|  |
| --- |
| **Enter and View****[name of home][date of visit]**Wheelchair in a corridor outside a room in a residential care or medical setting. |



Using this template

**Remember to delete these two pages before finishing your report and
 checking your page numbers in the Contents section.**

What’s the purpose of this template?

This template has been produced to support Healthwatch publish effective Enter and View reports following visits to **residential and nursing care homes**.

Developed by Healthwatch Milton Keynes, with input from other Healthwatch, it is based on considerable experience of Enter and View activity in these settings. Used alongside the accompanying ‘Conversation prompts for Enter and View visits to residential and nursing care homes’, the aim is to help you focus on key areas of importance for residents.

## How do I use the template?

**Section 1:** Contents. Check this at the end of writing the report to ensure the section headings and page numbers are correct. You will probably need to right-click on the contents table and select ‘Update field’ to see the option to update the entries and page numbers.

**Sections 2 to 5**: These contain standard text that you can use. The text highlighted in yellow explains what you should write in its place.
**Section 2.3: ‘How we gathered the data’.** Some Healthwatch prefer to use this alternative heading and text. ‘**Disclaimer.** Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.’ You should decide which approach you prefer, balancing being clear and confident of your findings with any feedback you might anticipate from the care home provider.

**Section 6:** Summary of findings**.** See below for guidance.

**Sections 7&8:** Text highlighted in yellow explains what you should write in its place.

## Summary of findings section: general guidance

There is guidance throughout this section of the template to suggest some of the areas you might focus on under each of the key headings. The suggestions align with the accompanying conversation guide for visits. But remember, that isn’t meant to be used rigidly as a checklist, so Authorised Representatives should have focused on what they gathered from conversations and their own observations. You should delete all the guidance text in the ‘Summary of findings’ section of this template.

* Each sub-section (6.1-6.6) should be succinct and based on evidence. Each should rarely be more than a page long.
* The findings reported should be your team’s overall conclusions from considering what you (i) heard from residents and their families/friends, (ii) observed yourselves, (iii) took from your conversations with staff where that felt in line with (i) and (ii).

When it’s useful, you should mention why you reached a conclusion. But you should avoid separately describing repeatedly in turn for every topic the detail of what you were told by residents, what you were told by relatives, what you were told by staff, followed by what you observed.

For example, you might write:
‘The menu is displayed outside the dining room and is given to each resident in their room. Most residents in the dining room did not require assistance but for the few that did, we saw care staff by their sides helping where needed.’
* Photos can be helpful to illustrate things such as the building layout, accessibility, information about residents’ meetings, menus, and personalisation. But remember your report isn’t a sales brochure. Remember to right-click on the photos that you include and select ‘View Alt text’ to add a description of the image for anyone who will be using a screen reader.

If photos identify people, remember to get a photo consent form signed by them.
* Using gender-neutral pronouns can help to keep comments and views anonymous. For example, ‘We spoke to a resident who said they felt …’
* The conversation notes handed in by the visiting team will provide all of the information**.** It is up to the report writer to ensure (i) anonymity for those spoken to, (ii)appropriate photos are used and consent saved, information in each section reaches appropriate conclusions from the notes of the conversations.

**Safeguarding and Deprivation of Liberty:** The purpose of Healthwatch Enter and View visits isn’t for a formal inspection with any official patient safety role. Authorised Representatives should avoid trying to hunt for issues, but they are advised to be alert for anything that doesn’t appear right. If a concern has been identified, then this should be discussed with your Healthwatch manager, and appropriate advice should be sought before publishing details in this report.

**Front cover of report – large photograph version**Replace the photo with one suitable for your report. To do this:

1. Right-click on the mouse and select Change picture. Find and ‘Insert’ the photo you wish to use.
2. Move and resize that picture as needed by clicking and dragging on the white circles, but don’t stretch the image out of proportion.

Replace the Healthwatch logo on the bottom right of the page with the logo for your own Healthwatch.

**Report title in the page footer**

Double-click at the bottom of a page and replace the text that says [Report title] with the title of this Enter and View report. Click on ‘Close header and footer’ on the menu ribbon or just double-click again in the middle of a page.

1 Contents

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Heading

# 2 Introduction

## 2.1 Details of visit

|  |  |
| --- | --- |
| Name of home | [name of home] |
| Service provider  | [name of the company that operates the home] |
| Date and time  | [date followed by start and finish times of the visit] |
| Authorised representative (s)  | [list of names of the Healthwatch team that conducted the visit] |

## 2.2 Acknowledgements

Healthwatch [name] would like to thank the service provider, staff, service users and their families for contributing to this Enter and View visit, notably for their helpfulness, hospitality, and courtesy.

## 2.3 How we gathered the data

This report is based on our observations and the experiences of the residents, relatives and staff we spoke to on the day of the visit.

