Evidence)**

Without the correct workforce – the right number of staff, with the right skills, in the right places – residential care provision will be unstable and unable to meet the needs of older people living in residential care both now and in the future.

Commissioning, Regulation and Inspection

Literature Review

Local Authorities in Wales currently face the twofold obstacle of rapidly rising costs in adult social care and significant budgetary constraints. Alongside this, the increased demand due to demographic changes, and the increasing complexity of needs and acuity levels of older people means that the task of providing care has become more intensive and complex.

Whilst current policy strongly promotes services that enable older people to remain in their own homes for longer, the importance of high-quality residential and nursing care cannot be underestimated, given the known increase of older people in Wales over the next decade, particularly those over the age of 80 and levels of disability, chronic ill-health and corresponding frailty.

It is clear that as the number of older people continues to grow in Wales there will be a corresponding increase in the demand for care to be delivered in a residential or nursing setting.

Guidance from both the Welsh Government¹⁰¹ and the Institute of Public Care¹⁰² have advised that in order to ensure there is sufficient, appropriate provision for current and future needs, commissioners must have a good understanding of the existing market upon which to conduct an analysis and then make a judgement.

However, CSSIW’s National Review of Commissioning for Social Services in Wales 2014¹⁰³ found that ‘services are not sustainable in the traditional commissioning model’. Although the Review found that Local Authorities recognised this, they did not find evidence of an in depth analysis of the needs and resources of communities, and the sustainability of future services.

Furthermore, research by LE Wales (Future of Paying for Social Care in Wales, First Report to the Welsh Government, April 2014) found that accurate information about people who funded their own residential care was not available, “There may well be a significant number of these self-funders that are not captured here. For example, it has been estimated that in England, 43% of individuals staying in care homes were fully self-funded in 2013”¹⁰⁴.

Without knowledge of the numbers of those older people who will require residential or nursing care, it is not possible for commissioning and future planning to be sustainable, and fully meet the future needs of older people in Wales.

Around 90% of care home provision for older people is supplied by the independent sector, i.e. voluntary and for-profit organisations¹⁰⁵. According to recent market analysis, the last five years has seen a significant increase in demand for residential and nursing care in line with an ageing population. However, industry revenue has

not grown substantially and is only expected to increase at a compound annual rate of 0.2% in the five years between 2013 and 2018¹⁰⁶.

Market analyses have also highlighted the following factors that have the potential to adversely impact commissioning costs and the sufficiency of the care home market:

- Staffing and pay levels
- Running costs
- Care home fees¹⁰⁷

These factors are particularly significant in Wales where “profit as a percentage of income most clearly lags behind the UK average”. This is in part as a result of high staff costs relative to fee income¹⁰⁸.

Pay levels in the sector will continue to be an issue, with operators perhaps seeking to limit pay increases in line with the national minimum wage. This, according to Colliers International Research, would be a false economy as staff, especially senior staff, have to be incentivised and rewarded for maintaining high care and amenity standards and effectively marketing the homes’ services. If a business in the healthcare sector loses its senior motivated staff, it will typically result in deteriorating standards and profit¹⁰⁹.

However, research indicates that despite these challenges “expenditure could be reduced through more effective and collaborative commissioning, including procurement of services”¹¹⁰.

In their review of Commissioning in Adult Social Care, the Care and Social Services Inspectorate for Wales (CSSIW) identified that “current commissioning arrangements for dementia services will not deliver sustainable services for adults who need care and support in Wales”¹¹². The report goes on to highlight that the “current and projected service demands for adult social care services and the resulting financial pressures present a significant challenge to Local Authorities and Health Boards if they are to meet the current and future needs of vulnerable citizens”¹¹³.

The field work for the CSSIW Review was specific to five regions and was conducted in Blaenau Gwent, Vale of Glamorgan, Swansea, Merthyr Tydfil and Flintshire. However, findings reflect the broader landscape across Wales and illustrate the current situation faced by all of Wales’ 22 Local Authorities and 7 Health Boards. The Commissioner recognises the importance of this review and welcomes its recommendations, with particular emphasis on those that called for Local Authorities and Health Boards:

- to integrate health and social care provision, and develop joint plans for the commissioning of services;
- to develop outcomes based commissioning strategies, with contract monitoring and review;

- to ensure that joint commissioning plans have appropriate governance arrangements¹¹⁴.

Research by the Joseph Rowntree Foundation shone a light on Essex County Council's approach to commissioning social care. It shows that the Council has shifted its commissioning approach from "top-down monitoring, inspection and regulation to one that builds relationships, invests in the development of care home staff, and instils a shared vision for care and support for older people"¹¹⁵.

The 'Essex approach' builds upon the work of My Home Life, which aims to improve quality of life in care homes through a relationship-centred approach that focuses on building positive relationships and connections between and among older residents, care home staff and managers, and with commissioners¹¹⁶.

A core feature of the Essex approach is "the simultaneous focus on commissioning and provision; the council did not just expect care homes to change and improve, but required sustainable, systemic improvements across the health and social care community. Putting this approach into practice, Essex replaced the previous Quality Monitoring team in the council with a small Quality Improvement (QI) team, changing its relationship from a 'hands-off', punitive approach to monitoring, to working alongside care homes to achieve better outcomes for older residents. The My Home Life themes have become part of the council's contracting and procurement processes, meaning that funding and contractual decisions are based on quality outcomes, rather than traditional measures such as numbers of people or beds"¹¹⁷.

In short, good commissioning should involve identifying the needs to be met and the desired outcomes, planning how best to meet those needs, procuring high quality and cost effective services and monitoring service delivery to ensure outcomes are being achieved¹¹⁸.

Through improved commissioning, adult social care can achieve better outcomes for service users, carers and families; make sure services are designed to meet the needs of service users; make the best use of resources; and keep an on-going check on the quality and impact of services.

Commissioning is not simply a process of analysis, procurement and review. "Values and principles shape who gets what, how, when and where"¹¹⁹. It is these values and principles that will determine the quality of life that older people in Wales will be enabled to achieve through residential care.

In addition to quality monitoring activities that commissioners will undertake, the Care and Social Services Inspectorate for Wales is the body responsible for inspecting social care and social services to make sure that they are safe for the people who use them¹²⁰, and it regulates and inspects residential and nursing care homes based on compliance with the National Minimum Standards, and inspection tools that it has developed.

The Welsh Government White Paper, 'The Future of Regulation and Inspection of Care and Support'¹²¹, has proposed to change the regulation and inspection of care and support. A forthcoming 'Regulation and Inspection Bill' will introduce an outcomes based inspection regime, the involvement of citizens in inspection, require providers to produce an annual report on their services and widen the workforce role of the Care Council for Wales into service improvement, and rename it the National Institute of Care and Support. The proposals to develop an outcomes based inspection regime could see a move away from compliance with National Minimum Standards, and support the changes that have been identified in research needed within commissioning.

Review Findings

Commissioning

Evidence from Health Boards and Local Authorities highlighted that Local Authorities are generally the lead partners in commissioning.

Local Authorities base their commissioning practices on 'Fulfilled Lives, Supportive Communities', the Welsh Government's 2010 commissioning framework, guidance and good practice¹²². This established a set of 13 commissioning standards, along with guidance on nine key commissioning challenges at a strategic level.

To fully understand the different approaches to commissioning in Wales, the Commissioner required information from Local Authorities and Health Boards that confirmed:

- What they are commissioning
- Whether they are commissioning for quality of life
- How they monitor and seek assurance that the quality of life and care will safeguard and promote the wellbeing of older people

The majority of responses from Local Authorities and Health Boards clearly highlighted that the statutory focus has been on contractual frameworks and service specifications rather than seeking assurances about the quality of life of older people living in care homes. This was confirmed by CSSIW's National Review of Commissioning for Social Services in Wales 2014¹²³, which found that there was an inadequate focus on the quality of care provided and people's quality of life.

Residential and nursing care homes form part of the whole health and social care 'system', and should be treated as such in an inclusive and consistent manner. Therefore, when a Local Authority or Health Board commissions a place for an individual within a residential or nursing care home, their responsibility should be to not only lay out service specifications and to ensure that the care package can be delivered within their fee structure, but to also actively seek on-going assurances that an older person is safe, well cared for and has a good quality of life.

The evidence from Health Boards showed that this has often not been the case and that commissioning and monitoring in the past has focused solely on the clinical, nursing element of a placement and not even on wider primary healthcare needs let alone the full quality of life of an individual. However, as Hywel Dda University Health Board demonstrated in their oral evidence, they are now beginning to take steps to widen the scope of their review visits.

“The review officers that go in were previously concentrating on the reviews around the health care, for the nursing care etc. However we’ve enhanced that now so they’re looking at the environment and considering other aspects of the home and what’s being delivered, how that’s being managed.” Hywel Dda University Health Board (Oral Evidence)

According to the Welsh Government’s NHS Wales Planning Framework¹²⁴, Health Boards have a responsibility to plan ‘for the health of the entire population (not just planning for the services they provide)’. They therefore have a responsibility to ensure quality of life for all older people living in care homes, not just the individuals for whom they commission care home places.

Both Betsi Cadwaladr University Health Board and Hywel Dda University Health Board have taken action to ensure that the health of all older people in care homes is considered by introducing ‘residential liaison nurses’ whose role is to up-skill care staff in basic, but essential, healthcare issues such as continence care and to access and deploy specialist nursing support where necessary from the local primary care teams.

Evidence from Health Boards demonstrated a commitment to a change of focus during commissioning and monitoring, moving away from a clinical focus towards a more holistic approach for the benefit of an individual.

“There’s a great deal of work that needs to go on in terms of how we commission the care from the residential homes and the nursing homes. So we are very clear from the outset what their [an individual’s] expectations are. Like a contract of care really and what they’re expecting to deliver and work with us in partnership.” Betsi Cadwaladr University Health Board (Oral Evidence)

However, it is clear that these changes are at an early stage of moving towards a clearer, more ‘person focused’ approach to commissioning that can operate alongside a Health Board’s wider healthcare obligations to their whole population.

Responses from Local Authorities showed that while some have used service specifications to ensure that older people are supported to enjoy their basic human rights, there is an overall lack of quality assurance that is centred around quality of life, in current commissioning practice.

However, the majority of Local Authorities did state their intention to implement some form of quality monitoring tool in the near future, or that their current processes were under review.

Some Local Authorities are taking innovative approaches to their commissioning and fee structures in order to drive up quality. Bridgend County Borough Council, for example, has set up a 'quality fee standards system' that bases the fees paid to providers on the achievement of care standards that are higher than the current National Minimum Standards.

“[The ‘quality fee standards system’] Sets out principles and outcomes we want within care homes locally. They act as a positive vehicle for us to set out our high expectations around self-determination, lifestyle choice and preferences...” **Bridgend County Borough Council (Oral Evidence)**

While this could be used as a tool to drive up the quality of care that is provided in care homes within an area, there is the risk that, when under financial pressures, providers could become reliant on a higher 'quality fee' for the delivery of lower care standards and struggle to remain sustainable if the 'quality fee' is consequently removed.

Newport City Council described the joint work they are undertaking with Torfaen County Borough Council and local providers, to develop a fee methodology. Their fee modelling group is also considering how quality monitoring tools, that include a greater focus on quality of life, can be introduced.

“Torfaen and Newport at the moment have got a working group... to develop a fee methodology across both patches of Gwent. As part of that fee modelling group we've also got a quality group that's made up of some representatives from providers, and we're hoping to develop a common quality framework that providers can use that will help us and aid us with contract compliance, but will focus more on the quality of life and the experience of the older person within residential care.” **Newport City Council (Oral Evidence)**

Evidence from independent providers highlighted the difficulties in operating across different parts of Wales because there can be significant differences between the process of service specification and the practice of contract monitoring in different areas. This was also supported by evidence from Local Authorities and Health Boards and has been recognised by the Welsh Government, which stated, in Sustainable Social Services for Wales: A Framework for Action (2013)¹²⁵, that '... doing everything 22 times is not an option... The way in which commissioning, procurement and service delivery are organised must also change'.

