**Enter and View training**

**Introduction for trainer**

This training has been designed to be to delivered to up to 12 participants.

This PowerPoint presentation that includes these notes for the person who is delivering the session can be adapted to suit your individual organisation.

There is a version of this presentation that does not include these notes that you can send to participants after the training session.

This can also be sent in advance to anyone who asks because of their accessibility needs.

Take into account that some of the slides contain information that will help with responding to some of the exercises/discussion points that come beforehand.

But since all these resources are available on the Healthwatch Network site that is publicly accessible then it may be that some participants will have accessed the resources in advance anyway.

The training is planned to last for 5 hours in total (excluding breaks). However, you may feel some areas will flow faster than others, and some participants will ask more questions or wish to clarify different points.

If you are delivering the session in-person then it has been assumed that you will do this over one full day with a lunch break of up to 1 hour.

If you are delivering the session online then it is probably preferable to do this over two half-days.

The notes include suggested timing in minutes to allow for each part. You’ll need to keep an eye on a clock as you present the content and invite participants to contribute so that you keep to the overall time.

You will of course need to look through these slides and accompanying handouts to familiarise yourself with the content in advance. Consider how you are going to present each part and how you’re going to invite participants to contribute.

If you are co-delivering the session with a colleague then you could consider having some discussions in two smaller groups or breakout rooms. Bear in mind that doing this is likely to take a bit longer.

It’s suggested that you consider any minor changes that will make the content appear more ‘localised’ for you and your participants, but please do not skip any of the ‘topics’ unless specified.

**Slide2**

5 minutes

Adapt these Housekeeping points to suit whether you are running the session in-person at a venue or online to participants in different places.

If the session is at a venue then ensure you ask the people responsible for the building if a fire alarm test is due, where the emergency exits are located, and where the safe meeting point is. Let your participants know this at the start.

Ensure people know where their toilets are.

If the session is online then it’s useful to ask people to let you know if there’s anything going on for them that might mean they are distracted from the session or have to leave unexpectedly.

In the ground rules section for an online session, you should cover your expectations about use of the Chat facility. Will you be reading what people post in it and answering points raised there at the same time as taking them through the session? This may be a very difficult task as a sole trainer and you may decide to tell participants that you won’t be able to do that and ask them to raise hands to speak?

In any case, ask people to confirm if they can see the Chat window on their Teams or Zoom, as there are some occasions when it doesn’t appear for people. If someone can’t see it in their set-up then it’s suggested you avoid trying to fix that for them on the day as it could take a very long time and may not be possible. You’ll just need to remember that you can’t use it during the session.

Ask people to keep their microphones muted unless talking to reduce feedback and background noise. Remind people how to use the raise hand option.

**Slide 3**

5 mins

Talk through the slide, confirm that the aims will be revisited at the end of the session to ensure all points have been covered.

Remind the group that this session assumes they have completed the ‘Introduction to Enter and View’ and if they have not, they may find this more challenging. Hopefully this will have been covered in the joining information and before people attend on the day. If someone has joined who hasn’t completed the introductory session then of course make them welcome, but it may be useful to explain in advance that there may be points when you can’t cover more initial information due to time available.

**Slide 4 – a cover slide: Part 1.**

**Slide 5**

10 mins

Ask people to introduce themselves, where they are from (if everyone isn’t from the same organisation) and give an estimate of how many Enter and View visits they have been on to residential or nursing care homes from four options: 1) none yet; 2) a few; 3) quite a lot; 4) lots! (You can adapt these options but it is strongly suggested you don’t ask a broader introductory question due to the time it will take, unless you have a smaller group).

Take a couple of minutes to remind participants that:

* Healthwatch have a **legal power** to visit health and social care services and see them in action.
* This power to Enter and View is a way for Healthwatch to meet some of their statutory functions and allows them to identify what is working well with services and where they could be improved.
* It is **NOT** an audit or inspection.
* It’s about **listening to people** and giving them a voice.

This session assumes knowledge of the basic foundations of Enter and View as covered in the introductory training session.

**Slide 6**

5 minutes.

This is a (non exhaustive) list of the types of care homes that this training is focused on.

These are the types of standard care homes for residents aged over 65 years of age, or under the age of 65 who may have need of the same level of care.

To find out about the type of care offered by the home you will visit, you can use a simple google search such as ‘name of care home CQC’ and on the CQC page, look at the registration details which will tell you what type of care is provided, and how many people they are registered to care for.

BUT there are also homes for Assisted living for residents over the age of 18yrs of age, these are very different and would have a higher ratio of staff, possibly 1:1 staff ratio depending on the facility – some are for short to medium stay with the purpose of training and moving people to independent living, with others for long term stay.

When planning a visit, make sure that everyone from your team who will be going is clear about what type of home is being visited. Have a discussion about what this means for the approach you’ll take to engaging with residents. The principles covered in this training will apply to all types of home.

**Slide 7**

8 minutes

This is a refresher of things the group should have covered in the introduction to Enter and View training so shouldn’t have to be a large part of this session

Answers are on the next slide.

Ask participants to offer a few suggestions for the questions: ‘Why is it important to have a stated purpose? What does this achieve?’  
  
Answers should include these which are on the next slide:

A clear purpose for a visit leads to clear decisions about who should visit, when, and how the visit should be conducted.

