JRF JOSEPH ROWNTREE FOUNDATION

REPORT

IS EXCESSIVE PAPERWORK IN CARE HOMES UNDERMINING CARE FOR OLDER PEOPLE?

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This report explores whether the burden placed upon staff in care homes to produce paperwork is having a positive or a detrimental effect on the quality of care.

The project collated and reviewed examples of paperwork used in care homes for older people. It also explored recommendations for a more 'streamlined' system of paperwork that meets regulatory requirements but also provides greater scope for care homes to focus on improving relationships between care staff and residents.

Using a desk-based review of paperwork as well as interviews, focus groups and observations with care home staff, residents and carers, the report looks at:

- what paperwork is for and who decides this;
- how paperwork is used in care homes;
- whether paperwork contributes to what residents value;
- the implications of all of this for the quality of care residents receive; and
- recommendations for improving the organisation, application and impact of paperwork to help achieve better-quality care.

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EXECUTIVE SUMMARY

Attempts to improve the quality of care in older people's care homes have focused largely on the way in which care homes are regulated and held to account for poor delivery. Much of this has required changes to the types of 'paperwork' care homes are asked to complete – 'paperwork' being the documentation generated in the provision of care and in response to legislation, regulation, commissioning and best-practice guidance.

Despite a raft of improvement agendas in recent years, can we be sure that changes to the paperwork completed by care homes are improving care for older people? Is there a chance that the burden placed upon care homes to produce paperwork is actually having a detrimental effect on the quality of care?

This report examines these questions through an exploration of the role of paperwork in residential care for older people. The project collated and reviewed examples of paperwork used in care homes for older people and explored recommendations for a more 'streamlined' system of paperwork that meets regulatory requirements but also provides greater scope for care homes to focus on improving relationships between care staff and residents.

Approach

Two key beliefs were central to the project methodology. Firstly, the purpose of paperwork should be driven by the perspective of those whom it is intended to benefit: the residents. Secondly, care should be provided in a way that is 'human' – placing the creation and maintenance of meaningful relationships between care staff and care-home residents front and centre.

Our inquiry centred on three care homes – two in Birmingham and one in York. We also interviewed two large national providers of older people's care; one medium and one small provider of care; membership bodies for the care sector, the English Community Care Association (ECCA) and the National Care Forum (NCF); adult safeguarding boards; commissioners of care services

from local authorities; a strategic lead for adult and social care; a quality manager for a local authority; a social-care lead assessor; and of course the Care Quality Commission (CQC), the principal regulator of care homes.

The project explored documentation required in registered care homes in an attempt to identify 'must-dos' – those things that are regulated and assured by law, why this is the case, and the kind of evidence (the 'paper') regulators require. This included reviewing over 100 pieces of paperwork. Key stakeholders in the system were interviewed to explore how they view assurance and the role that paperwork plays in this process. The results of this work were explored with providers, service users and carers to understand how they view the relationship between the paper produced and the quality of care.

A total of 25 in-depth interviews of this type were conducted. In addition, for two days we shadowed staff in the participating care homes as they undertook their duties. We also ran two focus groups with frontline staff and one with carers/volunteers.

What we found

1 Purpose – what is paperwork for and who decides this?

Care homes have a list of core 'must-dos' informed by key legislation and embodied in 28 essential standards of quality and care. Yet different agencies also make requests of care homes, and these requests have different emphases across the country. As well as this moveable feast of 'must-dos', views about how guidance should be interpreted to meet funding or regulatory requirements vary. Additionally, some requests made by inspectors and regulators are seen by care homes as bearing little relation to an assessment of the quality of care provided by a home to its residents.

There seems to be very little co-operation between different regulators and commissioners, and some duplication arises when they ask for much the same information but with a twist to suit their own individual needs. From each person's point of view, what is requested is reasonable; however, the impact of several commissioners asking for similar but slightly different pieces of information places an extraordinary burden on the home. This composite impact (the burden of all the requirements felt together) is often what care-home staff describe when they complain about the paperwork burden.

With so many agencies defining the purpose and content of paperwork, producing a definitive list of the requirements and associated paperwork for care homes risks becoming a losing battle. Our interviewees tended to take the view that this reflected deeper uncertainties about what exactly should be valued in care. Without a shared view of what high-quality care looks like and what should be valued in care throughout the system and by all of its stakeholders – residents, relatives, care staff, commissioners and regulators – the chances of developing a comprehensive summary of the things care homes need to do in order to meet regulatory and commissioning requirements are limited.

2 Use and application of paperwork

In the care homes we visited, about half of the paperwork produced was used infrequently. However, staff still felt they had to produce it. Staff we spoke to felt the primary purpose of much of the paperwork produced was to ensure legal compliance. In some cases, staff felt that paperwork was designed inefficiently. In other cases, paperwork seemed to be inefficiently

implemented, with some room to eliminate or streamline wasteful internal procedures.

The burden of paperwork can take managers in care homes away from precisely the leadership activities they should be engaged in to ensure high-quality care for their residents. Care staff that we spoke to suggested that frontline staff and managers should be judged primarily on their ability to deliver good care or on the effectiveness of their leadership and management – not on their ability to fill in or check paperwork. But the latter is precisely what sometimes happens.

Use and application of paperwork was explored further in three particular areas of care-home activity: care planning and associated daily records, risk assessments, and staff supervision processes. In summary, we found that while care plans are important documents, they aren't always able to capture the essence of the resident, and a resident's voice can be lost when the plans are seen mainly as a set of care needs and requirements. In terms of risk assessments, we found that risk is often averted rather than managed. When the focus is on avoidance of risk (due to a care home's fear of blame or litigation) rather than enablement, then residents' wishes and priorities can be a secondary consideration. Finally, in relation to staff supervision, despite related paperwork being rigorously assessed by regulators, this does not always result in effective staff development and performance management practice. In short, we found that there are a number of examples where paperwork does not help to achieve the outcomes for which it is intended.

3 Paperwork and its contribution to achieving what residents value

As has been suggested above, there are limits to the ability of paperwork to support good-quality care. This is also true in terms of quantifying and measuring the quality of interactions between care staff and residents in a care home. It is these interactions between people that form transactions of care, and it is the quality of these transactions – the balance of influence between residents, relatives and care staff, and how things are done by people to people – that are of ultimate value to residents and their relatives. However, the ability to capture on paper the transactions between carers and residents that make for high-quality relationships in care is limited, and much more needs to be done in the inspection and judgement process to increase the weight given to observed high-quality care relationships in homes. Used in this way – to assess all of the other aspects of a care home's working culture and care ethos – the paperwork could help contribute to better-quality relationships and to strengthening residents' voice in the care process.

Conclusions

The project set out to explore whether the burden of paperwork has a detrimental impact on the delivery of high-quality care. We found that regulators and commissioners assume that residents benefit from the completion of paperwork. Yet the indications are that residents, rather than being the beneficiaries of regulatory regimes and their accompanying paperwork, are often at their mercy. Not only is it possible to comply with paperwork while failing to provide care that is of the highest quality, responding to regulatory and commissioning requirements can also actively prevent the delivery of good care in some instances. This happens mainly through reducing the amount of time staff members have to undertake other care responsibilities, including the building of meaningful relationships, as well as acting as a barrier to listening to and acting upon residents' wishes.