Good Practice: Flintshire County Council

To ensure that quality of life is a core element of the commissioning process, Flintshire County Council has introduced an outcomes based quality monitoring process, which is based on consultations with older people and families about their expectations of residential care. The framework looks at 9 specific outcomes that care homes are required to deliver for older people:

1. Independence
2. Control over daily life
3. Rights, relationships and positive interactions
4. Ambitions (to fulfil, maintain, learn and improve skills)
5. Health (to maintain and improve)
6. Safety and security (freedom from discrimination and harassment)
7. Dignity and respect
8. Protection from financial abuse
9. Receipt of high quality services

This approach has now been agreed as the basis for the North Wales Quality Monitoring Framework for Care Home Placements.

A common framework across North Wales is a positive step to reducing the burden on providers, improving clarity regarding what care homes must deliver for older people, and ensuring that out of county placements can be delivered to consistent standards.

One of the defining elements of the framework in Flintshire is that it is carried out through an on-going quality monitoring approach that facilitates feedback from all residential care professionals. This process, described as a “quality circle”, enables information to be shared effectively, an essential part of any monitoring process.

“It’s about people sharing intelligence, and some of that’s about hard evidence that they’ve gathered during their professional visits or people bringing feedback that they’ve had because they’ve had contact with families or whatever. Also, hearing about changes that have happened in homes in staffing, [etc] and then we look at themes.” Flintshire County Council (Oral Evidence)

The quality circle is open to all professionals, such as social workers, district nurses and inspectors, as well as those providing day-to-day services within residential care, such as hairdressers and chiropodists. Residents groups and family members are also able to participate and provide any relevant information, which is essential

as, according to Margaret Flynn, who is leading the independent review into alleged abuse of older people in care homes in the south Wales valleys, they “notice the daily inattentions that pave the way for more serious transgressions and on-going cumulative neglect”.

A proactive approach to assurance that ensures intelligence is gathered at an early stage to identify issues before they become ‘full blown problems’ and also triangulates evidence from a wide range of professional sources, older people, families and care staff is essential for commissioners to evaluate the quality of life provided by care homes. This approach will enable the identification of factors that have been highlighted as ‘risks’ by the Welsh Government, CSSIW, Care Council for Wales, Local Authorities and Health Boards, such as the departure of a Care Home Manager, high turnover of staff, withdrawal of placements by other Local Authorities, or financial instability.

“It’s really trying to get in and work with the provider and trying to understand what problems that provider may be having so they don’t cause a problem further down the line. Staffing issues are an obvious candidate...if this needs more forceful action on our part as commissioner then we use our provider performance process.” **Caerphilly County Borough Council (Oral Evidence)**

The majority of written and oral responses from Local Authorities and Health Boards did not illustrate the ways in which shared intelligence and joint working were used in contract monitoring to ensure that older people were safe, well cared for and enjoyed a good quality of life. Instead their responses focused on the process, or strategy, of a formal annual review and complaints procedure and appeared to forget the individual, and their voice, which should sit at the heart of the quality process.

In some cases, the only information used regarding the quality of care appears to be from CSSIW inspection reports, with increased scrutiny being a reactive approach to issues raised by CSSIW, POVA (Protection of Vulnerable Adults), or through the Escalating Concerns process.

A report from the inspectorate alone cannot provide the depth of information needed to assure those commissioning services that older people are safe, well cared for and have a good quality of life.

Another issue identified in evidence from Local Authorities was that, those commissioning a wide range of services on behalf of older people are not experts in social care and do not fully understand the increasingly complex needs of older people, for example the increasing prevalence of older people living with dementia. It is therefore clear that there is an urgent need to up-skill those commissioning services in order to drive cultural change through outcomes based commissioning that has a clear vision of what good looks like.

The CSSIW National Review of Commissioning for Social Services in Wales 2014¹²⁶ identified that ‘current commissioning arrangements for dementia services will not deliver sustainable services for adults who need care and support in Wales’. Some Local Authorities provided evidence that demonstrated that they have recognised the urgency of this issue and have brought in expert advisers to assist.

Bridgend County Borough Council, for example, highlighted the work of their dementia liaison team, provided by the Alzheimer’s Society, and how important the third sector is in providing knowledge and external support to commissioners.

Similarly, Caerphilly County Borough Council is working with Dementia Care Matters, a consultancy that works to transform the culture of care in care homes for people living with dementia, to work with their commissioning team to improve the judgements they make about quality of life and care outcomes for older people. This has resulted in further training for a number of officers so that they can use this knowledge to raise the standards of residential care that they commission for older people.

Other evidence identified different approaches that aim to establish what good looks like from the perspective of an older person.

Monmouthshire County Council, for example, have taken steps to address the previous lack of individual voices within their contract monitoring procedures through initiating a ‘what matters conversation’. This helps social workers to find out what matters to older people before they enter care homes to inform the contract monitoring process.

A similar approach has been adopted by Aneurin Bevan University Health Board, who have developed ‘Care Home Ask and Talk’ (CHaAT) to capture the views of residents in care homes. This will be further enhanced by the Big Lottery funded Community Voice programme to develop an engagement project in care homes across Newport, Monmouthshire, Caerphilly and Blaenau Gwent.

The pilot phase of the project will place volunteers in four care homes so that they can identify ways in which services could be more tailored to take into account the views and concerns of older people.

These kinds of approaches are essential to ensure that commissioners are able to determine whether the care they are commissioning will deliver the best quality of life for an older person.

National Minimum Standards

In addition to the requirements set out in the Care Homes (Wales) Regulations 2002, the National Minimum Standards are used to determine whether care homes are providing adequate care and are meeting the basic needs of the people who live there.

Evidence from a range of organisations, including CSSIW, HC One, Bupacare, Western Bay collaborative, Caerphilly County Borough Council, Association of Directors of Social Services (ADSS) and the Welsh Local Government Association (WLGA) stated that the standards are reinforcing a culture of compliance to the bare minimum, rather than creating a culture where older people are supported to have the best quality of life.

The quality of life of older people needs to be articulated much more clearly within the standards and not seen as separate to personal care and clinical treatment. This separation has contributed to the current culture of task-based care where the recording of bowel movements, whilst important, is prioritised against the wider issue of an individual's quality of life. Quality of life should be the umbrella under which all other standards sit.

Evidence was also received that the National Minimum Standards are insufficient to meet the needs of the emotionally vulnerable and frail older people now living in care homes. Alzheimer's Society, RNIB Cymru, Action on Hearing Loss and DeafBlind Cymru criticised the standards for being unable to promote and uphold the rights of some of the most vulnerable older people. The standards do not clearly outline how to provide enabling care and support to older people with sensory loss and /or cognitive impairment and dementia.

Evidence from CSSIW also highlighted the limitations of the National Minimum Standards and their impact on older people.

“People expect us to police the basic standards, that’s all they want a regulator to do. Our view is that this isn’t good enough and actually the basic standards don’t promote equality.” CSSIW (Oral Evidence)

They stated that to address these limitations, they have undertaken a ‘modernisation programme’ that uses new inspection tools and represents a fundamental change to CSSIW’s approach to regulation and inspection.

Since 2012, they have used the Short Observational Framework for Inspection (SOFI)¹²⁷ to assess the quality of care in residential care where traditional interviews and conversations are difficult. This approach allows inspectors to evaluate the quality of interactions within care homes, interactions that fundamentally shape an individual’s quality of life, and has been welcomed by a number of care home managers who gave evidence to the Review.

“I found the way they’re inspecting, using the SOFI observation, has really helped in how we’ve perhaps not noticed how people interact with each other. When they’re doing maybe washing, or helping them with their hair, or bringing them a cup of tea. I think it really highlighted to me that that was an area that needed improving.” Care Home Manager (Oral Evidence)

However, Care Home Managers have reported a variance in individual inspectors' ability to utilise the new tool effectively and, as at any time of transition, there have been inevitable misunderstandings about CSSIW's changing approach.

Availability of Care Homes

Standard 10 of the Welsh Government's 'Commissioning Framework and Good Practice Guidance'¹²⁸ focuses on the need to promote service sustainability. Commissioning therefore has a central role to play in both the quality of life of an older person, as well as the wider current and future sufficiency and sustainability of residential and nursing care.

As part of the Welsh Government's prevention and integration agenda, an increasing number of older people are being supported to remain living in their own homes for as long as possible. This is to be welcomed when it is what the individual wants in order to maintain their independence and to deliver the best individual outcomes and quality of life.

The number of emotionally vulnerable, cognitively impaired and frail older people is likely to rise, meaning that the needs of those older people will be more complex and at a higher acuity than previously. The numbers of older people who may need the support provided in care homes must therefore be fully understood in order for providers and commissioners to plan effectively for the future.

However, CSSIW highlighted issues around insufficient planning, a lack of demographic assessment and projection into the future needs of older people living in care homes at both a national and Local Authority level.

“Demographic needs 2014 - Where is it? Where is the strategic plan that would then look at the cost as well as the provision? Within that provision, how much is required to be within sheltered housing accommodation, on then to residential care and nursing care homes. Where is that data? It's got to focus on people's needs and it's got to help to develop a market that will meet those needs.” CSSIW (Oral Evidence)

CSSIW also stated that without this planning there is “an immediate pressure which creates behaviours that are very much about day-by-day solutions rather than actually identifying what percentage of that population are going to be most vulnerable and what you therefore can do both within the community setting to prevent... [and ensure] meaningful residential as well as early intervention... Then you're working out how much residential care are you ever going to need and have you go it?”

Despite progress by Local Authorities on market position statements, there is no overview at a strategic level to ensure sufficient and appropriate care home places for older people in Wales, both now and in the future. Furthermore, there is also

a lack of data about the current and future needs of the ‘oldest old’ in terms of health, disability, incidence of cognitive impairments, sexuality, belief, and ethnicity. A finding reflected in the Joseph Rowntree Foundation’s Better Life Programme, which recommends continued investment in data sources to further understanding of health, disability, economic and social well-being in old people. The planning of residential and nursing care homes for older people requires accurate projections of the future numbers and needs of older people to ensure that residents can live in a care home appropriate for them and have the best quality of life.

Despite the on-going and changing need for residential and nursing care across Wales, and recent efforts to support managing supply, evidence received demonstrated the volatile and fragile nature of the market sufficiency of residential and nursing care in Wales.

Evidence from CSSIW also demonstrated that although it is difficult to clearly identify a particular barrier to achieving market stability and sufficiency, the result is that Wales is not an attractive place for providers to enter.

“Wales is not actually a sharp place to come in to as a provider. There are loads of barriers ... The biggest issue for Wales is the fact that there are 22 different Local Authorities commissioning.” CSSIW (Oral Evidence)

The Care Council for Wales and independent provider HC-One highlighted that the lack of registered care home managers in Wales is both a risk factor to the quality of care being provided and the ability for a provider to continue provision.

A shortage of appropriately skilled nursing staff was identified by the Royal College of Nursing in their evidence as a barrier to market sufficiency. They stated that workforce planning is premised on the needs of the NHS Health Boards and the hospitals that they run, as opposed to the needs of the whole population. This shortage in nursing staff has a particularly detrimental impact on older people living with dementia who may need access to specialist mental health nursing care.

Evidence from Local Authorities also highlighted that, as well as difficulties in accessing or recruiting specialist nursing staff, the higher cost of providing this specialist mental health nursing care was a significant barrier to providers entering and sustaining provision, especially in rural areas.