Providers may be more accepting of a visit if they understand why it’s being done.

Residents and family members or friends may be happier to speak to you if they know why you are asking them questions, and what is going to happen with the information they give you.

A clear purpose helps you collect information that will be useful.

A stated purpose needs to be able to stand up to scrutiny and show there was a clear reason for carrying out an Enter and View visit.

This section can be especially important for those Healthwatch who have been given a required number of visits to complete by their commissioners. Even if the starting point for them doing visits is ‘Because our commissioner asked us to’, they should still come up with a purpose other than that to help focus their activity.

Note: The carers talked about in the second example are informal carers (family/ friends), not paid care staff.

**Slide 8**

3 minutes

Run through any of the answers that the group didn’t get.

**Slide 9**

2 minutes

Talk through the slide. As participants should have completed the more general training session, this provides more of a refresher/ reminder to Authorised Representatives than needing a full discussion.

One aspect that may need clarification is the ‘arrival letter’. As per the general Enter and View training, the visit will either be an announced or unannounced visit. For an announced visit, the notification of visit letter will have been sent to the provider and all the details agreed. As a matter of courtesy, an arrival letter is a summary of the original letter of notification but also includes the names of the ARs attending, and the name of the lead AR (next slides), and the contact details of the local Healthwatch staff member to be contacted if there are any issues with the visit. If the visit is unannounced, the arrival letter should combine the information that would be in the notification letter as well as the arrival letter.

**Slide 10**

2 minutes

Talk through the slide. As participants should have completed the more general training session, this provides more of a refresher/ reminder to Authorised Representatives than needing a full discussion.

One aspect that may need clarification is the ‘arrival letter’. As per the general Enter and View training, the visit will either be an announced or unannounced visit. For an announced visit, the notification of visit letter will have been sent to the provider and all the details agreed. As a matter of courtesy, an arrival letter is a summary of the original letter of notification but also includes the names of the ARs attending, and the name of the lead AR (next slides), and the contact details of the local Healthwatch staff member to be contacted if there are any issues with the visit. If the visit is unannounced, the arrival letter should combine the information that would be in the notification letter as well as the arrival letter.

**Slide 11**

15 minutes - for this slide and the next slide, however you choose to cover this part.

Either:  
  
(i) ask the group to offer some thoughts on the role of the Lead AR compared to the rest of the AR team. If your training is in-person then it could be useful to note people’s suggestions on a flip-chart pad or whiteboard. If the training is online then if you are confident to do so, you could plan to share your screen in a different way and type suggestions onto this slide, a Word document or virtual whiteboard. But it would be fine to just ask for a few contributions and not take notes.

Or

(ii) alternatively, you could go straight to the next slide and go straight to the discussion about the roles.

**Slide 12**

Timing included in the previous slide.

It is important to gauge the understanding that the group have of the responsibilities of each role.

The lead AR can absolutely engage with residents, although they may need to spend their time with the manager or other staff (4th bullet point).

Internally, some people refer to this as ‘running interference’ – basically, helping ensure the home manager and other staff don’t hover over residents during conversations. This might be especially useful if the care home staff are trying to ‘manage’ the conversations with residents, or if their presence is inhibiting free and open conversation with the ARs.

It is important to reiterate that engaging means having conversations with residents, making sure you are letting residents do the talking, ARs gently guiding conversations to gather relevant information.

**Slide 13**

5 minutes.

Leading into the break – hopefully there won’t be too many questions at this stage – but it is worth allowing a couple of minutes for people to ask about anything that needs clarifying.

Chances are, it will be coming up in the session ahead.

If there are questions about DBS checks – that is for the local Healthwatch to decide on and should be referred back to local policy. You can find more general information about DBS checks in the Healthwatch England ‘Guide to Volunteering’ that can be found on the Network site.

**Slide 14**

15 minute break.

**Overall timing for Part 1 up to this point = 1 hour before this break.**

**1 hour 15 minutes after this break.**

**Slide 15**

3 minutes

Ask people to put their hand up if they have ever heard the expression ‘DoLs’ before?  
  
Ask them to keep their hand up if they knew before now that it stood for Deprivation of Liberty Safeguards?

Tell people that the abbreviation is used in a lot of places but often not explained - so don’t worry if you weren’t sure about it!

**Slide 16**

10 mins

Talk through the slide.

Ask participants:  
If you’ve done an Enter and View visit did you come across things which might have related to DoLs?  
If you’ve not done an Enter and View visit, what are your thoughts about DoLs?

Note: it doesn’t matter too much where conversation on this goes, we are just getting participants to think about the issues overall.  
  
Tip: before you run the training, take a look at your own Local Authority policy and guidance to get an idea of the sorts of things these cover to help you facilitate this discussion.

You can bring these points into your discussion:

DoL could be a stairgate at someone’s door – is this the least restrictive way to keep someone from wandering? Would a pressure alarm on the floor be a better option? If the gate is there to stop other resident’s wandering into other people’s bedrooms – this is not an appropriate response by the Home. They should be looking at how to manage the wanderer’s behaviour not locking other people away.

DoL could be not being allowed to leave the care home to go to the shops or for a walk with family or friends.