Paperwork and responding to compliance regimes can also influence the behaviour of staff in a way that limits effective practice.

Instead of being an addition to care value, paperwork can lead to 'subtractions' in care – by this we mean that there are things that the paperwork literally takes away from the delivery or management of care. Five of the most significant subtractions are described below:

Paperwork and responding to compliance regimes can also influence the behaviour of staff in a way that limits effective practice.

Subtraction 1: leadership

Our interviewees felt that time spent by leaders completing or checking paperwork could be much better spent on leadership activities, being a visible presence in the home and demonstrating to colleagues how to build good relationships with residents and staff.

Subtraction 2: value of care

Interviewees suggested the value being placed on paperwork was too high compared to the value placed on providing high-quality care. The system has to value and reward caring qualities (as opposed to rewarding the ability to fill in forms) if we are to solve issues of poor care.

Subtraction 3: vocation

Unnecessary differentials in capability and divisions of labour within care homes are being created because people are judged on their ability to fill in paperwork more than on their ability to deliver good care. This can have the effect of alienating people from their job and reducing their sense of vocation, taking them further away from the reason that they entered a care profession in the first place.

Subtraction 4: co-operation

The paperwork doesn't drive providers, commissioners, contractors and regulators to higher levels of co-ordination and doesn't help them to establish a shared value system for care. In fact, in some ways paperwork actively destabilises co-operation between agencies and people within the care system.

Subtraction 5: professional autonomy

Regulation can lead to regularisation. It can reinforce the mechanistic nature of some care practice, for example regular bed-rail assessments. We need people to take action in a system of care because they recognise that it is the right thing to do at the time. Routine cannot be a substitute for thought – it can't replace timely professional judgements and, the danger is that if it does so, it reduces the authority of the professional and their belief in their vocation.

It is clear the balance between prevention of poor care and promotion of good care appears to be out of kilter. Care homes spend an inordinate amount of time attempting to cover themselves for fear of potential blame or litigation for poor care. Paperwork has become an industry in its own right, fuelled by a sense of fear and insecurity.

Recommendations

In conducting this study, we set out to explore the design of a more streamlined approach to paperwork that could help care homes respond to some of the inconsistencies and challenges this report identifies. Our

practical engagement with care homes has prevented us from the somewhat naive belief that sorting out the paper is the fix. No one, in any of our interviews, thought that changing the paperwork would help if tackled in isolation from other factors that influence care practice – commissioning and regulation. As a result, our recommendations are organised into limited steps to improve the paperwork in the short term and recommendations for longer-term systemic change.

Short-term recommendations

The full report contains a list of specific recommendations to improve:

- incident reporting forms;
- alignment of national inspection criteria across agencies such as CQC, the National Health Service (NHS) and local commissioners;
- sharing and use of information across inspectors of care;
- local geographical alignment (improving consistency of approaches to inspection taken by commissioners and regulators in specific local areas); and
- organisation of the paperwork for different audiences (organising a set of paperwork that can be owned and used by the resident and organising paperwork that is used more by staff on a day-to-day basis).

Long-term recommendations

The full report contains reflections on the systemic, behavioural and attitudinal changes required to create the kind of environment in which compliance and monitoring activities in care homes could work in greater favour of residents and care staff alike.

- Providers and residents should play a greater role in defining the judgement criteria for high-quality care. At a care-home level, consultation should be undertaken to identify the 'moments that matter' to residents, relatives and staff in the provision of care.
- Assessment is usually based on a very narrow definition of compliance. Translated, this often means using the 'right' forms and completing them in the 'right' way. This version of compliance gives no weight to the meaning of choice, participation, dignity or respect. These are observable in the day-to-day transactions between residents and staff. Observing and judging the quality of those transactions is one way of thinking about judging the relationship between care staff and residents. An approach to inspection that involves observed assessment would need to focus on understanding transactions of this type in care.
- High-quality relationships exist when care-givers and residents have a shared understanding of tolerable risks. Good care would see the primary role of risk management as enabling residents to live their lives in a way that they value as opposed to defending the home from potential litigation or reputational loss. If this is to happen in practice, a number of changes are required in the way staff are supported.
- At a care-home level, support and professional development for staff are required to help them understand how to discuss and manage risks in a fair, open and balanced way.
- At a system-wide level, the biggest threat to effective risk enablement is the lack of collective accountability in the system. Currently providers, commissioners and regulators do not have a shared investment in achieving high-quality care because they fear being blamed for failure.

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1 INTRODUCTION

Over the next 20 years the number of people in the UK aged over 85 will double. Increasingly, we must remind ourselves that 'older people' means all of us, not some mysterious 'other'. The Joseph Rowntree Foundation (JRF) wants to understand how approaches to risk and regulation in care homes can be developed in ways that support good relationships and improve people's quality of life. This report, commissioned by JRF, responds to that question.

What this report is about

It is estimated that over 376,000 older people live in around 10,300 care homes in the UK. They are a largely hidden group. Yet in recent years there has been increasing evidence of poor treatment and infringement of people's basic human rights across the residential care system, including the treatment of older people (CQC, UK Adult Social Care Survey, January–March 2012). Attempts to improve this situation have focused on enhancing the quality of care and have been led by a range of agencies such as the Department of Health, local authorities and the CQC (the regulator for care homes).

This improvement drive has focused largely on the way that care homes are regulated and held to account for poor delivery. Much of this has required changes to the type of paperwork care homes are asked to complete and changes to bureaucratic systems used to improve accountability and transparency in the system. Yet despite a raft of improvement agendas in recent years, can we be sure that changes to paperwork are improving care for older people? Is there a chance that demands on care homes to produce paperwork are actually having a detrimental effect on the quality of care?

Previous research commissioned by JRF found that there is a perception in some care homes that the burden of paperwork reduces the time available to deliver high-quality care (Owen *et al.*, 2012). The production

of paperwork as an assurance mechanism for quality can be a source of tension between providers of care and those who regulate and commission it. This report explores this particular challenge in more detail. It focuses on the paperwork employed in care homes to satisfy the needs of the various regulatory regimes to which they are subject and seeks to answer a simple, central question: does this paperwork help produce better-quality care? We have used the term 'paperwork' throughout this report as shorthand for the documentation generated in the provision of care and in response to legislation, regulation, commissioners and best-practice guidance.

In doing this work we have had two main aims:

- to collate and review the paperwork used in registered care homes for older people, with particular reference to regulatory requirements and risk management;
- to make recommendations for a more streamlined set of paperwork that both meets the requirements of regulators and provides greater scope for care homes to focus on relationships and what is important to older people.

Why is this report needed?

Public confidence in the regulatory and inspection regimes that should protect us when we are at our most vulnerable is plummeting and government initiatives to improve care quality and strengthen regulation are being announced at ever-shorter intervals.

In 2010, the Council for Healthcare Regulatory Excellence (CHRE) argued for a more proportionate and more agile process of regulation, with more insight and less oversight. Simply applying more regulation, it acknowledged, would not necessarily offer an adequate solution.