This market volatility can have a significant impact on the lives of older people. The collapse of the Southern Cross Healthcare Group in 2011, for example, which ran over 750 care homes with 31,000 residents across the UK, resulted in a great deal of uncertainty and upheaval for many vulnerable older people and their families.

Evidence from many Local Authorities stated that they have begun, on a local or regional basis, through their commissioning processes and the development of market position statements, to discuss whether current provision matches the needs of the older population in their area.

Evidence from Carmarthenshire County Council demonstrated that they took action in the form of a 'payment premium' to encourage the provision of specialist care for people living with dementia after their own market analysis showed a shortage in this area.

“We put a dementia premium on, to try and diversify providers, because we recognised that there was an increased need for dementia care ...we added a dementia premium and we felt that would encourage some of the residential care providers to diversify into dementia care, and that did work. I think it was partly linked to their own market analysis because they saw that was the way the trend was going in terms of people coming in. So you can influence and shape in terms of ... obviously that was linked to a financial incentive, really, but I think that has worked in our county.” Carmarthenshire County Council (Oral Evidence)

However, the majority of Local Authorities recognised that the choices available to older people are often restricted by a lack of capacity in some areas, despite their best efforts to support choice. This can result in older people having to move away from their family and communities or live in a care setting that is not entirely appropriate for their needs.

“We’ve always strived to ensure that people have their choice of home and in the past when it hasn’t been available then they may have stayed in hospital. That presents its own problems. Over the years the choice of homes has reduced as the supply has dwindled although more is coming on now. It does present a problem - clearly people want the home nearest to them, but that can still entail a significant degree of travelling and we try and fit in with the wishes of the older person and their carers.... it’s not always possible, particularly with the pressure on beds in hospitals.” Powys County Council (Oral Evidence)

“It is a very fragile situation because if we take certain decisions we could destabilise the market completely. An example of that would be that we would be very strong on wanting to get rid of shared rooms. It is a disgrace that we are still doing it in Wales. They knocked this out in England five/ten years ago yet we’re still doing it in Wales. As soon as we moved on that we would have loads of beds that would go out of the market. It’s because they haven’t got the capacity.” CSSIW (Oral Evidence)

Evidence from Care Forum Wales identified that current fee structures are acting as a barrier to entry and that providers feel under pressure from Local Authorities to deliver increasingly complex care at lower costs during times of budgetary pressures.

Local Authorities also stated that there are real issues in terms of the stability of the market at the moment and that smaller locally owned homes are particularly vulnerable as they do not have the capacity to overcome the barriers outlined above.

“Potentially we could lose the small ones, the smaller, locally owned homes are the ones that are potentially vulnerable under that. Because they don’t have the capacity to deal with those issues..... So there are real issues in terms of the stability of the market at the moment.” **Caerphilly County Borough Council (Oral Evidence)**

The closure of smaller homes, particularly those in rural areas, is a particular concern as larger providers are less likely to be attracted to these areas due to the sparse population and lower workforce availability, leaving significant gaps in market sufficiency in an area for future years.

In order for older people in Wales to access high quality residential and nursing care that meets their needs, there must be a sufficient number of appropriate care settings, of the type that older people want, in the places that they need them. The evidence has shown that this is not the case and that there are a number of barriers working together to prevent older people being able to choose where they want to live and what type of care services they receive.

Self-funders

It is not known exactly how many older people arrange and pay for their care independently of a Local Authority, or Health Board in Wales, although many of the respondents to the Commissioner’s questionnaire were self-funders, or rely on their families to support ‘top-up’ payments so they can remain in their care home.

Evidence from the Association of Directors of Social Services (ADSS) stated that self-funders are not empowered individuals. Often they may be completely unknown to social services and, as a result, do not have the awareness of, or access to, support that all individuals may need while living in a care home.

This current lack of knowledge about the number of self-funders in Wales who are living in care homes has an impact on the quality of life of older people because it is not clear what support and advice individuals are receiving and the extent to which the quality of care that self-funders receive is monitored. This also means that Local Authorities and Health Boards have difficulties in planning for future need and provision.

Support Available for Self-Funders

Evidence from the ADSS highlighted that self-funders must be thought of from the outset, including whether they have access to support, information and advocacy, for the commissioning process to be considered consistent and competent.

Evidence from the British Association of Social Workers stated that self-funders will often receive less support from a social worker during the decision making process to move into a care home and while they live there. They stated this is often due to a lack of time, pressure on social worker case loads and the greater responsibility that social workers have towards those individuals whose care is funded through a Local Authority.

Many questionnaire responses from residents who are self-funders and their families stated that they are fearful about raising concerns and complaints with a provider because of the perceived risk that they may be asked to leave the care home and would not know how to manage such a situation without support. A lack of support means that older people who pay for their own care may be less well placed to raise concerns about the quality of their care and, as a consequence, may experience unacceptable quality of care.

Quality of Care Delivered to Self Funders

When Local Authorities and Health Boards are monitoring the quality of care that is provided in care homes to older people, this is against the National Minimum Standards and additional standards that they may have set when they commissioned a package of care for an individual. Any quality monitoring therefore only applies to those individuals whose care is commissioned by the Local Authority or Health Board and not to individuals who have arranged and paid for their care independently.

Evidence from Health Boards demonstrated that professionals that monitor the quality of care, such as Nurse Assessors, may not be aware of the circumstances and healthcare needs of individuals who pay for their own care, because their focus is on monitoring quality for funded residents.

“When our Nurse Assessors go in, [they are] going in to review the placement. They are reviewing not just the standard of nursing care but that person in that environment and the holistic care that that person is given...And it’s about, I suppose, do our mechanisms take account of everything. I think if you were going back a few years it probably didn’t but I think we’re definitely seeing a shift now.” **Hywel Dda University Health Board (Oral Evidence)**

Local Authorities also gave evidence that stated that they did not have any access or rights to look into the quality of care or experiences of self-funders.

“We get basic data. We ask the providers to tell us, but that’s as far as it goes, as far as Carmarthenshire’s concerned. We don’t have any access or rights to visit or ask self-funders about their experience.” **Carmarthenshire County Council (Oral Evidence)**

Questionnaire responses from the families and friends of self-funders stated that the health of their relatives had deteriorated quickly and was not recognised and acted upon by any visiting Local Authority and Health Board staff because they only monitored the individuals who were funded by their bodies.

It is perhaps reasonable to assume that when a commissioning body enters a residence, they will take appropriate action if they become aware of unacceptable care that is being provided to an individual, regardless of their funding. However, as self-funders are not included in regular quality monitoring, an issue must be serious enough to come to the attention of the commissioning body before any action can be taken.

Future Planning

Local Authorities and Health Boards are unable to fully plan for the future needs of the older population and required provision of residential and nursing care if they are unaware of the total number of self-funders living in care homes, or how many self-funders are likely to live in care homes in the future.

If a Local Authority conducts a market position statement to identify current and future needs, but it is not aware of the number of self-funders, its predicted needs and planning could be inadequate to support the provision of care that is the right type, quality and price.

Evidence from Local Authorities during the commissioning roundtable discussion stated that self-funders often paid more for their care compared to those whose places are funded by a Local Authority.

“What I don’t find fair is providers who can provide a service for somebody on the Local Authority rate if they’re a service user of a Local Authority, but then charge a couple of hundred pounds more if somebody’s self-funding, and I think that’s really appalling.” Local Authority Commissioner (Oral Evidence)

Regulation and Inspection

The Care and Social Services Inspectorate for Wales (CSSIW) is the body responsible for the regulation and inspection of care homes across Wales. They inspect against the Care Homes (Wales) Regulations 2002 and the National Minimum Standards, which, as highlighted above, do not give sufficient focus to quality of life.

This has been recognised by CSSIW who stated in their evidence that the National Minimum Standards are no longer sufficient to deliver and monitor quality of life. They stated that their desire to move away from the ‘tick box’ approach to inspection has contributed to their modernisation programme, which includes the development of the SOFI tool described above and the proposed development of a Quality Judgement Framework, which will have a much greater focus on quality of life.

This modernisation programme is an important step forward to ensure that the quality of life of older people in care homes becomes a key element of the regulation and inspection system. However, CSSIW do not have responsibility for inspecting healthcare delivery in care homes, which is a key part of an individual's quality of life.

While Healthcare Inspectorate Wales is the body responsible for inspecting healthcare in Wales, they stated in their evidence that they do not inspect the standard of health care delivery within care homes as this falls outside of their remit.

“We don’t do work in the homes ourselves. We don’t have an on-going day to day responsibility in the inspection of how that’s done within homes, or the way in which LHBs commission.” Healthcare Inspectorate Wales (Oral Evidence)

This means that there is currently not appropriate or effective scrutiny of the delivery of healthcare in nursing care homes.

Evidence from the Board of Community Health Councils in Wales (CHCs), who have the power to monitor the delivery of NHS funded care and identify areas in which improvements must be made, stated that they could potentially address this gap as they have access to 400 community volunteers with a knowledge of the health service and a willingness to enter residential settings and monitor the delivery of healthcare. However, they have received conflicting legal advice from the Welsh Government and independent lawyers about the extent to which the powers under their legislation allow them to enter care homes to monitor the delivery of healthcare. This means that the potential for CHCs to monitor healthcare within care homes has not yet been explored.

“We’ve already got training packages in place and it’s just that there’s no point in delivering it unless we can get in there and do it, but we’re ready to go. We’ve been ready to go for eight years now and it’s been eight years - I have been pushing this issue.” Board of Community Health Councils in Wales (Oral Evidence)

Utilising CHC members to undertake monitoring work in care homes would also introduce a broader lay-perspective into the inspection system, something that has been successful in other parts of the UK and would support the Welsh Government's aim to 'actively engage citizens within our regulation and inspection regime', something that is currently being explored as part of work around the forthcoming Regulation and Inspection Bill.

Evidence from providers, Local Authorities, Health Boards and the inspectorate has demonstrated that a range of different commissioning, monitoring and inspection methods are used to quality assure care.

As commissioners, Local Authorities and Health Boards demonstrated that while they will commission and quality assure against the National Minimum Standards, they may also set other higher standards for providers to reach that as a result will vary across Wales. In addition to the future development of new inspection frameworks by CSSIW, there is significant variation in the understanding of 'quality of life' and how this is monitored.

When this is combined with the evidence that suggests the provision of healthcare in residential settings is not currently being sufficiently regulated and inspected, the current commissioning, regulation and inspection system is not working in an integrated and consistent way to ensure older people can achieve the best quality of life regardless of the particular care home or area in which they live.

The Regulation and Inspection Bill provides an opportunity to set out a single outcomes framework for quality of life and care of older people in care homes rather than the current system of National Minimum Standards. The framework would ensure alignment between all of the agencies involved in the planning and delivery of care, from providers to commissioners to inspectors, essential to ensure that quality of life truly sits at the heart of residential and nursing care.

An enabling and integrated approach to regulation and inspection is essential to drive improvements and support the delivery of care that has quality of life at its heart. Whilst a range of work has begun to move towards this approach, the regulation and inspection system still currently has an insufficient focus on quality of life.

Requirements for Action

My required actions range from system changes to changes around very specific aspects of care. In formulating these actions, I have sought advice from a wide range of experts and I have focussed on action that will have the most impact, clearly linking my actions to intended outcomes. I have linked my required actions back to the current and developing policy agenda in Wales, in particular to the National Outcomes Framework, as well as the opportunities afforded to us by forthcoming legislation and the good practice that already exists in Wales.