# 3 What is Enter and View?

Part of the local Healthwatch programme is to carry out Enter and View visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families, and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists, and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service, but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first-hand.

Healthwatch Enter and Views are not intended to identify safeguarding issues specifically. However, if safeguarding concerns arise during a visit, they are reported in accordance with Healthwatch safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about, they need to inform their lead, who will inform the service manager, ending the visit.

In addition, if any staff member wishes to raise a safeguarding issue about their employer, they will be directed to the Care Quality Commission, where they are protected by legislation if they raise a concern.

## 3.1 Purpose of visit

[Stated purpose of the visit]

## 3.2 Strategic drivers

[This section should explain the organisational decision to run this visit/ programme of visits.

It can give the rationale behind the stated purpose, the research that underpins the thinking, or any changes to the health and care landscape or legislation.]

4 Overall summary

[On no more than one page, you should summarise the main key findings from your visit].

5 Methodology

[This section should show:

* Announced or unannounced visit
* Arrival and departure time and the timeframe within which Authorised Representatives engaged with residents.
* How the information was gathered/ collated
* Demographics: At the very least, this section should give a breakdown of how many residents, relatives/friends, and staff were spoken to. Particularly regarding residents, there should be details of their gender. Other demographics can be included, especially if these are useful for achieving the purpose of this visit. For example, disability or impairment might be helpful when looking at communication.

The example below is included for inspiration only and should be replaced with details of your own visit:

The visit was prearranged with respect to timing, and an overview explanation of the purpose was also provided.

The Authorised Representatives (ARs) arrived at 10:00 AM and actively engaged with residents between 10:00 AM and 1:00 PM. They left at 2:30 PM.

On arrival, the AR(s) introduced themselves to the Manager, and the visit details were discussed and agreed. The ARs checked with the provider whether any individuals should not be approached or were unable to give informed consent. The Manager provided the ARs with a thorough tour of the Home and introduced them to staff and residents along the way. The ARs were subsequently afforded access to all parts of the Home for the duration of the visit.

The ARs used a semi-structured conversation approach in meeting residents on a one-to-one basis, mainly in the communal areas. The checklist of conversation topics was based on the pre-agreed themes for the Care Home visits. Additionally, the ARs spent time observing routine activity and the provision of lunch. The ARs recorded the conversations and observations via hand-written notes.

Residents were approached and asked if they would be willing to discuss their experiences. It was made clear to residents that they could withdraw from the conversation at any time.

A total of four residents and one family member took part in these conversations.

In respect of demographics: -

* Five residents were male
* One resident was under 40 years old
* One parent who had been advised of our visit had coordinated their regular visit to their son so that they could speak with us.

At the end of the visit, the Manager was verbally briefed on the overall outcome.]

6 Summary of findings

## 6.1 Overview

This section should describe the Home in general terms. The CQC registration details are helpful for accurately describing what type of care the Home is registered to provide and the maximum number of residents it can care for.

It is useful to provide details of how many people were living at the home on the day of the visit.

Other points that might be helpful are:

* How long the home manager has been employed in the role?
* The location of the home - a residential area / quiet/ on a main road?
* Was the building custom-built as a care home or something similar, or was it converted from something else?

## 6.2 Premises

Depending on what your Authorised Representatives heard from people and observed during the visit, some of the areas you might cover in this sub-section are:

* Comfort and layout of the home. Number of floors and availability of lifts/stair lifts.
* Accessibility of the home and surrounding gardens.
* Ease of getting around the home. Can residents find what they want in different parts of the home? Do they need to ask for help getting to where they want to be in the home?
* Residents’ views of the bedrooms.
* Residents’ views on the gardens and surrounding grounds.
* The experience family and friends have when they come to visit a resident.
* Appropriateness of layout of the dining areas for the type of resident. (Were spaces left at tables for wheelchairs?)
* Is there Dementia friendly décor/ signage?
* Were there any strong/ lingering odours?
* Were there any obvious hazards?
* Did residents seem happy with the temperature (Too hot? Too cold?)
* Overall impressions of whether the place felt like a personal home to residents. Were there signs of people having personalised parts of it?
* Overall impression of cleanliness and maintenance.

## 6.3 Staff interaction and quality of care

Depending on what your Authorised Representatives heard from people and observed during the visit, some of the areas you might cover in this sub-section are:

* How responsive are staff to residents’ needs? Do they communicate and engage with them well in addition to providing practical physical support?
* Are the cultural and faith needs of individual residents known and catered for by the home and its staff?
* Do residents feel cared for and at home?
* Can residents get up in the morning when they want to and go to bed at the time they want to?
* Do they get the support they need to get up, wash and get appropriately dressed?
* Do bedbound residents feel their personal care is adequate (how often are they bathed/ given the opportunity to brush their teeth)?
* Do residents feel safe and treated with respect and dignity? Do they feel they can be themselves and express their personalities?
* As far as possible, are residents involved in creating their own care plans? Are they aware of them; have they read them; did they sign them?
* Is the complaints process well-promoted? Does it get used? Do complaints get acted on?
* What happens when residents need medical care that’s not available from staff at the home? What happens when residents have dental or eye care needs?
* How do residents get their hair done and nails cared for? Does the clothes laundry service meet residents’ needs?
* What induction and training do staff get when they start? What ongoing training and development is available for staff? Does any of this include considering the diversity of residents they are working with and other EDEI topics?