**You can read more about Deprivation of Liberty here - https://www.scie.org.uk/mca/dols/at-a-glance/**

Safeguarding training, which includes reference to DoLs, should be undertaken before you carry out a visit. Each local Healthwatch should arrange their own, or will be able to organise it through the Local Authority.

**Slide 17**

5 minutes

Remember this is not full DoLs training, and is just a section to ensure people are aware of the topic.

**It’s important to emphasise that the AR is not expected to be the judge of a DoLs.**

Best practice is to ask the senior staff member during the conversation on arrival whether there are any DoLs in place with any of the residents.

As with a Care Plan – Healthwatch do not have the authority to ask to look at these, but the Care Home management can advise if there are any, who they apply to, and when they expire. And they should be able to.

During the visit, ARs can make a point of observing things that may amount to a deprivation of liberty and ensure that these are recorded accurately in their notes and advising the lead AR at the end of the visit. The lead AR can then ask about these during the end of visit meeting with the care home manager/ senior staff member.

If the team believe there are unauthorised, even inadvertent, DoLs in place, this should be escalated to the Local Healthwatch Safeguarding Lead and/ or management team (if they are different people) who will be able to contact the Local Authority to share the concerns and have the potential DoL investigated according to local policy and process.

**Slide 18**

10 mins.

Run through the definition on the slide and then have a discussion about the question:  
‘What things might you see in a care home which could make you wonder if you should report a concern about how someone is being cared for or looked after?’

You can prompt participants further, depending on what suggestions they’ve made, by also asking: ‘Might there be things that residents or their family members mention to you that could make you wonder if you should report a concern?’

This particular section is fairly general and assumes that the Local Healthwatch have delivered their own specific and localised safeguarding training. DoLs and Safeguarding training should be undertaken before you carry out a visit. Each local Healthwatch should arrange their own, or will be able to organise it through the Local Authority.

There is a (non-exhaustive) list of examples on the next slide.

If attendees have not yet had safeguarding/ DoLs training, refer them to their local Healthwatch team to organise this.

**Slide 19**

12 mins.

This list is not exhaustive – but it is a list of things Enter and View visits may be able to help ensure are not happening.

Obviously when we visit anywhere, we hope to see the polar opposite – eg: encouraging visits and involvement, sufficient staff and low turnover etc.

We’re not doing a visit to catch people out or test/check things. We’re just there to observe and see things from the point of view of the people who live there.

Ask participants if they are surprised by any of the things on this list? Are there any that they want to clarify?

[**Tip**: People may want to share things they have seen and it’s useful to have some real-life examples from some of the participants. But remember there is a lot to get through and these incident specific conversations will be best had during a full safeguarding training session. So, try to concentrate on moving on to the ‘What our responsibility is’ which is covered on the next slide.]

This is one of the reasons we have the conversations we have, and why the reporting we do must be shared with the Providers, the commissioners, and the regulators of the care home. Enter and View is a way to gather evidence of both good and bad practice directly from those receiving the care. Providers can keep all sorts of records which commissioners and regulators will look at, but numbers on a piece of paper are very different to the qualitative (people’s experience) evidence that a local Healthwatch can provide.

For some further background reading about increasing cases of neglect in care homes, see this item from Care Rights UK: Overlooking poor care: how to prevent neglect — Care Rights UK

**Slide 20**

5 minutes.

Reiterate that each local Healthwatch will have a Safeguarding Policy which must be followed and that they should have completed specific Safeguarding training before carrying out Enter and View visits.

The most important thing about the DoLs and the Safeguarding is that ARs feel confident about what to do if they see something – they don’t need to manage the situation, just report it (at whatever level that might be).

In some circumstances such as if someone else is at risk or a crime is being committed then reporting of abuse can be done without consent. BUT CHECK with your line manager.

**Slide 21**

10 minutes

[Video runs for just under 6 minutes. A few minutes allowed for people to get it playing on their own systems and/or for a couple of comments/reflections after people have watched it].

In-person training: if you have the technology available – it is useful to play this Bookcase Analogy video: **https://www.youtube.com/watch?v=kkvyGrOEIfA**

Online training: do consider that playing a video to people joining an online session can sometimes be difficult if their connection lags and they can’t see what you are seeing with video and audio running clearly. It’s fairly common to find at least a few participants say they can’t see anything. It’s often easier to ask them to click on the link and watch the video directly through their own computer.

Depending on how your timing is going for the training overall, you could suggest people take a short tea/comfort break here and watch the video during that time. If you do this then be very clear about what time you are going to start the session again.

**If you need to provide people with a transcript of the video then you should get this from the notes in the Powerpoint file. The transcript is not repeated in these notes pages.**

**Slide 22**

5 minutes

Read through the slide

Explain to the group that, while they may not be able to get consent to refer to any conversations they’ve had with people with dementia, they will be able to use their observation of how they react to various staff, noises, activities. It is also important to note whether staff are encouraging hydration, engaging with the person – or even the way they might manage any agitation or distress that the person might present with.

It is also important to remember that this person may really enjoy company so don’t just ignore them if they appear happy for the AR to sit and chat to them. Being observant and aware of the non-verbal cues will let the AR know if they are not welcome, or if the person is beginning to get tired or bored.