In 2011, the Commission on Funding of Care and Support (the Dilnot Commission) reported on its inquiry into the funding of adult social care in the UK. The report celebrated the fact that people are living longer but acknowledged that, for those needing care, this brought 'fear and uncertainty' over future care and support, and argued for a root and branch reform of the system.

In 2012, the Secretary of State for Health commissioned the Nuffield Trust to investigate whether there should be an 'Ofsted-style' rating system for health and social-care providers. Its report, *Rating providers for quality: A policy worth pursuing?* (March 2013), concluded that provider ratings could improve accountability and care quality, but with some caveats on how these were constructed. In particular, the report noted that ratings were highly unlikely to identify lapses in care, and that these would need to be linked to other surveillance systems in the health system in order to assure quality.

As part of its new regulatory proposals, the CQC intends to build on this initial work and, over the next three years, plans to develop a rating system that can be used to assess the quality and safety provided by an organisation.

Also in 2012, the government launched its 6Cs campaign, a three-year strategy to refocus nursing on the six principles of care, compassion, competence, communication, courage and commitment. And yet a recent poll on behalf of the Royal College of Nursing (21 April 2013) warned that 'nurses are drowning in paperwork' and spend 2.5 million hours a week on administration. Administration is clearly an 'A' not a 'C'.

In 2013 there were calls to organise the NHS around a single definition of quality – care should be effective, safe and provide as positive an

experience as possible. The role of the National Quality Board is to provide leadership for quality across the health and social-care system, and in its report *Quality in the new health system – maintaining and improving quality from April 2013* (January 2013), it states:

> Robust systems and processes to monitor, manage performance and regulate the quality of care provided to patients are essential. However, the success of these is almost entirely dependent on the values and behaviours of staff and organisations working throughout the system.

In addition, at the time of writing, the CQC is also consulting on changes to the way that it regulates, inspects and monitors care. It has recently announced, for instance, the appointment of 600 'lay inspectors' – members of the public with personal experience to carry out checks in care homes.

Yet despite these numerous initiatives and the more recent checks and balances introduced to improve the quality and safety of health and social-care services (Quality Surveillance Groups and a revised Adult Social Care Outcomes Framework – ASCOF – for commissioners, for example), relatively few organisations routinely have direct access to care homes, and inspection visits can be fairly infrequent and limited in scope. Those organisations that do routinely have access include:

- the CQC, the statutory regulator for health and social care, setting the standards for what providers should be doing and the outcomes that people should experience;
- local councils, which also commission care, and whose contracts with providers set out the quality of care expected, based on the ASCOF;
- the NHS, which undertakes inspections of care homes in its role as commissioner;
- professional bodies and individuals, such as social workers; and
- other less-frequent visitors such as fire inspectors and the Health and Safety Executive.

While these inspection visits and other regulatory arrangements have the potential to create a huge volume of paperwork for care-home providers, what they achieve in terms of safeguarding, raising care quality and improving the quality of life for care-home residents is less clear. Nor are they raising public confidence in care-home provision. A recent YouGov poll for the Alzheimer's Society revealed that, among those responding to the survey, 70 per cent said they would feel scared about moving into a care home in the future, 53 per cent said they would be concerned about the potential for abuse should a relative go into a care home, and 63 per cent said that care homes are not doing enough to prevent abuse.

Methodology

It must be emphasised that the complexity involved in exploring and assessing the regulatory paperwork generated in care homes cannot be overstated. There is no single standard format for paperwork production and homes may use different terminology for different bits of paper, or address their obligations in different ways. Many participants were unable to say how many bits of paper they produced, and were not always clear who these were for.

The project took an active approach to exploring the documentation required in registered care homes in an attempt to identify 'must-dos' – those aspects of care where paperwork was mandatory. Key stakeholders in the system were interviewed to explore how they view assurance and the role that paperwork plays in this process. We explored the results of this work with providers, service users and carers to understand how they view the relationship between the paper produced and the quality of care.

Central to the project methodology has been two key beliefs. Firstly, the purpose of paperwork should be driven by the perspective of those whom it is intended to benefit: the residents. Secondly, care should be provided in a way that creates and maintains high-quality relationships between care staff and care-home residents. A number of authors in recent years have elaborated what is meant by 'relational care' and high-quality relationships in a residential-care setting (Owen *et al*., 2012; Fox, 2013). In this paper, when referring to 'relational' care we simply mean care that focuses on improving the relationship (physical, social and emotional) between staff and residents.

Our inquiry centred on three care homes – two in Birmingham and one in York. We also interviewed two large national providers of older people's care, one medium and one small provider of care, membership bodies for the care sector (ECCA and NCF), adult safeguarding boards, commissioners of care services from local authorities, a strategic lead for adult and social care, a quality manager for a local authority, a social-care lead assessor, and of course the CQC.

One of the most valuable parts of the project was a practical exploration of the current use of the relevant paperwork, viewed from the perspective of residents, carers, relatives and volunteers, frontline staff and managers. A total of 25 in-depth interviews of this type were conducted. In addition, for two days we shadowed staff in the participating care homes as they undertook their duties. We also ran two focus groups with frontline staff and one with carers/volunteers.

We created a framework to help interrogate the purpose of the paperwork involved and the degree to which it helped meet aspirations for high-quality relational care. This framework consisted of the following themes:

- Purpose – what the paperwork is for, who decides this and whether it is the right purpose. We also explore the issue of ownership, and the extent to which paperwork takes account of what matters to people.
- Use/application – how the paperwork is implemented and used; views about its efficiency and effectiveness in addressing risks; whether it is the right tool for the job; issues of duplication and consistency of implementation.
- The role of paperwork in achieving high-quality care – what specific sets of paperwork set out to achieve, whether they achieve it and challenges in achieving it.
- Redesign opportunities – ways to improve paperwork, feasibility of doing this and the implications of change.

The chapters that follow are organised in relation to these four main themes.

2 PURPOSE – WHAT IS THE PAPERWORK FOR, AND WHO DECIDES THIS?

One of the first tasks for the project was to understand the 'must-dos' – what paperwork 'must' be produced and who says it is necessary.

The registration process and subsequent care-quality and safety inspections are regulated by the CQC. Regulation is centred around 'essential standards' of care quality and safety, which consist of 28 regulations set out in two bodies of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. For each regulation there is a related outcome – a description of the experience the CQC expects people to have as a result of the care provided by the care home.

Care Quality Commission regulations

When the CQC checks for provider compliance, it particularly focuses on 16 regulations that fall within Part 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The remaining twelve regulations are related to more day-to-day management issues within care homes. When concerns are raised about delivery against this set of regulations the CQC will follow this up with subsequent checks.

A brief summary of the CQC outcomes and their relationship to the regulations in Part 4 of the Health and Social Care Act 2008 is included in Appendix 1.

In addition to these regulations, the CQC states that providers also have to respond to a range of additional legislative requirements, such as the Mental Health Capacity Act 2005 and the Equality Act 2010. Responses to some aspects of these additional legislative requirements are covered already through the essential standards.