Any change, particularly systemic change that reboots the system and redefines an approach to care, needs strong leadership and drive to ensure that it delivers in a way that is meaningful to the older people that the change is intended to benefit. Without taking away from the leaders in their own fields that there are across Wales, there is a clear role for the Welsh Government to lead from the front, both in respect of expected change and providing support to our wider services and the organisations under my Review to ensure not just that the change outlined in my report is delivered, but that the intended outcomes are delivered as well.

Following formal agreement, in line with the requirements of the Commissioner for Older People (Wales) Act, of the action that will be taken by the bodies subject to my Review, I will also agree how compliance against these actions will be reported and how assurance will be provided that the intended outcomes have been delivered.

Whilst there will be some resource implications to implement the required actions, I have been conscious of constraints on public finances and realistic in laying out my expected outcomes and action.

If the change required that has been identified in my Review is not delivered, the price that is paid by older people will be too high. Increasingly, in the years to come, a failure to act will expose public bodies and independent providers to litigation, reputational damage, time spent undertaking remedial action or formal investigations into failures in care and will further increase pressures upon the NHS and social services.

Key Conclusion 1: Too many older people living in care homes quickly become institutionalised. Their personal identity and individuality rapidly diminishes and they have a lack of choice and control over their lives.

Link to Welsh Government policy and legislative areas: National Outcomes Framework for the Social Services and Wellbeing Act 2014, Declaration of the Rights of Older People in Wales, A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs, Integrated Assessment, Planning and Review Arrangements for Older People.

Required Action	Outcome	Impact of not doing	By whom /By when
<p>1.1 A national approach to care planning in care homes should be developed and implemented across Wales. This must support:</p> <ul style="list-style-type: none"> • The full involvement of the older person to ensure they have an effective voice, including advocacy support where necessary. This may include independent advocacy or advocacy under the Mental Capacity Act. • Ensuring the older person's personal history, social and cultural interests, occupation, achievements, likes, dislikes and aspirations are understood and reflected in their future life. This must include meeting the diverse needs of older people who are lesbian, gay, bisexual or trans, 	<p>Older people receive information, advice and practical and emotional support in order for them to settle into their new home beginning as soon as a decision to move into a care home is made (Action 1.1, 1.2).</p> <p>Older people's physical, emotional and communication needs are fully understood, as are the issues that matter most to them, and these are reflected in the services, support and care that they receive.</p> <p>Older people have real control over and choice in their day-to-day lives and are able to do the things that</p>	<p>Older people are unable to settle into their new home, which has a detrimental impact upon their health and wellbeing.</p> <p>The individual needs, wishes and aspirations of older people are not recognised or understood and as a result their ability to do the things that matter to them is significantly undermined, as is their quality of life and mental wellbeing.</p> <p>Older people are unable to communicate effectively, which leads to an increased risk of isolation, withdrawal and emotional neglect.</p> <p>Older people are denied their rights to self-determination,</p>	<p>Welsh Government</p> <p>November 2015</p>

<p>those who are Black, Asian or minority ethnic and those with or without religion or belief.</p> <ul style="list-style-type: none"> • Transitional support once a decision has been made to move to a care home to ensure that the care planning process begins prior to moving into the care home. • Meeting the emotional needs of older people to ensure they feel safe, valued, respected, cared for and cared about. • Meeting the communication needs of people living with dementia and/or sensory loss. • The needs of Welsh language speakers and those for whom English is not their first language. • Entitlements to healthcare and assessment for and referral to healthcare services. • Individual rights versus risk management. • Multidisciplinary assessment (across Health Boards, Local Authorities and including specialist third sector 	<p>matter to them, including staying in touch with friends and family and their local community.</p>	<p>autonomy and control over their lives.</p>	
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<p>organisations) and specialist clinical assessment.</p> <p>This guidance should clearly align to the new National Outcomes Framework, which underpins the Social Services and Wellbeing (Wales) Act 2014.</p> <p>National reporting of the quality of care plans and care planning against the national guidance and against the intended outcomes of the national Outcomes Framework should be undertaken annually (see action 6.10).</p>			
<p>1.2 All older people, or their advocates, receive a standard 'Welcome Pack' upon arrival in a care home that states how the care home manager and owner will ensure that their needs are met, their rights are upheld and they have the best possible quality of life. The Welcome Pack will make explicit reference to:</p> <ul style="list-style-type: none"> • How the care home manager will support the resident as they move into their new home. • Standard information about their human rights in line with the Welsh Declaration of the Rights of Older People.* 	<p>Older people are aware of their rights and entitlements, and what to expect from the home.</p> <p>Older people are clear about how they can raise concerns and receive support to do so.</p>	<p>Older people are unaware of the support that should be available to them while making the transition into their new home, which can lead to low expectations and a lack of accountability for providers.</p> <p>Older people are at risk of neglect and abuse as they are unaware of who to speak to should they need help in making a complaint or need support to stand up for their rights.</p> <p>Older people are at risk of not receiving that to which they</p>	<p>Welsh Government & Care Home Providers</p> <p>March 2016</p>

<ul style="list-style-type: none"> • A Statement of Entitlement to health care support.* • Support to sustain and promote independence, continence, mobility and physical and emotional wellbeing. • Ensuring their communication needs are met, including people with sensory loss. • Maintaining friendship and social contact. • Support to help them maintain their independence and to continue to be able to do the things that matter to them. • The development and maintenance of their care and support plan and what will be included in it.* • Ensuring a culture of dignity and respect and choice and control over day-to-day life. • The skills and training of staff. • Their right to independent advocacy and how to raise concerns. * <p>(The areas marked with * should be standard in format to ensure</p>		<p>are entitled to, leading to an undermining of their health, wellbeing and quality of life.</p>	
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consistency across Wales)			
1.3 Specialist care home continence support should be available to all care homes to support best practice in continence care, underpinned by clear national guidelines for the use of continence aids and dignity.	Older people are supported to maintain their continence and independent use of the toilet and have their privacy, dignity and respect accorded to them at all times (Action 1.1, 1.3, 1.5).		Welsh Government Guidance April 2015 Health Boards Implementation December 2015
1.4 National good practice guidance should be developed and implemented in relation to mealtimes and the dining experience, including for those living with dementia.	Mealtimes are a social and dignified experience with older people offered real choice and variety, both in respect of what they eat and when they eat (Action 1.1, 1.4).	Older people do not enjoy mealtimes, are at increased risk of malnutrition and ill health through a lack of support at mealtimes and miss out on meaningful and important social interaction. The dignity of older people is significantly undermined.	Welsh Government April 2015
1.5 An explicit list of 'never events' should be developed and published that clearly outlines practice that must stop immediately. The list should include use of language, personal care and hygiene, and breaches of human rights.	Older people are treated with dignity and respect and language that dehumanises them is not used and is recognised as a form of abuse (Action 1.1, 1.3, 1.4, 1.5, 4.6).	Unacceptable practice continues and goes unchallenged.	CSSIW March 2015
1.6 Older people are offered independent advocacy in the following circumstances:	Older people living in care homes that are closing, as well as older people that are	Older people are unable to secure their rights or have their concerns addressed, which	Local Authorities &

<ul style="list-style-type: none"> • when an older person is at risk of, or experiencing, physical, emotional, financial or sexual abuse. • when a care home is closing or an older person is moving because their care needs have changed. • when an older person needs support to help them leave hospital. <p>For those with fluctuating capacity or communication difficulties, this should be non-instructed advocacy.</p> <p>When a care home is in escalating concerns, residents must have access to non-instructed advocacy.</p>	<p>at risk of or are experiencing physical, emotional, sexual or financial abuse, have access to independent or non-instructed advocacy.</p>	<p>places them at increased risk of harm.</p> <p>An increased risk of adult practice reviews and civil litigation.</p>	<p>Care Home Providers & Health Boards</p> <p>April 2015</p>
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Key Conclusion 2: Too often, care homes are seen as places of irreversible decline and too many older people are unable to access specialist services and support that would help them to have the best quality of life.

Link to Welsh Government policy and legislative areas: Social Services and Wellbeing (Wales) Act and National Outcomes Framework, Sustainable Social Services: A Framework for Action, Together for Health – Stroke Delivery Plan 2012-16

Required Action	Outcome	Impact of not doing	By whom / By when
<p>2.1 A National Plan for physical health and mental wellbeing promotion and improvement in care homes is developed and implemented. This draws together wider health promotion priorities, as well as particular risk factors linked to care homes, such as loneliness and isolation, falls, depression, a loss of physical dexterity and mobility.</p>	<p>Older people benefit from a national and systematic approach to health promotion that enables them to sustain and improve their physical health and mental wellbeing.</p>	<p>Older people are at increased risk of falls and ill health.</p> <p>Older people’s physical and mental health will decline more quickly than it needs to and they have an earlier need for more specialist care.</p> <p>An increase in workload and pressure for the care home workforce.</p> <p>An increase in referrals to NHS services, as well as earlier and longer hospital admissions for older people.</p>	<p>Lead Welsh Government</p> <p>March 2016</p>
<p>2.2 Older people in care homes have access to specialist services and, where appropriate, multidisciplinary care that is designed to support rehabilitation after a period of ill health.</p>	<p>Older people receive full support, following a period of significant ill health, for example following a fall, or stroke, to enable them to maximise their independence and quality of life.</p>	<p>Older people have reduced mobility, increased frailty and loss of independence, with an increased risk, due to immobility of significant health problems, such as pressure ulcers, pneumonia and deteriorating</p>	<p>Health Boards and Local Authorities in partnership</p> <p>July 2015</p>

<p>2.3 A National Falls Prevention Programme for care homes is developed and implemented. This should include:</p> <ul style="list-style-type: none"> • Enabling people to stay active in a safe way • Up-skilling all care home staff in understanding and minimising the risk factors associated with falls • The balance of risk management against the concept of quality of life and the human rights of older people, to ensure that risk-averse action taken by care staff does not lead to restrictive care. <p>National reporting on falls in care homes is undertaken on an annual basis (see action 6.8).</p>	<p>Older people's risk of falling is minimised, without their rights to choice and control over their own lives and their ability to do the things that matter to them being undermined.</p>	<p>mental health.</p> <p>Older people are at an increased risk of falls leading to reduced mobility, increased frailty and loss of independence, with an increased risk, due to immobility of significant health problems, such as pressure ulcers, pneumonia and deteriorating mental health.</p> <p>Significant financial impact on the NHS due to increased admissions.</p>	<p>Welsh Government</p> <p>November 2015</p>
<p>2.4 The development and publication of national best practice guidance about the care home environment and aids to daily living, such as hearing loops and noise management, with which all new homes and refurbishments should comply. This guidance should also include mandatory small changes that can be made to care homes and</p>	<p>The environment of all care homes, internally and externally, is accessible and dementia and sensory loss supportive.</p>	<p>Older people are unable to move around the care home safely and independently or do the things that they enjoy.</p> <p>Older people struggle to communicate with each other and staff, leading to isolation and withdrawal.</p>	<p>Welsh Government</p> <p>July 2015</p>

outdoor spaces to enable older people with sensory loss and/or dementia to maximise their independence and quality of life.

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Key Conclusion 3: The emotional frailty and emotional needs of older people living in care homes are not fully understood or recognised by the system and emotional neglect is not recognised as a form of abuse.