**Slide 23**

15 minutes

This is allowing 5 minutes to talk through the points on this slide. Then 10 minutes to invite any participants to share thoughts on engaging with people with dementia during visits.

Comfortable in the first line means: Make sure you’re in a good place to communicate. Ideally it will be quiet and calm, with good lighting. Busy environments can make it especially difficult for a person with dementia to concentrate on the conversation, so turn off distractions such as the radio or TV.

Note: Remember that this is a topic on which people might want to share more personal experiences and so it would be good to allow them to do that, within the overall time available.

**Slide 24 - break**

**Overall timing for Part 1 = 2 hours 30 minutes before this break**

For an in-person session, this is where it is suggested you would have **up to 1 hour lunch break**.

For an online session, delivered in two halves, this is where it is suggested you might split the training and deliver Part 2 separately.

**Slide 25 – a cover slide: Part 2.**

**Slide 26 – inclusion, equality, allyship.**

3 minutes.

*Trainer Note: The Healthwatch service has a shared value of equity. If as the trainer you feel you would benefit from a stronger grounding in this to prepare for delivery of this session then you could complete the introductory e-learning course that is available here:*

*https://network.healthwatch.co.uk/e-learning/2024-08-08/introduction-equality-diversity-equity-and-inclusion*

**This is an important section of the training and should not be cut out even if you are looking to deliver a shorter version of this course.**

Start this section by acknowledging to the group that some people may find the topic confusing and be uncertain about the direct relevance to our work.

Remind them that the Healthwatch service shares the value of Equity: We’re compassionate and inclusive. We build strong connections and empower the communities we serve.

To do our jobs properly, it’s essential that we reflect on the wide range of experiences people have through their lives and with the health and care services they receive. Ask participants to take some time after this training to reflect on their own ‘inner’ thoughts about what’s covered, and consider any steps they might commit themselves to taking to ensure they work in a way that empowers all the care home residents we’re there to serve.

**Slide 27**

7 mins

If your training is in-person then it could be useful to note people’s suggestions on a flip-chart pad or whiteboard during this discussion.

If the training is online then if you are confident to do so, you could plan to share your screen in a different way and type suggestions onto this slide, a Word document or virtual whiteboard. But it would be fine to just ask for a few contributions and not take notes.

Ask the group if they can think of examples of how one resident’s experience of something at a care home might be different to the experience that other residents are having because of their personal characteristics?

You are hoping to hear comments about things such as these examples below. If necessary, you could prompt people for ideas by starting people off with the part of the sentence that is in bold. Some of these are covered in the next slide where you can mention any that people didn’t come up with.  
  
**Being excluded from activities because** of language barriers.

**Care staff and Nursing staff not knowing how to provide personal care to someone** who has transitioned;

Care staff coming from **certain countries or cultures where being gay is illegal** – or ‘against God’ and not being able to separate this from their care responsibilities.

There could be any number of cultural differences around **food or expectations about behaviour** that just aren’t found in the care home.

**People who don’t look like you** or the people you remember growing up with/ hanging out with.

**Gay men with Dementia** – they may have come out after ‘Section 28’ had ended, but their memories may have them back in the times where being Gay was illegal – they may be fearful that people will ‘find out’, or they may feel that they have to ‘come out’ all over again.

**Trans people** may have different personal care needs. They may experience staff lifting sheets to ‘have a look’ (a true story relayed by a trans resident)

Differences could lead to people feeling unsafe, left out, fearful, or just ‘different’ (and not in a comfortable way).

Note: Do something to make clear that is a list of points that have been raised by LHW following real visits. You can add to this as you become more experienced in delivering this training.

Ask the group why it’s important then that ARs are aware of cultural, ethnicity, and other identity differences when visiting care homes?

Note: You can find more information about ‘Section 28’ here - The 20th anniversary of the repeal of section 28 of the Local Government Act 1988 - House of Commons Library

**Slide 28**

5 mins.

Use this slide as needed to cover points from the discussion on the previous slide. Check that the group have come up with these, or these types of answers. Talk through any that weren’t mentioned.

Summarise also (if not mentioned before) that there are many individual differences that could lead to people feeling unsafe, left out, fearful, or just ‘different’ (and not in a comfortable way’)

Note: Do something to make clear that is a list of points that have been raised by LHW following real visits. You can add to this as you become more experienced in delivering this training.

**Slide 29**

10 mins

This is a discussion exercise to do with the group.

Explain that it’s important to remember that a different – and more negative – experience of care can be more likely for people who are already experiencing inequalities. It can then compound inequality further.

Explain that you’re not going to ask people to share personal details with everyone else. You’re just inviting people to take a minute to think about this in relation to themselves.

Ask the group to think about themselves personally. Where would they place themselves on each of these scales from left to right?

How close does that put them to power in our society? Do they have parts of themselves that cause them to feel disempowered?

Invite people to share any thoughts about how they understand ‘privilege’? What does it mean to them?

After you’ve invited some people to share their thoughts, you can give them this description:  
Privileges are advantages, benefits, or special rights that individuals or groups possess in society due to certain aspects of their identity, background, and/or circumstances that provide benefit to them as they navigate the world. Most of us have different amounts of privilege at different times or places in our lives. It doesn’t mean that every white British person is automatically going to have a manor house and go to private school. But it does mean that systems in different places are set up with particular people in mind. – You can give examples of black British people being offered ‘skin toned’ prosthetics (or even sticking plasters!) because that is the ‘standard’.