The CQC reported to us that there is no list of required paperwork for use in care homes. Yet it would be difficult to evidence achievement of CQC outcomes without key pieces of paperwork. There were a number of urban myths circulating among the care homes we visited regarding the paperwork that inspectors require. This generates even more paper as different care homes have different views about what is required.

In order to achieve a clearer view of the 'must-do' paperwork, we undertook a systematic review of the nine regulations that our interviewees suggested tend to drive the majority of routine care-home documentation. For each regulation we explored:

- whether the legislation made direct reference to the paperwork; and
- whether accompanying CQC guidance about best practice or the judgement framework for inspectors and description of outcomes refers to the use of paperwork.

Drawing on the views of care managers we interviewed, we also made an assessment about whether it would be difficult in practice to adhere to the regulation without producing paperwork. This analysis is in Appendix 2.

Of the nine regulations reviewed, only three referred explicitly to a requirement for paperwork in order to meet legal obligations set out in the Health and Social Care Act 2008. Yet having reviewed CQC guidance for inspectors and the judgement framework, there are clear expectations that paperwork of some description is required to respond to nearly all of them. In reality, care homes read regulations in conjunction with CQC guidance and available best practice. Without these additional pieces of information, a full interpretation of what is required cannot be realised.

Local quality-assurance and compliance regimes

Staff in each of the care homes we spoke to referred to additional quality assurance and compliance regimes that are devised and implemented locally – for example, paperwork relating to the funding of care for particular residents, or the need to meet regulatory requirements in other fields, such as health and safety, the Mental Health Capacity Act 2005 and safeguarding.

Care-home staff spoke about holding different types of contracts from different commissioners, while the English Community Care Association, the largest representative body for care in England, shared with us its members' concerns about the increasing burden of paperwork, duplication and alignment of the inspection process. One interviewee said:

"... the burden of contracts has increased. For example, I know of someone who went to his trustees with an NHS contract that was produced ten years ago – it was seven pages long – and one that was produced five years ago, which was clearly larger, and a current contract of some 1,000 pages."

Manager of care home

Interviewees relayed numerous examples of paperwork duplication. For example, the CQC and local safeguarding boards ask to see different incident reporting forms that play largely the same role. Staff at one care home we visited explained that in just a matter of weeks, the home was visited by

three different agencies responsible for assessing quality – by the CQC undertaking an assessment in relation to the essential standards of quality and care; by a local branch of the NHS undertaking a Quality Assessment Framework (QAF) monitoring visit; and on several different occasions by social workers from the local city council reviewing assessments that the care home had made about particular residents in receipt of council funding. These visits may be considered necessary – after all, vulnerable people are being cared for and we need to make sure that the quality of care is both good and safe. But to what extent do they represent a duplication of effort on the part of quality inspectors?

We reviewed the monitoring framework for the QAF visit in some detail and compared it to the CQC framework. There were a number of similarities. Despite the NHS inspection team having access to the recent CQC inspection report (they brought it with them to the inspection visit), they still continued to ask similar questions to the CQC inspection framework. The home scored 100 per cent in the NHS inspection and the care manager from this home was surprised that the NHS team did not focus on more thematic issues where there were areas for improvement identified by the CQC.

In practice, then, a wide range of agencies define the purpose of paperwork and are driving the production of it in care homes. Moreover, what those agencies require is not always easy to ascertain – first, because not all regulatory and commissioning guidance explicitly requires the production of paperwork and second, because if it does, it doesn't necessarily state what that paperwork should look like. A more concerning view is that paper production doesn't help us to assure standards – it appears difficult to trust what is produced, even if it is current and you have a copy of it to hand.

There seems to be very little co-operation between different regulators and commissioners, and some duplication arises when they ask for much the same information but with a twist to suit their own individual needs. There are also local variations arising from different commissioning regimes approaching the measurement and assessment of quality of care in different ways. From their point of view what is requested is reasonable; however, the impact of several commissioners asking for similar but slightly different pieces of information places an extraordinary burden on the home. This composite impact (the burden of all the requirements felt together) is often what care-home staff describe when they complain about the paperwork burden.

A more concerning view is that paper production doesn't help us to assure standards – it appears difficult to trust what is produced, even if it is current and you have a copy of it to hand.

Unreasonable demands

Some of the care-home staff we spoke to felt that commissioners' demands were sometimes unreasonable and extraneous. For example, at one they were asked whether they had a staff noticeboard – this was a commissioner requirement.

Several managers spoke about carrying out assessments for commissioners who wanted to understand the amount of time that residents spend on leisure activities, physical activity, using computers and so forth. One manager said she did not regard this request as unreasonable, but that the time required to track this information throughout the home was entirely disproportionate to the benefit received. For this manager, the degree of usefulness of this paperwork revolved around whether there was a direct relationship between it and the quality of the experience of residents in the home. "If no one wants to go on a computer this week, does it mean that we are providing poor care?" she wondered. We came across many

other instances where care-home staff felt questions asked in inspection and assessment exercises would not help determine whether the home was delivering high-quality care. Yet care managers frequently do not feel able to question the appropriateness of these demands:

"You've got to be quite strong to say 'I don't believe that's the case and I'm going to find out.' If it's the regulator coming in and saying something – it's a balancing act about whether to argue the toss too much. If you think the assessment isn't picking up the right things you have the right to ask the question. But people don't often want to because they are afraid of what the consequences will be."

Care-home manager

Another area of concern among care homes is the credibility of individual assessors. There were several comments about the ways in which information was judged and the lack of consistency in this judgement:

"You can challenge but you have to be careful – they have all the power and you have to make a judgement about whether it is worth it."

Care-home manager

The usefulness of paperwork

For paperwork to support care quality and be genuinely useful, staff have to see it as having a purpose – of fulfilling a function in their normal routines. There were some examples of this – the daily record sheet and care plan, for instance. One frontline care worker said:

"Sometimes in handover we don't see each other, if someone's late or already busy doing something. Without something like this [the daily record sheet and care plan] we'd struggle to get up to speed; I know I would – there simply aren't enough hours in the day. You've got to write some stuff down – but I do think it can be overkill."

Frontline care worker

But the examples of genuinely useful paperwork were few, and among the staff we spoke to most had very little say about what paper they really needed and found helpful to use. Only care plans, daily records, frequent assessments and risk assessments were consistently top of the usefulness list. When paperwork was seen as having a high value, or when people could recognise a concrete relationship between the paperwork and their role in the care home, then adherence to its completion was likely to be higher. One staff member suggested that despite a desire from staff to only use paperwork relevant to the job and to helping residents, often they still have to complete paperwork to protect themselves and care homes from litigation:

"People are taking people to court more often these days. It's about having the information there, so you can say what you're doing. We're doing it in case we get sued, not because it's in the best interest of the resident."

Frontline care worker

Summary

In summary, care homes have a list of core 'must-dos' informed by key legislation and embodied in 28 essential standards of quality and care. Yet different agencies also make requests of care homes and these requests have different emphases across the country. In addition to this moveable feast of 'must-dos', views about how guidance should be interpreted to meet funding or regulatory requirements also vary. Additionally, some requests made by inspectors and regulators are seen by care homes as bearing little relation to an assessment of the quality of care provided by a home to its residents.