Link to Welsh Government policy and legislative areas: Together for Mental Health - A Strategy for Mental Health and Wellbeing in Wales, National Outcomes Framework 2014, Mental Health (Wales) Measure 2010, National Dementia Vision for Wales 2011 and the Intelligent Targets for Dementia. NICE Dementia Quality Standard 2010. NICE Dementia Quality Standard (2010) and NICE Clinical Guideline 42. November 2006 (amended March 2011)

Required Action	Outcome	Impact of not doing	By whom / By when
3.1. A national, standardised values and evidence based dementia training programme is developed that covers basic, intermediate and advanced levels of training, which draws on the physical and emotional realities of people living with dementia to enable care staff to better understand the needs of people with dementia.	All staff working in care homes understand the physical and emotional needs of older people living with dementia and assumptions about capacity are no longer made (Action 3.1, 3.2).	Older people are at risk of emotional neglect, as well as continuing to be misunderstood and labelled as 'challenging' or 'difficult', because the care home workforce is unaware of how to communicate and respond to their needs.	Welsh Government November 2015
3.2 All care home employees undertake basic dementia training as part of their induction and all care staff and Care Home Managers undertake further dementia training on an on-going basis as part of their skills and competency development, with this a specific element of supervision and performance assessment.		Older people feel anxious and fearful, confused and disorientated and their ability to have control over their lives is undermined. An increase in hospital admissions and a greater need for health care as a result of older people's needs not being understood or met. A greater risk of incidences of unacceptable care. A significant increase in the	Local Authorities & Care Home Providers Begin January 2016

		<p>pressures faced by the care home workforce.</p> <p>A wider perception across society that residential and nursing care lacks compassion.</p>	
<p>3.3 Active steps should be taken to encourage the use of befriending schemes within care homes, including intergenerational projects, and support residents to retain existing friendships. This must include ensuring continued access to faith based support and to specific cultural communities.</p>	<p>Older people are supported to retain their existing friendships and have meaningful social contact, both within and outside the care home. Care homes are more open to interactions with the wider community.</p> <p>Older people are able to continue to practice their faith and maintain important cultural links and practices.</p>	<p>Older people living in care homes are lonely and socially isolated, lack opportunities for meaningful social contact and their ability to practice their faith and important cultural practices is lost. Care homes are isolated within and from their communities, undermining the care and wellbeing of older people and access to wider community resources and support.</p>	<p>Care Home Providers & Local Authorities</p> <p>November 2015</p>
<p>3.4 In-reach, multidisciplinary specialist mental health and wellbeing support for older people in care homes is developed and made available, including:</p> <ul style="list-style-type: none"> • An assessment of the mental health and wellbeing of older people as part of their initial care and support plan development and their on-going care planning. • Advice and support to care staff 	<p>The mental health and wellbeing needs of older people are understood, identified and reflected in the care provided within care homes. Older people benefit from specialist support that enables them to maximise their quality of life.</p> <p>Older people are not prescribed antipsychotic drugs inappropriately or</p>	<p>Older people living with dementia are at risk of accelerated cognitive decline and the inappropriate use of antipsychotic drugs. On-going mental health issues significantly undermine their quality of life.</p> <p>An increase in workload and pressure upon care staff.</p> <p>An earlier need for specialist residential care and an increase in Continuing Healthcare Costs.</p>	<p>Health Boards</p> <p>November 2015</p>

<p>about how to care effectively for older people with mental wellbeing and mental health needs, including dementia, and when to make referrals.</p> <ul style="list-style-type: none"> • Explicit referral pathways and criteria for referral. • All residents on anti-psychotics are monitored and assessed for potential withdrawal and reviews are conducted in line with NICE guidelines. 	<p>as an alternative to non-pharmaceutical methods of support and NICE best practice guidance is complied with (Action 3.4, 3.5).</p>		
<p>3.5 Information is published annually about the use of anti-psychotics in care homes, benchmarked against NICE guidelines and Welsh Government Intelligent Targets For Dementia.</p>			<p>Health Boards September 2015</p>
<p>3.6 The development of new safeguarding arrangements for older people in need of care and support in Wales should explicitly recognise emotional neglect as a form of abuse, with this reflected in guidance, practice and reporting under the new statutory arrangements.</p>	<p>Emotional neglect of older people is recognised as a form of abuse and appropriate action is taken to address this should it occur.</p>		<p>Welsh Government November 2015</p>

Key Conclusion 4: Some of the most basic health care needs of older people living in care homes are not properly recognised or responded to.

Link to Welsh Government policy and legislative areas: Fundamentals of care, National Service Framework for Older People, Together for Health: a Five Year Vision for NHS Wales, Setting The Direction, Together for Health: Eye Health Care Delivery Plan for Wales 2013-2018, NHS Wales Delivery Framework 2013-14 and Future Plans, Rural Health Plan – Improving Integrated Service Delivery across Wales, Together for Health: A National Oral Health Plan for Wales 2013-18, National Outcomes Framework for the Social Services and Wellbeing (Wales) Act 2014.

Required Action	Outcome	Impact of not doing	By whom / By when
<p>4.1 A clear National Statement of Entitlement to primary and specialist healthcare for older people in care homes is developed and made available to older people, including:</p> <ul style="list-style-type: none"> • Access to regular eye health, sight and hearing checks • Dietetic advice and support • Access to podiatry and dentistry services • Access to specialist nursing services • GP access and medicines support • Specialist mental health support • Health promotion and reablement support <p>This must cover both residential and</p>	<p>There is a consistent approach across Wales to the provision of accessible primary and specialist health care services to older people living in care homes and older people’s healthcare needs are met (Action 4.1, 4.2, 4.5).</p> <p>Older people in nursing care homes have access to specialist nursing services, such as diabetic care, tissue viability, pain management and palliative care (Action 4.1, 4.2).</p> <p>Older people are supported to maintain their sight and hearing, through regular eye health, sight and hearing</p>	<p>Older people are unable to see or hear properly, undermining their ability to communicate and their independence, placing them at greater risk of isolation and falls, emotional withdrawal and poor mental health (Action 4.1, 4.2, 4.3).</p> <p>Older people in nursing homes have preventable physical health conditions, unnecessary pain and their overall wellbeing is undermined through on-going poor management of chronic health conditions.</p> <p>Older people lose their teeth unnecessarily and are unable</p>	<p>Lead Welsh Government</p> <p>March 2015</p>

<p>nursing care.</p> <p>Care home providers ensure older people receive information about their healthcare entitlements as part of their 'Welcome Pack' (see action 1.2).</p>	<p>checks (Action 4.1, 4.2, 4.3).</p> <p>Older people are able to, or supported to, maintain their oral health and retain their teeth (Action 4.1, 4.2, 4.3).</p> <p>Older people have full access to dietetic support to prevent or eliminate malnourishment and to support the management of health conditions (Action 4.1, 4.2, 4.3).</p>	<p>to eat the foods they prefer; individuals' specific dietary needs are not met, which can lead to malnutrition and undermines their overall health.</p> <p>An increase in workload and pressure for the care home workforce.</p> <p>An increase in hospital admissions due to falls and a lack of primary care support to maintain independence.</p> <p>A failure to deliver on the Social Services National Outcomes Framework and the Fundamentals of Care for older people in residential and nursing care homes.</p>	
<p>4.2 A formal agreement is developed and implemented between the care home and local primary care and specialist services based on the Statement of Entitlement. This should include:</p> <ul style="list-style-type: none"> • Referral pathways, including open access • Waiting times • Referral and discharge 			<p>Health Boards & Care Home Providers</p> <p>April 2015</p>

<p>information</p> <ul style="list-style-type: none"> • Advice and information to support the on-going care of the older person in the home • Access to specialist services for older people in nursing homes, in line with the Fundamentals of Care Guidance. 			
<p>4.3 Care staff are provided with information, advice and, where appropriate, training to ensure they understand and identify the health needs of older people as well as when and how to make a referral.</p>	<p>Care staff understand the health needs of older people, and when and how to access primary care and specialist services (Action 4.3, 5.4).</p>		<p>Health Boards</p> <p>November 2015</p>
<p>4.4 Upon arrival at a care home, older people receive medication reviews by a clinically qualified professional, with regular medicine reviews undertaken in line with published best practice.</p>	<p>Older people receive appropriate medication and the risks associated with polypharmacy are understood and managed.</p>	<p>Older people are at risk of potentially dangerous interactions between multiple medications.</p>	<p>Health Boards</p> <p>Begin April 2015</p>
<p>4.5 Community Health Councils implement a rolling programme of spot checks in residential and nursing care homes to report on compliance with the National Statement of Entitlement and Fundamentals of Care.</p>	<p>Older people are able to challenge, or have challenged on their behalf, failures in meeting their entitlements.</p>	<p>Older people living in care homes are denied access to an independent health watchdog and there is no independent challenge to failures to meet healthcare entitlements.</p>	<p>Welsh Government</p> <p>November 2015</p>

Key Conclusion 5: The vital importance of the role and contribution of the care home workforce is not sufficiently recognised. There is insufficient investment in the sector and a lack of support for the care home workforce.

Link to Welsh Government policy and legislative areas: Social Care Workforce Development Programme, Sustainable Social Services for Wales: A Framework for Action, Social Services and Wellbeing Act, National Outcomes Framework, Integrated Assessment, Planning and Review Arrangements for Older People

Required Action	Outcome	Impact of not doing	By whom / By when
<p>5.1. A national recruitment and leadership programme is developed and implemented to recruit and train future Care Home Managers with the right skills and competencies. The programme should include accredited continuous professional development for current and future care home managers and should support them to be leaders of practice and champions of a positive care home culture.</p> <p>Annual national reporting on the availability of skilled and competent Care Home Managers in care homes across Wales, including the impact of vacancy levels upon older people's quality of life and care.</p>	<p>Care homes have permanent managers who are able to create an enabling and respectful care culture and support paid carers to enable older people to experience the best possible quality of life.</p>	<p>Care homes are without or share managers and care homes are without leadership or overview.</p> <p>Managers do not have the skills, competencies or support required to ensure the delivery of safe and high quality care.</p> <p>An increased risk of unacceptable quality of life and care for older people.</p> <p>There is a lack of information available to support workforce planning.</p> <p>There is a lack of opportunity for the professional development of Care Home Managers.</p>	<p>Care Council for Wales</p> <p>April 2016</p>
<p>5.2 The development and implementation of a national standard acuity tool to include guidelines on staffing levels and skills required to</p>	<p>Older people are cared for by care staff and managers who are trained to understand and meet their physical and</p>	<p>A lack of time and skills places pressure on care staff that impacts upon the quality of life of older people and leads to a</p>	<p>Welsh Government & Care Home</p>

<p>meet both the physical and emotional needs of older people.</p>	<p>emotional needs, including the needs of people with dementia and sensory loss, and who have the competencies needed to provide dignified and compassionate care.</p>	<p>focus on task-based care, which increases the risk of potential emotional neglect.</p>	<p>Providers April 2016</p>
<p>5.3 A standard set of mandatory skills and value based competencies are developed and implemented, on a national basis, for the recruitment of care staff in care homes.</p>	<p>Older people receive compassionate and dignified care that responds to them as an individual (Action 5.3, 5.4, 5.5).</p>	<p>Older people are cared for by people who do not understand and are not able to meet their needs (Action 5.3, 5.4, 5.5).</p>	<p>Care Council for Wales & Care Home Providers From September 2015</p>
<p>5.4 A national mandatory induction and on-going training programme for care staff is developed and implemented. This should be developed within a values framework and should include:</p> <ul style="list-style-type: none"> • The physical and emotional needs of older people, including older people living with dementia. • Adult safeguarding, emotional neglect and ‘never events’. • How to raise concerns. • Good communication and alternative methods of communication for those living 		<p>Older people receive care and support from care staff who do not have the skills, values or competencies to work in care homes, which can place older people at risk of harm and/or emotional neglect.</p> <p>Poor practice goes unchallenged due to a lack of appropriate training and a lack of support for those who want to raise concerns.</p> <p>An increase in workload and pressure on care staff.</p>	<p>Care Council for Wales December 2015</p>