People who are Hearing have a privilege over Deaf and Hard of Hearing people in a world set up for people who can hear… Able bodied people have the privilege of not having difficulty entering buildings with stairs or narrow doorways etc

People living in care homes may experience their care differently if they are funded to be there by the Local Authority/ NHS or if they are self funded. If they have a particular need such as diet (vegan or vegetarian for example), if they are bedbound or if they are mobile, if they adhere to a particular faith or have a cultural need that the Care Home is not able to meet.

**Slide 30**

5 mins

It’s also important to consider how microaggressions can affect people’s experience – either of care, or of engaging with us if we don’t try to be aware of them.

Microaggressions stem from our biases and send messages that perpetuate stereotypes. They can be defined as “… brief and commonplace daily verbal, behavioural or environmental slights, whether intentional or unintentional, that communicate hostile, derogatory, or negative attitudes toward stigmatized or culturally marginalized groups” (Derald Wing Sue)

The difference between microaggressions and overt discrimination or macroaggressions, is that people who commit microaggressions might not even be aware of them.

Getting someone’s name wrong repeatedly because it’s not one we are familiar with from our own background would be a microaggression. Or assuming that someone has certain tastes in food or music because of their ethnicity and immediately talking to them about that could be a microaggression.

You could suggest that after the training people watch this 4-minute film: [New film cuts to the heart of racist micro-aggressions | shots Magazine](https://magazine.shots.net/news/view/new-film-cuts-to-the-heart-of-racist-micro-aggressions#:~:text=This%20new%20short%20film%20from,race%2Drelated%20micro%2Dagggressions)

(You may need to copy and paste this link below)

https://magazine.shots.net/news/view/new-film-cuts-to-the-heart-of-racist-micro-aggressions#:~:text=This%20new%20short%20film%20from,race%2Drelated%20micro%2Dagggressions

**Slide 31**

5 minutes

Remind people that this relates to both how people might experience their treatment at the care home, and how we could unintentionally treat them when we are speaking to them.

Talk through the slide.

This is also an opportunity to encourage people to take the Healthwatch England Training: [An introduction to Equality, Diversity, Equity and Inclusion | Healthwatch Network](https://network.healthwatch.co.uk/e-learning/2024-08-08/introduction-equality-diversity-equity-and-inclusion)

(You may need to copy and paste this link below)

https://network.healthwatch.co.uk/e-learning/2024-08-08/introduction-equality-diversity-equity-and-inclusion

**Slide 32**

5 mins

Read through the slide

As part of an Enter and View visit, you don’t need to be an expert or have all the answers – you only need to understand that all of the topics covered so far will have a bearing on someone’s experience of their care.

If you don’t know that these things exist, it will limit your understanding of their experience and may mean that, for example, you may not identify where a recommendation might be made regarding staff training/ awareness.

Note: Before presenting the training you may find it useful to read through this summary of terms such as ethnicity and ethnic minority if you don’t feel confident to explain these. (You will probably need to copy and paste this link)  
https://www.lawsociety.org.uk/topics/ethnic-minority-lawyers/a-guide-to-race-and-ethnicity-terminology-and-language   
  
Nationality is about the legal status of being affiliated to a particular nation, usually through citizenship. Broadly this is where birth certificates and/or passports are relevant.

**Slide 33 – Cover slide: The visit**

**Slide 34**

3 minutes

Most of this is a reminder only as this is standard Enter and View information and will have been covered in general Enter and View training.

The situation of a resident having just passed away or a severe medical situation arising during the visit may not have been covered with participants before. Tell the group that a suggested approach to have agreed would be:

* Consider the size of the home and where the situation has arisen in terms of how likely it is that many other residents will be aware of what has happened.
* Stay out of the way of any emergency activity, keep in the background as much as possible, and stop what you were doing if the situation is ongoing.
* Talk to the home manager or another senior member of staff and ask them what they would like you to do.
* They may suggest that you wait a short time somewhere out of the way and then continue with the visit as planned.
* Alternatively, they might ask if you could leave and come back on another occasion to complete the visit. You should follow their preference.
* If they do suggest you continue the visit, ask for their view on how much other residents will be aware and affected by what has happened.
* Be aware of how other residents might have been affected as you are talking to them.
* It’s important to remember that it’s not your role to pass the news of what has happened on to other residents or family members / visitors.
* The Lead Authorised Representative should check how other Authorised Representatives have been affected by the event, find out if they are feeling okay to continue with the visit activity, offer an opportunity to talk about how they are feeling. An opportunity to talk about what has happened should be repeated after the visit. The Lead Authorised Representative should let the Healthwatch Manager know what happened and talk to them about how they are feeling about it.

**Slide 35**

7 minutes,

Talk through the slide.

Find your person – decide who it is that you are going to approach to have a conversation with. – hopefully, you and the team with you will be offered a tour of the premises – you will need any access codes that are used.

Familiarise yourself with the Conversation Guide template which gives you both ideas of things to talk about with residents and staff – and also ideas of things to look out for to make your own observations.