Our interviewees tended to take the view that the absence of a definitive list of paperwork, and competing and conflicting inspections, reflected deeper uncertainties across the care system about what exactly high-quality care looks like and what should be valued in care.

3 USE AND APPLICATION OF PAPERWORK

Across the care homes that we worked with in depth, we were signposted to and collected 101 different pieces of paperwork, all of which informed the care of residents.

This was not an exhaustive collection, since we excluded more peripheral paperwork relating to the care environment (e.g. insurance certificates or assessment logs for equipment such as hoists). No one could point us to a definitive list of paperwork requirements. This reinforces the point that there is no single standard set of paperwork.

Types of paperwork

The chart in Appendix 3 provides a list of the types of paperwork produced across the three participating care homes. When we interviewed care-home staff we asked them about the type of paperwork produced, who tends to use the paperwork, how often it is issued and why it is produced. The chart identifies our analysis of: who the paperwork is mainly used by (frontline care staff or managers); whether it is primarily a response to funding requirements, regulators or established views about best practice; and how often the paperwork is used. We used this as a simple analytical tool to establish broad trends and patterns that could apply to the purpose and application of paperwork in care homes.

In summary, based on an analysis of what staff told us, we found that:

- About 70 per cent of paperwork is viewed as a legal requirement to help respond to particular regulatory regimes. About 50 per cent of the paperwork produced is felt to play some part in helping to deliver best practice. And about 6 per cent specifically relates to funder requirements.
- The majority of paperwork produced is used by managers in ensuring compliance with regulatory and/or funding requirements for the home.

- Paperwork used by frontline staff includes: records of patient consent, medical administration records, daily records of care, care plans, malnutrition screening tools, (bed) turning charts, hygiene charts, fluid balance and stool charts, monitor charts (weight, blood pressure etc.), activity plans for residents and various assessments (e.g. bed rail, breathing, continence, manual handling).
- The majority of paperwork that is used daily or regularly is used by frontline staff – managers and others tend to use paperwork more infrequently.
- About half of all paperwork generated by staff is then used by others on an 'infrequent' basis.

And overall, while all of the paperwork produced is arguably intended to benefit residents, in reality residents in the care homes that took part in this project had very little input into its production. For example, one social-work assessor we spoke to said:

"Our assessment pro-forma is rubbish; it doesn't give a holistic picture of the person. This is poor drafting and a lack of focus. Documents are generally driven by the supply side, what the system does, [rather] than the demand side, what the person wants or needs."

Social-work assessor

Challenges in the implementation of paperwork

Findings from this review were discussed with interviewees to understand more about issues of implementation, including how these different types of paperwork are used by frontline staff and managers in practice and the potential opportunities to improve the use of paperwork by staff. A number of key issues emerged.

Time

The time spent on paperwork is a huge factor and many of the managers we spoke with acknowledged that completing paperwork, checking others' completed paperwork, or helping staff complete paperwork took them away from precisely the leadership activities they should be engaged in to ensure high-quality care for their residents. One senior manager said approximately 20 per cent of her time – one day a week – was spent handling paperwork.

Value of paperwork

Different types of paperwork were attributed different levels of value by those completing them and using them for their work, linked to their direct usefulness, outlined above. Duplication of paperwork was a major factor in it being undervalued by staff.

Ability to make personal judgements

Some frontline staff felt that paperwork did not always allow them to use their common sense in interpreting information. While staff recognise that there is a set of rules by which they will be judged, some feel they are being assessed on each rule separately, rather than being left to use their own professional judgement to interpret the most appropriate response to the

system of rules as a whole. There are some areas of practice where staff feel they could achieve high-quality care with less paperwork if they were able to use their own judgement in interpreting this broader system of rules, rather than having to evidence a response to each rule separately. Some felt that their professionalism is being eroded by having to follow inflexible rules. For example, one interviewee said:

"They are making us do double risk assessments and I really don't understand that. There is a section where we have to put 'this resident is frail – we have to wash and feed them and they are at a greater risk of developing infection' – some of it is common sense. A frail resident is going to be at greater risk of picking up infection! A resident we feed and have to give drinks, we have to fill out a form to say they are at greater risk of getting a urinary infection because we give them drinks."

Frontline care worker

Internal duplication

How paperwork is organised and carried out also varies widely from provider to provider, while some duplication of effort arises not from regulators' requirements but from internal processes adopted by the provider. For example, staff at one care home we spoke to printed off individual client records for review despite having this same information accessible more readily and more speedily in electronic spreadsheet form. A staff member that we interviewed felt that eliminating duplication with just this one process would enable staff to spend more time with residents and less on paperwork.

Electronic record-keeping

Although staff at a number of the care homes we spoke to used standard electronic record-keeping systems, they all said these should not be seen as a silver bullet. They still require a degree of interpretation and adaptation to make them appropriate for the specific care home. As one interviewee put it:

"I know that people have electronic records – when I arrived at [the care home] we had just bought a package, but to be honest you still need to understand what needs to be done and make modifications that suit your home. If you don't understand what you are doing, then you can't tell anyone about it – which means that it becomes even more of a tick-box exercise. I know that some homes are fully computerised and have policy teams that sort all of their compliance issues out – in my view this is like comparing Tesco's to an independent retailer."

Care-home manager

Keeping abreast of changes in policy and regulation

Some of the care homes we encountered had dedicated quality and policy staff responsible for staying abreast of changes in the regulatory, legislative or funding landscape. But in smaller care homes this job is typically left to the CEO or a senior manager who must fit it around their other responsibilities. One manager said:

"The CQC tells you that it is all up to you – but this is a bit of a cop out. It is still your responsibility to be up to date about what you do in your home and, for a small provider like us, this is a nightmare. We subscribe to a number of membership organisations; of these, the National Care Forum is the best. They send you a weekly newsletter which describes all the changes – in honesty, it takes me a week to go through it all and much longer to review the changes and think about what this means for our home."

Care-home manager

This same manager also recognised that there can be disadvantages in not reviewing changes in legislation or regulation 'at source', relying instead on second-hand sources that may reflect inaccurate interpretations. Balancing paperwork completion with care responsibilities presents particular pressures for providers with limited staffing or those struggling to achieve economies of scale and/or viability.

The quality of written information

The quality of what is written and how this is judged were areas of immense concern for all of the homes we spoke to. Care-plan completion was identified in particular. Among the most frequently cited obstacles to high-quality completion of paperwork were high staff turnover and poor literacy or English-language skills. One interviewee said:

"I had one carer years ago, I can't prove it but I'm very sure that she couldn't read and write. She'd never got her glasses or she'd forgotten her pen or ... suddenly the penny dropped and I really don't think she could write and I backed off after that."

Care-home manager

Opportunities to improve implementation of paperwork

As can be seen from the above examples, care staff can struggle to digest the large amount of information and regulatory requirements they are expected to respond to in their work. Many managers we spoke to recognised that some of their staff did not have the skills necessary for completing paperwork to the required standard. Yet most of our interviewees also said that improving staff responses to paperwork doesn't necessarily improve their care practice. For example, writing down a risk isn't the same thing as being able to comprehend the nature and implications of what could happen to a resident.