<p>with dementia and/or sensory loss.</p> <ul style="list-style-type: none"> • Supporting without disabling. • The rights and entitlements of older people. • Care, compassion, kindness, dignity and respect. 			
<p>5.5 All care homes must have at least one member of staff who is a dementia champion.</p>			<p>Care Home Providers</p> <p>September 2015</p>
<p>5.6 A National Improvement Service is established to improve care homes where Local Authorities, Health Boards and CSSIW have identified significant and/or on-going risk factors concerning the quality of life or care provided to residents and/or potential breaches of their human rights.</p> <p>The national improvement team should utilise the skills of experienced Care Home Managers, as well as other practitioners, to provide intensive and transformational support to drive up the standards of quality of life and care for residents as well as to prevent and mitigate future safeguarding risks.</p> <p>This service should also develop a</p>	<p>Care homes that want and need to improve the quality of life and care of older people have access to specialist advice, resources and support that leads to improved care and reduced risk.</p>	<p>Older people live in care homes where poor practice continues, their quality of life is poor and they are at risk of emotional abuse and neglect.</p> <p>The resources of commissioning teams are diverted to supporting failing care homes.</p> <p>An increase in workload and pressure for care staff.</p>	<p>Welsh Government Lead in partnership with Local Authorities, Health Boards, Care Home Providers</p> <p>September 2016</p>

range of resources and training materials to assist care homes that wish to improve in self-development and on-going improvement.			
5.7 The Regulation and Inspection Bill should strengthen the regulatory framework for care staff to ensure that a robust regulation of the care home workforce is implemented for the protection of older people.	Older people are safeguarded from those who should not work within the sector.	Older people receive care and support from care staff who do not have the skills, values or competencies to work in care homes, placing older people at risk of harm and emotional neglect. Vetting and barring procedures to prevent employment of unsuitable staff provide only partial protection for older people living in care homes.	Welsh Government April 2018
5.8 A cost-benefit analysis is undertaken into the terms and conditions of care staff. This analysis should include the impact of the introduction of a living wage and/or standard employment benefits, such as holiday pay, contracted hours and enhancements.	The true value of delivering care is recognised and understood.	There is a restricted recruitment pool due to continued difficulties in recruiting people with the right skills, values and competencies.	Welsh Government January 2016

Key Conclusion 6: Commissioning, inspection and regulation systems are inconsistent, lack integration, openness and transparency, and do not formally recognise the importance of quality of life

Link to Welsh Government policy and legislative areas: Sustainable Social Services for Wales: A Framework for Action, Social Services and Wellbeing Act, National Outcomes Framework

Required Action	Outcome	Impact of not doing	By whom / By when
<p>6.1 A single outcomes framework of quality of life and care, and standard specification, is developed for use by all bodies involved in the regulation, provision and commissioning, and inspection of care homes and should flow through to become a defining standard within the future Regulation and Inspection Act. It must include references to the following*:</p> <ol style="list-style-type: none"> 1. Independence and autonomy 2. Control over daily life 3. Rights, relationships and positive interactions 4. Ambitions (to fulfil, maintain, learn and improve skills) 5. Physical health and emotional wellbeing (to maintain and improve) 6. Safety and security (freedom from discrimination and harassment) 	<p>Quality of life sits consistently at the heart of the delivery, regulation, commissioning and inspection of residential and nursing care homes.</p>	<p>There are unacceptable variations in the standards set for the care of older people, an inconsistent focus on quality of life and inconsistent and conflicting requirements upon providers.</p>	<p>Welsh Government April 2015</p>

<p>7. Dignity and respect 8. Protection from financial abuse 9. Receipt of high quality services</p> <p>*Source: Flintshire Outcomes Framework</p>			
<p>6.2 Care home providers, commissioners and CSSIW should develop informal and systematic ways in which to ensure they better understand the quality of life of older people, through listening to them directly (outside of formal complaints) and ensuring issues they raise are acted upon.</p> <p>Annual reporting should be undertaken of how on-going feedback from older people has been used to drive continuous improvement (see action 6.10).</p>	<p>Commissioners, providers and inspectors have a thorough understanding of the day-to-day quality of life of older people living in care homes (Action 6.2, 6.3).</p> <p>Older people's views about their care and quality of life are captured and shared on a regular basis and used to drive continuous improvement (Action 6.2, 6.3).</p>	<p>Issues are not addressed before they become significant, impactful and costly to remedy (Action 6.2, 6.3).</p> <p>Opportunities to make small changes that can make a significant difference to quality of life and care are missed.</p> <p>Safeguarding issues are not identified at an early stage.</p> <p>Older people feel ignored, powerless and unable to influence issues that affect their lives.</p>	<p>Care Home Providers & Local Authorities & Health Boards & CSSIW</p> <p>April 2015</p>
<p>6.3 Lay assessors are used, on an on-going basis, as a formal and significant part of the inspection process.</p>			<p>CSSIW</p> <p>April 2015</p>
<p>6.4 An integrated system of health and social care inspection must be developed and implemented to provide effective scrutiny in respect of the quality of life and healthcare of older people in nursing homes.</p>	<p>The quality of life and healthcare of older people living in nursing homes is assessed in an effective way with clear and joined up annual reporting (Action 6.4, 6.5, 6.6).</p>	<p>Poor practice is not identified and older people are placed at increased risk of harm or do not receive that to which they are entitled (Action 6.4, 6.5, 6.6).</p>	<p>Welsh Government lead (Action 6.4, 6.5, 6.6)</p> <p>December 2015</p>

6.5 Annual integrated reports should be published between inspectorates that provide an assessment of quality of life and care of older people in individual nursing homes.			
6.6 An annual report on the quality of clinical care of older people in nursing homes in Wales should be published, in line with Fundamentals of Care.			
<p>6.7 Annual Quality Statements are published by the Director of Social Services in respect of the quality of life and care of older people living in commissioned and Local Authority run care homes. This should include:</p> <ul style="list-style-type: none"> • the availability of independent advocacy in care homes • quality of life and care of older people, including specific reference to older people living with dementia and/or sensory loss • how the human rights of older people are upheld in care homes across the Local Authority • the views of older people, advocates and lay assessors about the quality of life and care provided in care homes 	<p>Older people have access to relevant and meaningful information about the quality of life and care provided by or within individual care homes and there is greater openness and transparency in respect of the quality of care homes across Wales and the care they provide (Action 6.7, 6.8, 6.9, 6.10).</p>	<p>A lack of transparency undermines older people's ability to make appropriate decisions, undermines wider public confidence and acts as a barrier to systemic change.</p>	<p>Local Authorities - Outline AQS September 2015</p>

<ul style="list-style-type: none"> • geographic location of care homes <p>Further details of reporting requirements should be included as part of the Regulation and Inspection Bill.</p>			
<p>6.8 Health Boards include the following information relating to the quality of life and care of older people in residential and nursing care homes in their existing Annual Quality Statements:</p> <ul style="list-style-type: none"> • the inappropriate use of anti-psychotics • access to mental health and wellbeing support • number of falls • access to falls prevention • access to reablement services • support to maintain sight and hearing <p>Further areas for inclusion to be developed as part of the AQS guidance published annually.</p>			<p>Health Boards</p> <p>September 2015</p>
<p>6.9 The Chief Inspector of Social Services publishes, as part of her Annual Report, information about the</p>			<p>CSSIW Annual Report</p>

<p>quality of life and care of older people in care homes, which includes the following:</p> <ul style="list-style-type: none"> • the quality of life of older people in care homes who are bed-bound • the quality of life of older people in care homes living with dementia • the quality of life of older people in care homes living with sensory loss • the implementation of care plans in older people's care homes • the accuracy of external statements from independent providers • how the human rights of older people are upheld in care homes across Wales 			
<p>6.10 Care home providers report annually on the delivery of quality of life and care for older people. This will include:</p> <ul style="list-style-type: none"> • Quality of life of older people against the Standard Quality Framework and Supporting Specification. 			<p>Care Home Providers December 2015</p>

<ul style="list-style-type: none"> • Levels and skills of staff including staff turnover, use of agency staff and investment in training • Number of POVA referrals, complaints and improvement notices, including full details on improvement action when a home is in escalating concerns. 			
<p>6.11 A national, competency based, training programme for commissioners is developed, to ensure that they understand and reflect in their commissioning the needs of older people living in care homes, including the needs of people living with dementia.</p>	<p>Older people are placed in care homes that can meet their needs by commissioners who understand the complexities of delivering care and are able to challenge providers about unacceptable care of older people.</p>	<p>Older people are placed in care homes that are unable to meet their needs.</p> <p>Commissioners are unable to challenge poor practice.</p>	<p>Care Council for Wales</p> <p>December 2015</p>

Key Conclusion 7: A current lack of forward planning means that the needs of older people in care homes will not be met in the future.

Link to Welsh Government Policy and legislative areas: Sustainable Social Services for Wales: A Framework for Action, Social Services and Wellbeing Act, National Outcomes Framework.

Required Action	Outcome	Impact of not doing	By whom / By when
<p>7.1 A national plan to ensure the future supply of high quality care homes is developed, which includes:</p> <ul style="list-style-type: none"> • a national demographic projection of need, including anticipated trends in and changes to the type of provision required as a result of increasing acuity and dependency. • a clear statement on the preferred type of provider base/ market in Wales. • a national analysis of barriers to market entry. • a clear statement on investment to grow social enterprise and co-operative social care sectors, particularly in areas with a low provider base. • a clear action plan to deliver the preferred provider base/market. 	<p>Forward planning ensures there is a sufficient number of care homes, of the right type and in the right places, for older people.</p>	<p>Older people are not cared for in their own communities or in a location of their choice and live in care homes that are unable to meet their acuity and dependency levels</p>	<p>Welsh Government January 2016</p>

<p>7.2 NHS Workforce planning projections identify the current and future level of nursing required within the residential and nursing care sector; including care for older people living with mental health problems, cognitive decline and dementia.</p>	<p>Forward planning and incentivised recruitment and career support ensures that there are a sufficient number of specialist nurses, including mental health nurses, to deliver high quality nursing care and quality of life outcomes for older people in nursing homes across Wales (Action 7.2, 7.3).</p>	<p>Nursing care homes close due to difficulties in recruiting qualified and competent nurses or older people are placed in care homes that are unable to meet their needs (Action 7.2, 7.3).</p>	<p>Welsh Government March 2015</p>
<p>7.3 The NHS works with the care home sector to develop it as a key part of the nursing career pathway, including providing full peer and professional development support to nurses working in care homes.</p>			<p>Health Boards March 2016</p>

Next Steps

Requirements for Action

The Commissioner's Requirements for Action clearly outline the change that is needed to drive up the quality of life and care of older people living in care homes across Wales.

The Commissioner expects, as do older people and the large number of individuals and organisations that responded to her Review, that the public bodies subject to her Review will take concerted action to deliver the change required and through this to embed quality of life at the heart of residential and nursing care within Wales and ensure that older people receive that to which they are entitled.

Implementation of the Commissioner's Requirements for Action

The Commissioner has requested, in line with the Commissioner for Older People (Wales) Act 2006, that the bodies subject to the Requirements for Action in this report provide, in writing, by 2 February 2015, an account of:

- How they have complied, or propose to comply with the Commissioner's Requirements for Action; or
- Why they have not complied with the Requirements for Action; or
- Why they do not intend to comply with the Requirements for Action.

Formal written notices will be issued to any bodies that fail to respond or provide inadequate information. If the response received is not deemed satisfactory after this process, the Commissioner reserves the right to draw it to the attention of the general public.

Requirements for Action / Recommendations Register

The Commissioner is obliged to keep a register of the recommendations made in the report and the actions taken in response. The register must be available for the general public to view. It will be published on the Commissioner's website and made available to individuals on request.