GDPR: best practice is to keep any personally identifiable information collected to a minimum. First name (or preferred form of address), age, gender, ethnicity, potentially how long they have been in that particular care home. If there is a certain characteristic to be explored through the stated purpose of the visit (sexuality/ disability etc) then record that. Your explanation to Residents should stress that the information they provide will be used anonymously (which is different to confidential), and that the raw data/ notes will be destroyed in line with your Healthwatch retention/ GDPR policies.

Note: If there are questions from the group about why we collect the demographics, it is because there is value in showing that the evidence reflects the experiences of a wide number of people living in the home, rather than just one or two. It’s also important to help identify if the experience of some people is different to that of others because of their demographic characteristics.

It can be important to note gender and ethnicity as these differences may highlight particular areas of good practice, or potential improvements – but in general terms.

If it is a very small home, it is likely that staff will know who has been spoken to anyway. To keep things anonymous is then up to the person writing the report – they should be using non-specific pronouns (they/ them) and perhaps not including direct quotes if the phrasing may lead to identification. If, while speaking to someone, they say something that you think would make a great quote – tell them you like that sentence and ask if it would be okay to use it in the report. Consent should always be our first thought!

**Slide 36**

10 minutes for this and the next slide (if you are using the next slide)

You could have a quick discussions about the pros and cons of each location – including your Healthwatch view/ policy on different spaces. The next slide is a deeper discussion activity about having conversations with residents in their bedrooms.

People might want to chat about what ‘Safety first’ means to them – this is covered in the next slide.

If you know all the participants’ Healthwatch does not allow conversations in bedrooms, and so you are not using the next slide, then ‘Safety’ here, different to the resident safety, is about making sure that ARs are not put into difficult situations.

When people have dementia, they can often develop false beliefs and there is the potential for accusations to be made. They may believe that someone has stolen their remote, their keys, their cash. Making sure that ARs work in pairs when talking to individual residents in less populated areas (bedrooms is generally the example) such as small lounge areas where it is only the ARs and the resident present, is a good way to get around this. It is mostly about common sense and being aware of the risks in the same way as any ‘lone working’ situation.

Busier communal areas are not such a risk, but there is less opportunity then for the resident to be able to speak freely if they are not having the best experience.

**Slide 37**

Timing: included in the time for the previous slide.

If all the participants’ Healthwatch don’t allow ARs to enter bedrooms then remove this slide.

Discussion –

Best practice is:

Knock and wait to be invited and then seek consent to speak with the resident

Door to stay open

Don’t sit on the bed

Two ARs – safety for both ARs and resident

These are some things someone who is bedbound might be able to tell us about:

What has led to them being confined to bed? – would they like to get out of bed? Would they be able to get out of bed if there were enough staff to assist them/ if they had an appropriate hoist/ wheelchair.

Loneliness and isolation – what happens for the resident to mitigate these?

Bathing/ personal hygiene – how often do they get bathed?

Are they supported to clean their teeth? What activities are provided to them? How do they manage meals?

Do they have a mattress that helps prevent pressure sores? Are the carers responsive to the call bell? Are they happy with the way their continence is managed?

How are they kept engaged and in touch with family and friends?

Additional discussion point if you have time: What are people’s overall thoughts about what we might be missing if we don’t talk to people who appear to be bedbound?

**Slide 38**

15 minutes

Tell people that this slide gives a general idea of how you might introduce yourself and start off a conversation with a resident. But of course, everyone will adapt the wording a bit to suit their style and the situation.

Invite those participants who have already done visits to care homes to share any thoughts about how they introduced themselves to residents to start a conversation.

Invite those participants who haven’t yet done any visits to care homes to share any concerns they have about introducing themselves and starting off conversations with residents.

Ask other participants to share any thoughts on what people raise.

Make clear what they talk to you about will be kept anonymous so people reading the report won’t be able to see who said what. This is not the same as confidential, as it will be included in a report and your conversation isn’t just a private interview.

**Slide 39**

10 minutes

Talk through this slide

Then ask the group to provide any other tips and tricks they might have to guiding conversations to cover the topics you’re hoping to cover with a resident without taking over the conversation.

If residents withdraw consent – AR should ask if it is OK to use the information already given. If the resident is agitated or distressed, reassure them that its fine, check in to see if they would like you to get a carer to sit with them, or if they are ok with being left alone.

**Slide 40 - break**

**15 minutes break**

**Overall timing for Part 2 up to this point = 1 hour 25 minutes before this break.**

**1 hour 40 minutes after this break.**

There is now 40 minutes to cover discussing the scenarios that follow.

Then that leaves 10 minutes for the final content that follows those.

The next slide includes some suggestions for how you might run the scenarios section.

**Slide 41 – scenario section of part 2**

**40 minutes has been allowed in the timings for this scenarios section.**

**Some Healthwatch may consider including some form of role play exercise at this point in the training instead of discussing scenarios. However, it’s suggested that it can be very difficult to ensure a role play provides something useful for all participants and will often depend too much on individual’s abilities to play the part of a care home resident or staff member, whilst avoiding caricature and stereotyping.**

**Our suggestion is that a wider range of useful issues will be covered with these scenarios, or others you may want to write yourself.**

It’s suggested that a small group would take 10 minutes to discuss each scenario. So, there is unlikely to be enough time to use them all if everyone talks about all of them fully.