A lot of power is attributed by the care system to what is written and how it is written. The pen might be mightier than the sword, yet a caring word or touch is of higher value to a resident than what is written down. Even though we say that we value caring skills, the rewards in the system are heavily weighted to paperwork completion.

While implementation of the paperwork to a sufficient standard remains a challenge in care homes, focusing primarily on staff members' ability to complete paperwork risks ignoring the other skills they are required to have and to nurture. Unnecessary differentials and division of labour are being

Even though we say that we value caring skills, the rewards in the system are heavily weighted to paperwork completion.

created within homes based on people's ability to fill in paperwork. We know from our interviews that this can have the effect of alienating people from their job and reducing their sense of vocation. Managers that we spoke to expressed concerns that the broader funding and regulatory environment places more emphasis on the ability to complete high-quality paperwork than to deliver high-quality care.

Staff we spoke to at two care homes told us of job roles that had been created primarily to support the completion of paperwork. In addition, a vast amount of management time is spent checking paperwork. Instead of being on the floor, demonstrating the caring skills and the value of care, leaders are in the office ploughing through care plans and risk assessments.

Summary

In summary, in the care homes where we interviewed staff, about half of the paperwork produced was used infrequently. However, staff still felt they had to produce it. Staff we spoke to felt the primary purpose of much of the paperwork produced was to ensure legal compliance. In some cases, staff felt that paperwork was designed inefficiently. In other cases, paperwork seemed to be inefficiently implemented, with some room to eliminate or streamline wasteful internal procedures.

It would be easy to regard the written quality of the paperwork in some homes as merely an inevitable language issue – but this is not just about being able to read and write English. It is also about knowing what to write, how to write it, who the readers are, and how what you have written might be interpreted.

The burden of paperwork can take managers in care homes away from precisely the leadership activities they should be engaged in to ensure high-quality care for their residents. Care staff that we spoke to suggested that frontline staff and managers should be judged primarily on their ability to deliver good care or on the effectiveness of their leadership and management – not on their ability to fill in or check paperwork. But the latter is precisely what sometimes happens.

4 THE ROLE OF PAPERWORK IN ACHIEVING HIGH-QUALITY CARE

So far, we have considered who defines the purpose of paperwork, whether people feel it is the right purpose and how paperwork is implemented. As a next step to understanding the relevance and value of paperwork in care homes, we analysed whether particular types of paperwork helped to achieve the intended outcomes.

In order to assess this we focused on three specific areas of activity and their associated paperwork:

- care planning and associated daily records;
- risk assessments; and
- staff supervision processes.

For each activity we asked care staff about what they wanted to achieve from the paperwork in relation to achieving high-quality care, whether they felt the paper helped to achieve this and, if not, why not. The results for each activity and set of paperwork are summarised below.

Care planning

What should the paperwork do?

While we identified several different versions of care plans, all of them aimed to achieve one or more of the following broad aims:

- to capture the results of a general assessment in a way that would describe the type of care the resident needed;

- to capture progress against a planned programme of care and provide a clear record of high-quality care to a range of people that are interested in that care (e.g. residents, families, care staff and other agencies).

Those that had tried to develop shorter or more focused care plans recognised the tension that exists between regulators' and commissioners' demands for more detail:

"When we started doing care plans they were more of a tick list that came out from the CQC, but we did just tick the box but that wasn't enough and now we write an essay and it's still not enough."

Frontline care worker

Two of the care homes we spoke to were modifying their care-planning documentation to make it more useable for staff and residents, and to better engage residents in the care-planning process. For example, one national care home described how its previous care-planning process had been both 'weighty and bureaucratic', necessitating the employment of staff specifically to undertake care-planning management. The new documentation was planned carefully with 'customers' in mind, the aim being to engage residents as fully as possible in the care-planning process and make it more meaningful for them.

The care plan in practice

A number of interviewees referred to the problem of the care plan being out of date almost as quickly as it is written. All agreed some kind of record is required to establish benchmarks and targets, and to provide periodic guidelines for personalised care, but many also suggested that care plans should be supplemented by high-quality communication and additional day-to-day processes that ensure continuous and responsive care. As one carer put it:

"I never go to a care plan. If I want to know something I go to [name of colleague], the team leader, and ask 'how is this resident today?' The care plan could say something but it's only reviewed every three months. It only says hygiene things as well. They might need a two-handled cup but in three months' time that could totally change."

Frontline care worker

Care plans were felt to work well when they didn't just contain core information about care requirements, but also allowed flexibility to 'side-step' sections that were either not relevant to the resident or which professional judgement suggested might be better discussed in a different situation (e.g. including with a relative). In some homes, the option to miss sections out did not exist, or staff didn't feel confident enough to do this. As a result, there was a risk that the process could seem overly mechanistic both to the resident and to staff, the unnecessary questions detracting from the value of the care-planning process and acting as a turn-off for both staff and residents. Staff also reported a lack of clarity regarding which parts of the care plan play a predominantly administrative or regulatory role

(over which the resident has little control or ownership) and which parts are appropriate for greater resident input and ownership.

Staff felt residents' relatives and friends see a value in care plans because they give them reassurance. And yet family members and friends who already considered the resident to be receiving high-quality care (as they saw it) often didn't feel it necessary to consult their care plan to confirm this. One family member, for instance, said that she didn't need to refer to the care plan because the communication from staff about the resident's progress was exemplary.

Risk assessment

What should the paperwork do?

There is a significant body of literature about the role of risk in caring professions (Kemshall and Wilkinson, 2011; Lindley *et al*., 2012) and a broader debate in policy circles about how best to manage risk effectively as it relates to older people. As Lindley *et al*. (2012) suggest, the vulnerability of older people raises especially difficult social and psychological challenges in managing risk for users and providers of care. Some commentators have called for a move away from the traditional view that risks should be eliminated to a view of positive risk-taking in which risks are embraced, discussed and balanced to identify 'tolerable' and 'intolerable' risks (Carr, 2010). Our study identified a number of examples where staff have faced challenges in defining and managing the risks faced by residents and staff in care homes. This is reflected in the way that the aims of risk assessment as defined by the care staff we spoke to differed both within and across care homes.

Staff recognised that risk assessments were a necessary part of responding to a broader system of regulatory or commissioning compliance and of providing protections for residents. But for many, a tension exists between these two aims of risk management. Conducting a strong and robust risk assessment was a good way to demonstrate that risks had been considered, but assessments could also be used as a means to prevent risky behaviour and as a defence in the face of potential litigation.

The majority of care staff we spoke to felt that they should be aiming for the enablement of residents through positive risk-taking. The aim of risk management in this sense was to help the resident to live and receive care in a way that they value.

Risk assessment in practice

All care managers we spoke to offered examples of using risk assessments in a way that encouraged or enabled positive risk-taking. For example, staff in one care home talked about how a resident had said that he enjoyed going for walks to the shops. However, as his memory was deteriorating due to Alzheimer's, there were also risks involved in him not finding his way back to the care home. Having conducted the risk assessment, they found a solution that would enable the resident to walk to the local shops on his own – but with a volunteer at the care home following him to ensure his safety. The manager in this care home recognised that this may not have been possible were they a smaller provider with less capacity and resources.