Thanks and Acknowledgments

As Commissioner, I would like to express my sincere thanks to all of those who have been involved and provided support throughout the Review process. I would particularly like to thank:

- The thousands of older people and their families who provided evidence to the Review through questionnaire responses and other correspondence.
- Care home residents across Wales for allowing my team of Rapporteurs to visit their homes, observe their lives and hear first-hand about their experiences.
- My team of social care rapporteurs, who gave their time and dedication so generously and without whom the visits to 100 care homes across Wales would not have been possible.
- My Expert Advisory board, my Equalities and Welsh Language Advisory Board and my Older People and Carers Advisory Board, who provided invaluable knowledge, expertise and support throughout the Review.
- Care Home Managers and care home staff across Wales who facilitated visits by Rapporteurs and provided essential information and evidence to the Review.
- All of the individuals, groups and organisations who supported my call for evidence and distributed Review information and questionnaires across Wales on my behalf.
- All of the individuals, groups and organisations that provided written and/or oral evidence to the Review.
- The bodies subject to the Review for supporting my call for evidence and providing extensive written and oral evidence.
- My team of dedicated staff, who all played an essential role throughout the Review process.

My Review would not have been possible without the collective dedication and support of everyone above. A big thank you to you all.

Appendix 1: Members of the Commissioner's Advisory Boards

Commissioner's Advisory Board

- Laraine Bruce MBE. Care Checker
- John Moore Programme Manager, My Home Life Cymru
- Prof. John Williams Head of Department of Law and Criminology, Aberystwyth University
- John Vincent Chair, Welsh Senate of Older People
- Sue Phelps Director, Alzheimer's Society Wales
- Steve Milsom Former Deputy Director of Social Services, Welsh Government
- Susan Kent MBE. SRN. RSCN. Former Vice Chair, Aneurin Bevan University Health Board
- Nick Andrews Research and Practice Development Officer, All Wales Social Care Research Collaboration Project
- Steven Williams Volunteer Director, Crossroads Care South East Wales

Welsh Language and Equalities, Independent Advisory Board

- Heledd Thomas Office of the Welsh Language Commissioner
- Aliya Mohammed Chief Executive Officer, Race Equality First
- Alicja Zalensinska Director, Tai Pawb
- Shameem Nawaz Community Development Officer, Marie Curie Hospice
- Prof. Robert Moore North Wales Race Equality Network
- Dr. Roiyah Saltus Principal Research Fellow, Faculty of Life Sciences and Education, University of South Wales
- Dr. Paul Willis Senior Lecturer Public Health and Policy Studies, Swansea University
- Paula Walters Director, NHS Centre for Equality and Human Rights
- Jim Stewart Interfaith Council for Wales
- Paul Warren Director of Policy and Planning, Diverse Cymru
- Rachel Lewis Age Cymru Diversity Networks
- Eileen Smith Liaison Officer, Cardiff Gypsy and Traveller Project

Older People and Carers, Independent Advisory Board

- John Vincent Welsh Senate of Older People
- Hannah Davies Dementia Champion
- Jill Thomas Carers Wales
- Ralph Stevens Chair, Caerphilly County Borough Council 50+ Forum
- Steven Williams Volunteer Director, Crossroads Care South East Wales
- Angela Roberts Former Director, Carers Trust

Appendix 2: Social Care Rapporteurs

The Commissioner recruited a team of 43 Social Care Rapporteurs to undertake visits to care homes across Wales as part of her Review. The Rapporteurs were experts by personal and professional experience in the fields of sensory loss, dementia care, caring, nursing and social work. Many of them came from leading organisations in the public and third sectors, such as Action on Hearing Loss Cymru, Age Cymru, Alzheimer's Society, Care and Repair Cymru, Cwm Taf University Health Board and RNIB Cymru.

To ensure that all Rapporteurs were able to carry out the tasks required to the highest standards, those who applied went through a rigorous recruitment process, which included a detailed competency based interview, references and an enhanced DBS check, to ensure that exemplar safeguarding protocols were followed.

All Rapporteurs received training in social research methods, based on the Adult Social Care Outcomes Toolkit (ASCOT), as well as learning about the realities of the care home environment and establishing a safe, respectful and non-impactful presence, to ensure that they were equipped to observe and report back on the quality of life of older people living in care homes across Wales.

Rapporteurs also received training on adult safeguarding and Protection of Vulnerable Adults (POVA), before signing a Code of Conduct and Adult Safeguarding Protocol.

The Code of Conduct described the standards of professional conduct and practice required of them as they carried out their duties under the delegated powers of the Commissioner for Older People (Wales) Act 2006.

Key Tasks

Social Care Rapporteurs were responsible for undertaking the following key tasks:

- Visiting care homes in pairs and using the ASCOT framework to undertake a period of observation and listen to the views of care home residents, family members, care home staff, including the Care Home Manager (if available), and independent advocates.
- Writing up and reporting on observations and interactions with older people and care home staff.
- Participating in a de-briefing session(s) to discuss observations and findings, and to ensure that research methods and reporting guidelines were consistently followed.

Visits to Care Homes

- A strategic sampling framework was developed by the Wales Institute of Health and Social Care to facilitate the random selection of care homes across Wales.
- Correspondence was sent to all care homes about the progress of the Commissioner's Review, providing a detailed summary about the role of the Commissioner's Rapporteurs and what to expect should they be selected for a random visit.
- All care homes selected received a phone call on the day of the visit, with Rapporteurs normally arriving within 1-2 hours of this phone call.
- On arrival at the care home, all Rapporteurs were required to introduce themselves to the Care Home Manager or the most senior member of staff on duty.
- Visits to care homes by Rapporteurs lasted an average of 3-4 hours. During this time, they undertook a tour of the care home environment, carried out detailed observations of care home residents and spoke with residents' family members and friends, as well as care home staff.

Appendix 3: Organisations Subject to the Review

Health Boards

- Aneurin Bevan University Health Board
- Abertawe Bro Morgannwg University Health Board
- Cardiff & Vale University Health Board
- Hywel Dda University Health Board
- Cwm Taf University Health Board
- Betsi Cadwaladr University Health Board
- Powys Teaching Health Board

Statutory Bodies

- Care and Social Services Inspectorate Wales (CSSIW)
- Care Council for Wales (CCW)
- Welsh Government

Local Authorities

- Blaenau Gwent County Borough Council
- Bridgend County Borough Council
- Caerphilly County Borough Council
- The City of Cardiff Council
- Carmarthenshire County Council
- Ceredigion County Council
- Conwy County Borough Council
- Denbighshire County Council
- Flintshire County Council
- Gwynedd Council
- Isle of Anglesey County Council
- Merthyr Tydfil County Borough Council
- Monmouthshire County Council
- Neath Port Talbot County Borough Council
- Newport City Council
- Pembrokeshire County Council

- Powys County Council
- Rhondda Cynon Taf County Borough Council
- City and County Council of Swansea
- Torfaen County Borough Council
- Vale of Glamorgan Council
- Wrexham County Borough Council

Appendix 4: Organisations that Submitted Written Evidence

Statutory Bodies

- Care and Social Services Inspectorate Wales (CSSIW)
- Care Council for Wales (CCW)
- Welsh Government

Local Authorities

- Blaenau Gwent County Borough Council
- Bridgend County Borough Council
- Caerphilly County Borough Council
- The City of Cardiff Council
- Carmarthenshire County Council
- Ceredigion County Council
- Conwy County Borough Council
- Denbighshire County Council
- Flintshire County Council
- Gwynedd Council
- Isle of Anglesey County Council
- Merthyr Tydfil County Borough Council
- Monmouthshire County Council
- Neath Port Talbot County Borough Council
- Newport City Council
- Pembrokeshire County Council
- Powys County Council
- Rhondda Cynon Taf County Borough Council
- City and County Council of Swansea
- Torfaen County Borough Council
- Vale of Glamorgan Council
- Wrexham County Borough Council

Organisations

- 1000 Lives Improvement Service
- Action on Hearing Loss Cymru
- Age Alliance Wales
- Age Cymru
- Alzheimer's Society
- Board of Community Health Councils
- British Association of Social Workers in Wales (BASW Cymru)
- British Dental Association
- British Geriatrics Society (BGS)
- British Medical Association Cymru (BMA)
- Care Forum Wales
- Chartered Society of Physiotherapy in Wales (CSP)
- College of Occupational Therapists (COT)
- Deafblind Cymru
- Dementia Care Matters
- Pennaf Housing
- Royal College of General Practitioners Wales
- Royal College of Physicians in Wales (RCP)
- Royal College of Nursing (RCN)
- RNIB Cymru
- Shropdoc Doctors Cooperative Ltd (Shropdoc)

Health Boards

- Abertawe Bro Morgannwg University Health Board
- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Cardiff and Vale University Health Board
- Cwm Taf University Health Board
- Hywel Dda University Health Board
- Powys Teaching Health Board

Appendix 5: Organisations that Submitted Oral Evidence

Statutory Bodies

- Board of Community Health Councils
- Care and Social Services Inspectorate Wales (CSSIW)
- Care Council for Wales (CCW)
- Healthcare Inspectorate Wales (HIW)
- Welsh Government

Local Authorities

- Caerphilly County Borough Council
- Flintshire County Council
- Gwynedd Council
- Powys County Council
- Western Bay Collaboration (Bridgend, Neath Port Talbot and Swansea Councils)
- Welsh Local Government Association (WLGA)

Local Authority Head of Commissioning Roundtable:

- Blaenau Gwent County Borough Council
- Bridgend County Borough Council
- Caerphilly County Borough Council
- Carmarthenshire County Council
- Ceredigion County Council
- Denbighshire County Council
- Flintshire County Council
- Gwynedd Council
- Isle of Anglesey County Council
- Merthyr Tydfil County Borough Council
- Monmouthshire County Council
- Neath Port Talbot County Borough Council
- Newport City Council
- Pembrokeshire County Council

- Rhondda Cynon Taf County Borough Council
- City and County Council of Swansea
- Torfaen County Borough Council
- Vale of Glamorgan Council

Organisations

- Association of Directors of Social Services (ADSS)
- Age Cymru
- Alzheimer's Society
- British Association of Social Workers in Wales (BASW Cymru)
- British Dental Association
- Care Forum Wales
- Chartered Society of Physiotherapists (CSP)
- College of Occupational Therapists (COT)
- Dementia Care Matters
- Neath Port Talbot Social Care Academy
- Royal College of Physicians in Wales (RCP)
- Royal Pharmaceutical Society
- Royal College of General Practitioners
- Royal College of Nursing (RCN)

Thematic Roundtables:

Advocacy

- Age Cymru Swansea Bay
- Age Connects Cardiff and The Vale
- Age Concern North Wales Central
- Age Connects Wales
- Alzheimer's Society
- HERC Associates

Housing

- Community Housing Cymru
- Cymorth Cymru
- Gwalia
- Hafod Care

- Linc Care
- Pennaf Housing Group

Learning Disabilities

- All Wales Forum (Parents and Carers)
- Cartrefi Cymru
- Ceredigion Forum of Parents and Carers
- First Choice Housing Association
- Mirus

Nutrition

- Aneurin Bevan University Health Board
- Cardiff and Vale University Health Board
- Public Health Wales
- Unified Menu Planning Project (Aneurin Bevan University Health Board & Torfaen County Borough Council)

Sensory Loss

- Action on Hearing Loss Cymru
- Deafblind Cymru
- RNIB Cymru

Health Boards:

- Abertawe Bro Morgannwg University Health Board
- Care Home In Reach Team Bridgend (Abertawe Bro Morgannwg University Health Board)
- Powys Teaching Health Board

Health Board Roundtable:

- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Cardiff and Vale University Health Board
- Hywel Dda University Health Board

Health Board Commissioning and Healthcare Roundtable:

- Abertawe Bro Morgannwg University Health Board
- Aneurin Bevan University Health Board

- Betsi Cadwaladr University Health Board
- Hywel Dda University Health Board
- Powys Teaching Health Board

Independent Providers:

- Barchester Healthcare
- Bupacare
- Embrace
- HC-One

Care Home Manager Roundtable:

- Atlantic View, Cardiff
- Hafan Croeso, Glanamman
- Hafan Dementia Care, Ammanford
- Pontcanna House, Cardiff
- Quarry Hall, Cardiff
- Summerhill Group, South East Wales
- Sŵn-y-Môr, Aberavon
- Three Cliffs Care Home, Penmaen
- Talbot Court Care Home, Port Talbot

Equality Focus Group Sessions:

- Action on Hearing Loss
- African Caribbean Elder Society
- Dyfed Diners
- Hindu Council of Wales
- Muslim Council of Wales
- RNIB Cymru
- Somali Integration Society
- Swan Gardens Chinese Sheltered Accommodation
- Unique Transgender Network

Appendix 6: Adult Social Care Outcomes Toolkit (ASCOT)

Following an extensive literature review, the Commissioner decided to use the Adult Social Care Outcomes Toolkit (ASCOT), developed by the Personal Social Services Research Unit at the University of Kent and the London School of Economics, as the observation framework for care home visits.