Depending on the size of your group, you may decide, if you can, to split people into smaller groups to discuss the scenarios and answer the three questions.

You’ll need to work out in advance of the training how you will give people in different groups access to all the scenarios that are on the different slides. You may need to print some off if you are delivering an in-person session (you could use the handout version of this pack), or have them on a tablet or laptop for people to refer to.

If you are running an online session then you might decide to email the scenario slides to participants before the day so they can refer to them when you get to this point.

Take account of the time available and think about how long it will take for a group to talk though each scenario so that as many people as possible have a chance to contribute. You might decide to ask different groups to discuss different scenarios, with someone taking a few notes to then feed back to the full group afterwards.

If you just ask all groups to work through the scenarios starting with the first then you are quite likely to find no-one has got to the later ones.

Decide how you are going to feed back or recap when groups come back to the main group again. Don’t forget that you’ll need to allow a reasonable amount of time for this feeding back too and it’s likely people who were in other groups might also then have some comments. You’ll need to manage this so that the full discussions aren’t completely repeated. You’ll also need to allow a bit of time to contribute yourself if there are parts of the example answers that you think need to be mentioned.

If you decide to work through the scenarios with the full group of participants together then try to ensure everyone gets the opportunity to contribute. Invite different people to start off giving their thoughts, but also make sure they know they can ‘pass’ if they don’t want to contribute or want more time to think.

**There’s not a single right answer to each of the scenario questions. But in the notes section of each slide you’ll find some suggestions about the issues raised, what you might think about, and what you might do in each case. You can use these suggested points in your feeding back discussion with the group. You may want to copy them into a separate handout to send to the group after the training.**

**Slide 42**

See previous slide for suggestions on how to run the discussions of these scenarios.

It’s suggested that you should allow 40 minutes for this scenarios section of the training.

There’s no single correct answer to each of these scenarios. There’s likely to be a range of possible issues, things you might think about, and options for what you might do. Some of these will depend on more specific details of the situation if you came across it in real life.

The points below provide some suggestions to help you feed back and discuss the scenario with the group.

**Scenario discussion 1**

* Can you pick up anything from non-verbal cues? Does Lucy seem comfortable with the situation?
* Do you get any indication that Lucy is changing the subject because cognitively they don’t stay focused on the topic, or because they aren’t comfortable speaking with the care assistant there?
* Does the care assistant seem overbearing or not?  
    
  If you don’t pick up any concerns about feedback not being easy to gather from Lucy with the care assistant there:
* You could widen the conversation out to be less about the specific points you want to cover and ask about whether they’ve been enjoying the card game they were playing or talk about things you see around the room. You’d be trying to adjust your approach to chatting to bring a different mood/vibe to the conversation. This could lead on to them starting to talk about other activities in the home or other things about the surroundings.
* You could gently wrap up the conversation on the basis that you’re not going to gather much more about the areas you want to explore. You can’t insist someone answers your specific questions.  
    
  If you do have some concerns about feedback not being easy to gather from Lucy with the care assistant there:
* You could gently wrap up the conversation and go and speak to your lead Authorised Representative. See if you can arrange with them to come and talk to the care assistant and maybe lead them away to do something else. This might then leave you to talk to Lucy alone.
* Alternatively, you could keep an eye out for when the care assistant has left Lucy and go back and speak to them then. If the care assistant then rushed back to join you both, that might raise your concerns further.
* You could talk to the home manager at the end of the visit to ask if there might be a reason that some staff came across a bit over-protective of residents. Sometimes care homes that are very keen to be considered highly rated (especially if it’s maintaining an existing good rating) could be too keen to monitor every interaction.
* If the situation appeared particularly concerning then you might speak to the lead Authorised Representative or Healthwatch Manager about local Safeguarding arrangements.

**Slide 43**

See earlier slide for suggestions on how to run the discussions of these scenarios.

It’s suggested that you should allow 40 minutes for this scenarios section of the training.

There’s no single correct answer to each of these scenarios. There’s likely to be a range of possible issues, things you might think about, and options for what you might do. Some of these will depend on more specific details of the situation if you came across it in real life.

The points below provide some suggestions to help you feed back and discuss the scenario with the group.

**Scenario discussion 2**

* Did Malcolm understand who Healthwatch are and the role? Did he maybe think it was something else (a medical service perhaps) and now realises it isn’t what he’d thought?
* Is he worried about someone else in the home knowing he’s spoken to you, or overhearing what’s said?
* Has he forgotten the thing he’d felt was really important that he wanted to speak to you about?
* It could be useful to move away from using the conversation guide and start to just have a much more general and less structured conversation about things unrelated to the care home. Ask him about where he’s lived in the past or what he’s reading in the newspaper. This will help you get a better idea of his overall cognitive abilities in relation to talking about topics. It also means that if anyone else is listening in, they’ll think the conversation is non-threatening and of less concern to them. This might then help lead into him saying more about things relating to his experience in the home.
* Put down your pen and paper and just chat to him, person to person.
* After a while, you could try to return to explaining why you’re at the home, what Healthwatch’s role is. Explain clearly to him, but during this more casual conversation, that your service is independent and what’s said is kept anonymous.
* If it seems appropriate and you think he can make use of it, you could give him the phone number for your Healthwatch and let him know he’s welcome to call at some other point to share his thoughts about the home and other health and social care services.