One interviewee suggested that in the risk-assessment process too much emphasis is placed on avoiding risk for care homes as opposed to managing risk for the resident:

"I sometimes think that if you can evidence that you have done your best to minimise risk, I think risk assessments do need to be changed by putting in something that shows it's not just about the risk if they do it but the risk to the whole person if they don't do it. So saying someone can't go into the garden any more because they can't stand up, what risk is there to their emotional and psychological self? What other things might you be able to put in place to minimise it again?"

Care-home manager

Yet there were also examples of where risk assessments either hadn't been conducted, hadn't been conducted effectively or their results had not been adequately considered by staff. For example:

"You've got the sort of things where someone didn't write about risks associated with diabetes and thinks you can go and chop toenails and it doesn't matter – so detail is important."

Care-home manager

Staff find it difficult to strike a balance between defensive risk assessment and achieving positive, enabling risk-taking, but the reasons for this seem to be less to do with how the risk assessment forms are written and more to do with how they are interpreted by staff. Some lack confidence in distinguishing between 'tolerable' and 'intolerable' risks and some have strong preconceptions about what constitutes risk. Either scenario can lead to staff seeking to eliminate risk even before it has been properly considered or discussed with residents and their relatives. For example, a care-home manager told us about a member of staff that had denied a request from a resident for her to be able to make her own cup of tea in the kitchen on the grounds of health and safety concerns. The manager told that member of staff that this was a mistake and that "this is her home". She explained to the staff member that if there was no reason why the resident posed an unacceptable risk to safety (e.g. if she was not unsteady on her feet) – then there was no reason why she should be prevented from making her own cups of tea. A care-home manager suggested that this tendency to take the path of least resistance and to say 'no' to potential risks was at times reinforced by the actions of regulators or commissioners. She provided the following example of a visit from a fire officer:

"The fire officer went in and gasped, 'What have you got stuff in the corridors for? It will burn!' The way I saw it was that if she [the resident] was at home she could have this stuff like that – this is her home and you've sometimes got to stand up and say that to someone. It's a challenging area though ... You've got to be sensible, you can have things on the walls, but you can't block a fire exit. There's no reason why you can't make a place look homely, instead of like an institution; nobody wants to live in that, but when the authorities come in, it's hard to stand there and say 'I don't want to do that'."

Care-home manager

Care-home staff can also face an uphill struggle in encouraging positive risk-taking while also trying to demonstrate to regulators or commissioners that risks which might harm residents have been mitigated. Some described the necessity of repeating risk assessments (e.g. bed-rail assessments) to ensure that commissioner or regulator expectations were met when, in fact, the needs and situation of the resident had not changed. On balance, providers tend to play it safe, avoiding even 'tolerable' risk in favour of protecting themselves from litigation.

Supervision and support of staff

What should the paperwork do?

The supervision process in a care home is fairly rigorous both in relation to frequency and in ensuring accurate record keeping of courses, training and other information about each member of staff – and according to the homes we spoke to, this is an area that CQC inspectors always scrutinise closely. Managers that we spoke to told us that supervision is intended to support staff to improve the quality of their professional practice, but there were many reasons why this did not always happen.

Supervision in practice

The managers that we interviewed were cautious about the practical relationship between staff training, supervision and the ability of staff to delivery high-quality outcomes for residents:

"I'm sure that staff will have very mixed feelings about the purpose and usefulness of the supervision process."

Care-home manager

When we asked frontline staff about the usefulness of paperwork and processes associated with supervision, most indeed had mixed views, with the majority seeing it as just another hoop that had to be jumped through:

"It's OK – it comes round sooner than you know it."

Frontline care worker

"I'm not sure it makes us good at our jobs because it's just a process."

Frontline care worker

The skills required to motivate, coach and support staff should not be underestimated. Supervision, if it is to be more than a paper exercise, requires skill and experience, and staff do not always feel equipped for this. When we asked managers whether supervision was used as part of a disciplinary process, the general consensus was that the process rarely reached disciplinary action. But this was not because managers found other ways to support staff and improve their performance; more frequently, they admitted, it was because they 'ignored' the policy rather than embark on disciplinary action – which many still regard as a generally distasteful and difficult process. Overall, even among those who resorted to this tactic, it was felt that there were few consequences for staff who failed

to follow policies and procedures, unless infringements were to do with safety or risk.

"They come to me when they get sick of going with the flow – and say 'deal with it' – but there's often nothing recorded and if supervisors don't do their part or if warnings aren't given, then it's back to square one."

Care-home manager

Even where disciplinary measures were used these were rarely prompted by a lack of vocational commitment from staff – they were much more likely to be because of failures in the completion of paperwork.

In summary, the following issues emerge:

- The supervision process and associated paperwork are undertaken rigorously and this is an area that CQC inspectors always scrutinise closely. Yet this does not always result in effective staff development and performance management practice. For some, the supervision process was seen as a necessary 'hoop' to jump through as opposed to a support mechanism that would help deliver better outcomes for residents.
- Even when adhering to supervision policies and procedures, opportunities to identify and respond to staff development needs or poor care practice can often be missed. In particular, staff can lack the confidence or the skill necessary to use supervisory and disciplinary processes to support care staff and improve care practice.

Summary

This section has explored care staff's perceptions about whether paperwork is helping to achieve high-quality care in three distinct areas of practice (care planning, risk assessment and staff supervision). In the next chapter, we explore how relatives and carers of residents feel about the contribution of paperwork to high-quality care. We also ask whether paperwork and procedures in care homes, as currently configured, create sufficient space to capture those aspects of care that residents, relatives and carers really value.

5 PAPERWORK AND ITS CONTRIBUTION TO ACHIEVING WHAT RESIDENTS VALUE

This report has explored the purpose of paperwork in care homes, how paperwork is used in practice and whether paperwork achieves the purpose it sets out to achieve.

A central, underlying theme of this research has been to understand whether paperwork helps or hinders the creation and maintenance of meaningful relationships between care staff and care-home residents. To achieve this, the purpose of paperwork should be driven by the perspective of those whom it is intended to benefit: the residents. This chapter asks whether, and in what circumstances, the paperwork reflects the voice, choices and needs of residents.

The evidence base for *My home life* (Owen *et al.*, 2012) highlights the value of meaningful relationships, and personalised and respectful support, as two of the things that older people most value. It is these interactions between people that form transactions of care, and it is the quality of these transactions – the balance of influence between residents, relatives and care staff and how things are done by people to people – that are of ultimate value.

"In terms of care plans I know that my Mum and Dad's care plans are there and available to look at. I haven't felt the need because the communication between myself, my family and the staff here is exemplary."

Care-home volunteer and relative of resident

We held two focus groups with relatives and carers, and they all talked about the ethos of care – the opportunities they had to be heard and listened to,

the quality of care experienced by their loved ones, and their belief that their relatives had opportunities to participate as equals in the care process:

"There have been plenty of opportunities where someone could have really lost patience with my Dad; in the last day he chucked his bananas and custard over the whole table and now he's on liquid medication and he threw a whole basket of stuff over the nurse. No one has ever lost patience with him and that for me means I can go home knowing that no one will act in a fit of frustration. That to me is so important that no one is judging someone whose capabilities have been diminished."