The Toolkit describes eight domains that shape an individual's experience of social care and impact upon quality of life. The toolkit closely reflects the Commissioner's own Quality of Life Model.

ASCOT Domains	Commissioner's Quality of Life Model
Control over daily life	I have voice, choice and control
Personal hygiene, cleanliness and comfort	I can get the help that I need
Food and drink	I can get the help that I need
Personal safety	I feel safe and listened to, valued and respected
Social participation and involvement	I can do the things that matter to me
Occupation	I can do the things that matter to me
Accommodation, cleanliness and comfort	I live in a place that suits me and my life
Dignity	I feel safe and listened to, valued and respected

ASCOT also provides a way of capturing the experiences of older people who may not be able to describe their experiences directly, essential for older people who may have lost their ability to communicate or find traditional survey techniques difficult to understand.

ASCOT uses a mixed method approach, combining observation, semi-structured and structured interviews, as well as questionnaires. Evidence is gathered from the resident, both by observation and interview if appropriate, forming the foundation from which analyses are made about an individual's social care related quality of life. Additional evidence may also be gathered from residents' family members and friends, as well as care home staff, before a qualitative thematic analysis is utilised to analyse all data received.

For further information about ASCOT visit the Personal Social Services Research Unit website at: <http://www.pssru.ac.uk/index-kent-lse.php>

Appendix 7: Terms of Reference

A Review into the quality of life and care of older people living in care homes in Wales.

Proceeding under section 3 of the Commissioner for Older People (Wales) Act 2006, the Commissioner will Review the extent to which Local Authorities, Health Boards, Care Home Providers, Care and Social Services Inspectorate Wales (CSSIW), Care Council for Wales and the Welsh Government safeguard and promote the interests of older people living in residential and nursing care settings in Wales.

Specifically, the Commissioner will:

1. Seek the views of older people, their relatives, carers and others to understand the experiences of older people living within care homes in Wales.
2. Identify what Local Authorities, Health Boards, Care Home Providers, Care Council for Wales, CSSIW and the Welsh Government understand about the quality of life and care experienced by older people living in care homes.
3. Gather evidence about the procedures and actions that Local Authorities, Health Boards, Care Home Providers, Care Council for Wales, CSSIW and the Welsh Government have implemented in the past three years and have planned to safeguard the quality of life and care of older people and the evidence of their impact.
4. Consider whether current and planned changes are sufficient to drive up the quality of care and whether they will ensure that the interests of older people are safeguarded and promoted in care homes.
5. Make practical recommendations to Local Authorities, Health Boards, Care Home Providers and CSSIW as to what must be improved, changed or put in place to promote and safeguard the quality of life and care of older people living in care homes across Wales.

The terms of this Review do not include palliative or end of life care arrangements, extra care homes, sheltered housing or patients in specialist hospital long stay facilities. However, the Commissioner will share information and findings that may arise in these areas within the life of the Review with relevant bodies.

Review findings and required action

The Commissioner will publish recommendations that the public bodies subject to her Review will be expected to comply with. These recommendations will be focused on the overall aim of the Commissioner's Review, which is to ensure that quality of life sits at the heart of the provision of residential and nursing care in Wales.

Powers of the Older People’s Commissioner for Wales

The Commissioner has the power to review arrangements for safeguarding and promoting the interests of older people in Wales, or the failure to make arrangements or discharge functions, through powers derived from Section 3 of the Commissioner for Older People (Wales) Act 2006.

The Review must be to assess whether and to what extent the arrangements are effective in safeguarding and promoting the interests of older people.

In determining the interests of older people, the Commissioner will have due regard to the United Nations Principles for Older Persons and the Human Rights Act 1998.

Power of entry and interviewing

Under Section 13 of the Commissioner for Older People (Wales) Act 2006, the Commissioner, or a person authorised by her, may, for the purposes of a Review, enter any premises, other than a private dwelling, for the purpose of interviewing an older person accommodated or cared for there, and may interview the older person with their consent.

Appendix 8: Glossary of Terms

Advocacy: Advocacy supports and enables people who have difficulty representing their interests to express their views, explore and make informed choices and obtain the support they need to secure and uphold their rights. Advocacy is a fundamental element of equality, social justice and human rights.

Antipsychotic: Antipsychotics are a class of psychiatric medication that are used to manage psychosis, primarily in bipolar disorder and schizophrenia. They are also used to manage aggression or psychosis in people living with dementia, but this is combined with a significant increase in serious adverse events¹²⁹. NICE guidance therefore states that antipsychotics should not be a routine treatment for people with dementia¹³⁰.

Bed-bound: Someone who is confined to bed, unable to be assisted to get up and someone who will frequently need assistance to be repositioned to avoid pressure ulcers.

Care home: A home for people with additional care and support needs, often described as a 'residential' or 'nursing' care home to specify the level of care provided.

A residential care home will provide a room, shared living environment, meals and personal care and assistance (such as help with washing and eating).

A nursing care home will provide similar support but will also employ registered nurses who can provide nursing care for people with more complex health needs.

The term 'care home' is used throughout this report to refer to residential and nursing care homes across Wales.

Care staff: Social care workers that are employed to assist and enable older people living in care homes through the delivery of personal care and support in their daily lives.

Cognitive function: The mental action or abilities of thinking, understanding and remembering. Where cognitive function is impaired, people will often have difficulties with day-to-day memory, planning, language, attention and visuospatial skills (the ability to interpret objects and shapes)¹³¹.

Commissioning: The process of ensuring that care services are provided effectively and that they meet the needs of the population. Responsibilities range from assessing local population needs, prioritising outcomes, procuring products and services to achieve those outcomes and supporting service providers to enable them to deliver outcomes for individual service users¹³².

Continuing Healthcare: NHS Continuing Healthcare is a package of on-going healthcare arranged and funded solely by the NHS. It can be delivered in any setting and can include the full cost of a place in a nursing care home.

Controlling Care: A term developed by David Sheard, Director of Dementia Care Matters, controlling care is based on the belief that the Care Home Manager and care staff know what is best for their residents. It is defined by regulation, domination or command of another. Residents receiving controlling care have limited to no control and a lack of voice or choice over the care provided. It is care that actually stops, prevents, restricts and controls what people can or cannot do in their own living area, dining areas and places they spend time¹³³.

EMI (Elderly Mentally Infirm): EMI care homes are designed for older people who have mental health difficulties or a disease of the brain, such as dementia.

High Acuity Needs: Acuity can be defined as the measurement of the intensity of care and support required by a resident. An acuity-based staffing system regulates the number of care staff, nurses and managers on a shift according to residents' needs and is not based solely on numbers.

Market Position Statement: A practical document to enhance market functioning, which draws together current and future population analysis, commissioning strategies and market and customer surveys to lay out the changes necessary to meet the needs of the population and how the Local Authority will support and intervene to achieve this¹³⁴.

Market Sufficiency: Residential care provision for older people is dependent on the availability of high quality care and care home places. When both are present there is market sufficiency.

National Minimum Standards (Wales): In addition to the requirements set out in the Adult Placement Schemes (Wales) Regulations 2004, the National Minimum Standards are used to determine whether care homes are providing adequate care and are meeting the basic needs of the people who live there. These standards, monitored by the Care and Social Services Inspectorate Wales (CSSIW), cover all aspects of life in a care home, including moving in, caring for residents, safety and privacy and complaints about standards of care.

Neutral Care: A term developed by David Sheard, Director of Dementia Care Matters, which refers to care that is task-based and process-driven with little emotional input from care staff¹³⁵. Examples include silent personal care, inattention to lethargy, interactions between care staff and residents that lack empathy and little understanding about the resident's life history, which results in an inability to facilitate social interaction and enjoyment.

Person-centred Care: Holistic (whole) care that focuses on the individual as a person with a unique identity, needs and wishes to enable them to live a fulfilled life, reinforce their sense of identity and achieve a sense of wellbeing. This includes

consideration of social, physical, intellectual, cultural, emotional, health and care needs.

Polypharmacy: The use of multiple medications at the same time. It is most common in older people, with care home residents reportedly taking an average of 7.2 different medications on a daily basis¹³⁶, many of which may be excessive or unnecessary prescriptions¹³⁷. Concerns about polypharmacy include increased adverse drug reactions, drug-to-drug interactions, a decreased quality of life and decreased mobility and cognition.

Prevention: An inclusive term that describes preventative interventions that can sustain and maintain people's health, wellbeing and independence. It is defined by Age Alliance Wales¹³⁸ as:

1. Any interventions designed to reduce the risk of mental and physical deterioration, accident, disease or ill health and / or to promote long-term physical, social, emotional and psychological wellbeing.
2. Services that enable people to live independently or support people to live independently for longer.
3. Services that aim to promote quality of life, self-determination and community.

Profiling Bed: A bed (usually mechanical/electric) that is specifically designed to increase the comfort and wellbeing of users. Benefits include a significant reduction in the risk of pressure ulcers, assistance to fluid drainage and improved mobility. A profiling bed also prevents the risk of back injuries in nurses and care staff through enabling safer repositioning and turning of the user.

Reablement: Help or assistance to enable people to learn or re-learn the skills necessary for daily living, often delivered after a period of ill-health, such as a stroke. While a focus on regaining physical ability is central, addressing psychological support to build confidence as well as social needs and related activities is also vitally important and often neglected¹³⁹.

Restrictive Care: A term developed by David Sheard, Director of Dementia Care Matters, which refers to a culture of care that is controlling and restrictive. It is defined by a 'them and us' attitude with carers doing things 'to' rather than 'with' residents. This is contrary to the principles of 'being person-centred'¹⁴⁰ and respecting, supporting and understanding both the person's current experience and their experience prior to their arrival in the care home.

Social Care Rapporteur: An individual appointed by the Commissioner to observe and report back on the quality of life and care of older people living in care homes in Wales.

Soft foods: Foods that are easy to chew and swallow. These are useful for people who have trouble chewing food or have difficulty swallowing and may therefore be at risk of malnutrition. They are also helpful for people who are too weak to chew regular foods.

Task-based Care: A term used to describe care that is carried out in a mechanical and institutionalised way without any connection to the individual concerned or awareness of them as a person. Also known as token care, task-based care is devoid of kindness, compassion and understanding, and is defined by a culture in which residents have things done ‘to’ and ‘for’ them rather than ‘with’ them.

Values-based Training: Training based upon the values that shape, determine and provide the foundations of how care should be provided such as kindness, compassion and understanding, and human rights.

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