**Slide 44**

See earlier slide for suggestions on how to run the discussions of these scenarios.

It’s suggested that you should allow 40 minutes for this scenarios section of the training.

There’s no single correct answer to each of these scenarios. There’s likely to be a range of possible issues, things you might think about, and options for what you might do. Some of these will depend on more specific details of the situation if you came across it in real life.

The points below provide some suggestions to help you feed back and discuss the scenario with the group.

**Scenario discussion 3**

* A top issue this raises is whether there are enough staff employed at the home to sufficiently meet the needs of residents?
* In a larger care home, it’s more surprising that there isn’t someone in a reception role.
* If the visit was announced in advance then it’s more surprising that it took a long time for you to be let in.
* In this situation it seems more important to knock on bedroom doors and ask residents if you can speak to them. This is where it could be an issue if your Healthwatch has a policy of not going into residents’ bedrooms during Enter and View visits. Is this something your Healthwatch might reconsider if increasingly residents are bed-bound or spending more time in their rooms?
* Where was the poster displayed? Is it there now?
* Do you find that a survey for relatives in advance of a visit usually does get a good amount of responses? Should you consider giving relatives other options to communicate with you: telling them they can see you on the day of the visit, email, or phone?
* How many visitors do residents in the home get? Is the lack of communication from relatives because few visit to have seen the poster? What’s the visiting policy of the home?
* Are staff very focused on some tasks – for example ensuring the home is very clean, but this is to the detriment of spending time with residents?
* What can you find out about staff to resident ratios in the home? You might be told by the manager that they are good, but can you find out more from the local authority Compliance Team?
* Is the resident who is asleep in the day room okay? Have care home staff checked on him recently? Is there anything about that situation that gives you any cause for concern?  
  It’s beyond Healthwatch’s role to explore things such as whether medication is being given appropriately, but if you have concerns you should speak to the Healthwatch Manager about possibly raising this with contacts at the CQC or local authority.

**Slide 45**

See earlier slide for suggestions on how to run the discussions of these scenarios.

It’s suggested that you should allow 40 minutes for this scenarios section of the training.

There’s no single correct answer to each of these scenarios. There’s likely to be a range of possible issues, things you might think about, and options for what you might do. Some of these will depend on more specific details of the situation if you came across it in real life.

The points below provide some suggestions to help you feed back and discuss the scenario with the group.

**Scenario discussion 4**

* This raises the issue of what it might be that the home want to hide from you? What’s a typical day really like?
* Even if the Purpose of your Enter and View visit was for something less related (for example, to look at meals and nutrition) it would seem useful to give additional focus on the day to activities, choice and personalisation.
* After the visit, there could be a discussion with the Healthwatch Manager about whether to undertake another visit, but this time unannounced? It could be best to do that on the same day of the week so there’s less scope for the home to say the times aren’t comparable.
* Maybe this additional visit could be done after you’ve had an action plan back from the home following your report and recommendations. This would give a good reason for going back – to see those changes in action.

**Slide 46**

See previous slide for suggestions on how to run the discussions of these scenarios.

It’s suggested that you should allow 40 minutes for this scenarios section of the training.

There’s no single correct answer to each of these scenarios. There’s likely to be a range of possible issues, things you might think about, and options for what you might do. Some of these will depend on more specific details of the situation if you came across it in real life.

The points below provide some suggestions to help you feed back and discuss the scenario with the group.

**Scenario discussion 5**

* There appear to be some issues here that are likely to relate to the purpose of your Enter and View visit and feature in your report, whereas others appear to be things that Hassan needs detailed, individual advice on. Talk to your lead Authorised Representative about how you might help him access advice following the visit. You can’t give him the individual advice he needs right now, during the visit.
* Note the information he gives you down carefully.
* There’s a good chance that this situation raises the need for a referral within your local authority Safeguarding policy: he’s being pressurised and there are questions about whether his basic rights and needs are being met in the way they should be. Talk to the Healthwatch Manager about this.
* How was his care plan put together and agreed by him?
* How commonly do staff get consent from him for his personal care if there isn’t BSL interpreting readily available?
* Overall, how are the home communicating with him through each day?

**Slide 47 – Cover slide: After the visit section of Part 2.**

**Slide 48**

7 minutes

Debriefing is so that people can go home and leave the visit behind them. Not everyone will want a debrief, some people may want it later. The purpose of a debrief is to discuss and/ or anything that concerned you/ worried you – you should be able to go to bed that night and not lay awake thinking ‘Could I have…? ‘ Should I have...?’ – you should be reassured that everything that could/ should have been done was done or has been handed to someone who can/ will take care of it.

Your Healthwatch might offer individual/ group supervision which is where you can reflect on your own practice and get or give hints and tips to each other about how to improve your practice or what worked well for you – in either a particular situation, or in general.

**Slide 49**

2 minutes

Review the aims of the training as covered at the start. Does the group feel these were met?

**Slide 50**

1 minute

Note: adapt his slide to suit your Healthwatch or the various Healthwatch you’re providing the training for.

If your Healthwatch offers certificates then this is where you can congratulate people and tell them when and how they will get theirs.

**Slide 51 – back cover that you may adapt with your own details if you wish.**