## 6.4 Social engagement and activities

Depending on what your Authorised Representatives heard from people and observed during the visit, some of the areas you might cover in this sub-section are:

* Do all residents get to join in with activities? Does everyone feel included?
* Are there enough interesting things to do? Is there a variety, and does it include the sorts of things that individual residents want to do? How much does the programme of activities help residents keep their minds and bodies as active as their ability level allows? Do things happen throughout the week?
* Are there any activities for people who can’t leave their rooms? For people who can’t leave their beds?
* Are there staff clearly responsible for arranging activities? Who runs the different types of activity? Do the arrangements in place help meet residents’ needs?
* How easy is it for residents to keep in touch with family and friends? Can they keep in contact by phone or video? Are face-to-face visits enabled in a way that meets the needs of both residents and the visitors?
* Are there resident/ family meetings or feedback sessions, and what do they achieve?

## 6.5 Dining Experience

**While an observation around the appetising look/ smell of the food can be useful, this section should not contain the personal views/ preferences of the Authorised Representatives or involve ‘taste testing’ or ‘rating’ food after having sampled it.**

Depending on what your Authorised Representatives heard from people and observed during the visit, some of the areas you might cover in this sub-section are:

* What is the overall dining experience like for residents? How do they find the overall atmosphere? Is it a positive and enjoyable experience?
* Can everyone choose where to eat? When to eat? Who to sit with?
* Are residents satisfied with the choice of meals? Are they satisfied with how and when they get to choose what to eat? Does the home’s approach to meals help residents get the most from the range on offer?
* Can residents easily refer to and understand the menus? Does the way the menus are presented help them do this?
* How often do items on the menu change / rotate?
* Do residents think the meals look appetising? Are soft/ pureed foods served nicely?
* Are people’s preferences and dietary requirements met as they should be?
* Can people eat at their own speed? Do they get assistance from staff if they need it to eat?
* What are mealtimes like for people who can’t or don’t want to leave their rooms or who are bed-bound? Are meals placed where they can reach them? Are their meals hot by the time they get them? What happens if they spill their food or drink?
* Can residents get snacks and drinks between formal mealtimes? Is this easy for all residents to do? Is water always available to help maintain hydration?

## 6.6 Choice

Depending on what your Authorised Representatives heard from people and observed during the visit, some of the areas you might cover in this sub-section are:

This section should report on how much autonomy people have and can cover any number of areas:

* Overall, do residents appear to have a level of autonomy over what they do?
* How much choice do people have in personalising their rooms to make them their own? More than only pictures and photos?
* Do residents get to choose which of their clothes to wear?
* Do residents have some choice in when to have a bath/ shower?
* Do residents have any say in who provides personal care (gender matching)?
* If the opportunity arose to observe this, what happens if someone changed their mind about the meal they’ve ordered?
* What did you learn about any resident forums / meetings? Do they happen? Do they achieve things? What did you learn about other ways residents’ views and suggestions are acted on?
* What else was observed about staff asking residents how things were for them in that moment, like whether the TV was the right volume or how they were finding the room temperature? What did you conclude about how much residents can influence what is happening?
* Are professional language or BSL interpreters used (rather than friends, family or non-clinical care home staff) for GP visits and conversations involving significant decision-making or about care plans?

7 Recommendations

[Provide your recommendations here

* Avoid making too many recommendations, as there is a risk that the most significant and top-priority things will get less attention.
* All recommendations should clearly flow from things that have been mentioned in the earlier sections of this report.
* Recommendations should be succinct and clear and use a ‘SMART’ format, making them Specific, Measurable, Attainable, Relevant and Time-bound.
* If the recommendation is for anyone other than the home itself, make it clear who that is.
* Although we’d prefer they didn’t, some readers will probably only read this section of your report. So, make sure your recommendations are written in a way that means they are understandable when read alone.

You can help ensure this by not only mentioning what you’re recommending but also why. For example, ‘Improve the variety of food available each day on the lunch menu to better cater for people from a range of cultural backgrounds.’]

7.1 Examples of Best Practice

[Note any examples of best practice that you identified at the home here].

8 Service provider response

[Provide a copy of the response you have had from the service provider following sending them your draft report].