Relative of resident

Paperwork had very little to do with the views that relatives and carers had about the quality of care that their loved ones received. Among the homes we worked with, there was an appreciation from relatives that residents were regarded as people and that their wishes as people were (in the main) met and met well. Homes that went out of their way to do things for residents that were thoughtful and showed extra care and attention – taking a resident to a cricket match, say, or arranging a visit to the botanical gardens for a resident who had been a keen botanist – were singled out and commended for enabling residents to live more enjoyable, meaningful lives.

We saw someone in the final stages of dementia stroking a hamster. She appeared to be comforted by the action. She may have had little awareness of what was happening around her – but she was in no way ignored. In group-care settings, how everyone is treated becomes critically important. If individuals require different types of interactions to address their needs (as is usually the norm), the quality of this interaction can be directly observed in the behaviour of staff and in transactions between care staff and residents. If someone is ignored, admonished or treated poorly, this can set the tone for the whole ethos of a home. The quality of care transactions can respect – and preserve and protect – the value of the individual. But paperwork captures very little of this. It can record likes and dislikes, what has been done and what should be done. Many homes have spent time supporting frontline workers to enable them to write more descriptive care plans – but it is unlikely that recording this information can really capture the ownership, choice and the quality of transactions between people.

If someone is ignored, admonished or treated poorly, this can set the tone for the whole ethos of a home.

We came across one organisation, Sue Ryder, which through the organisation of its paperwork was giving weight to resident voice, choices and needs. The model privileged this information above other paperwork that the home needed to generate. This is described in the case study below.

Case study: Sue Ryder model

Sue Ryder has used service-user feedback as a means to drive revisions in the organisation of paperwork. The system places the service user at the heart of the documentation by simply describing 'them' – what a good day would look like for the service user, their likes, dislikes and so on.

It has a simple diagrammatic front sheet indicating whether additional support is required in other areas (communication, for example) to enable care needs to be met. The frontline care worker is therefore

only signposted to documentation that they need to in order to carry out effective, quality care. This information is called the Server User's Support Plan, and is contained in folder 1.

Folder 2 is the Service User's Health and Wellbeing Folder. This contains information such as letters from hospitals, service-planning tools, details of support plans/risk assessments, signature logs and review documentation.

Although simple, the design enables the service user's daily care to be separated out from the reviews, assessments and other documentation that are necessary for staff to understand what has been done and what needs to be done. The referencing between the two sets of documentation means it is always possible to see personal information about the service user first and ensure that this is used as part of any caring interaction.

Staff have to be well inducted in the use of this model, but it does get away from having a huge folder of information that can make it difficult for staff to find, use and update the bits that are most relevant for them.

This system has had good feedback from the CQC and, most importantly, from service users and their relatives, who are able to look at folder 1 and recognise the personality and needs of their loved one.

Even though the merits of the model are recognised by both residents and carers, paper cannot shape an ethos of good care – this has to be there from the outset. Paper can, however, get in the way of the interactions that both residents and staff value the most. It is the quality of interaction, not the paper, which determines greater choice and self-determination.

6 CONCLUSIONS

This project set out to explore whether the burden of paperwork as described in previous research (Owen *et al.*, 2012) has a detrimental impact on the delivery of high-quality care. In particular, we were interested in whether the production of paper, as an assurance mechanism for quality, directly benefits the resident.

Who benefits from 'the paper'?

We found that regulators and commissioners assume that residents benefit from the completion of paperwork. Yet the indications are that residents, rather than being the beneficiaries of regulatory regimes and their accompanying paperwork, are often at their mercy. Not only is it possible to comply with paperwork while failing to provide good-quality care, responding to regulatory and commissioning requirements can also actively prevent delivery of good care in some instances. This happens mainly through reducing the amount of time staff members have to undertake other care responsibilities. Yet paperwork and responding to compliance regimes can also influence the behaviour of staff in a way that limits effective practice (e.g. through risk management that does not enable residents to do what they value in their lives, or through care planning that does not adequately reflect the voice of residents and their families and carers).

The balance between prevention of poor care and promotion of good care appears to be out of kilter. Care homes spend an inordinate amount of time attempting to cover themselves for fear of potential blame or litigation for poor care. Paperwork has become an industry in its own right, fuelled by a sense of fear and insecurity.

Paperwork has become an industry in its own right, fuelled by a sense of fear and insecurity.

In this sense, it becomes difficult to see how paperwork could ever affect the types of relationships, values and human kindness that older people say they want from their care. In particular, the ability to capture on paper the transactions between carers and residents that make for high-quality relational care is limited, and much more needs to be done in the inspection and judgement process to increase the weight given to observed high-quality care relationships in homes. Used in this way – to assess all of the

other aspects of a care home's working culture and care ethos – paperwork could help contribute to better-quality relationships and to strengthening residents' voice in the care process.

What does the paperwork 'take away' from care?

Paperwork, rather than enabling care quality, can have the reverse effect. Its configuration and implementation, instead of being an addition to care value, can lead to 'subtractions' in care – by this we mean that there are things that the paperwork literally takes away from the delivery or management of care. Five of the most significant subtractions are described below:

Subtraction 1: leadership

In one home a senior manager estimated that she spent approximately 20 per cent of her time – a day a week – completing or checking paperwork. This was time she thought would be much better spent on leadership activities and being visible in the home to support others and to demonstrate through her actions how to build good relationships with residents and staff. Other managers interviewed also spoke about the time spent checking, completing, revising and organising paper and reading guidance. One manager spoke of her inability to catch up with implementing best-practice guidance, as updates were received on a weekly basis.

Subtraction 2: value of care

Some felt that the value being placed on paperwork was too high compared to the value placed on providing high-quality care. The Francis Report (2013) suggests one way to get student nurses to value dignity and respect in care settings would be to expose them to work on the frontline as healthcare assistants. Yet our review suggests that at the frontline in older people's residential care, a disproportionately high level of value is being accorded to filling in paperwork as opposed to issues of relational care. Getting carers to be more caring will solve issues of poor care, but only partly. We must also consider whether the system values the caring things that those carers do. The system has to value and reward caring qualities in order for this to happen.

Subtraction 3: vocation

Quality assurance and associated regulation focus on assuring the paper rather than the care. As a result, within homes, staff members were sometimes judged and performance managed in relation to their ability to fill in paperwork, rather than on their ability to provide high-quality care. There should be capacity to employ people who like to care for others and are good at this – after all, this is what we say we want care to do. However, unnecessary differentials in capability are being created because people are judged on their ability to fill in paperwork more than on their ability to deliver good care. The division of labour within homes based on people's ability to fill in paper can have the effect of alienating people from their job and reducing their sense of vocation. For some, this takes them further away from the reason that they entered a care profession in the first place.

Subtraction 4: co-operation

The paperwork doesn't drive providers, commissioners, contractors and regulators to higher levels of co-ordination and doesn't help them to establish a shared value system for care. The paperwork makes no

contribution to co-operation between agencies and people within the care system. In fact, in some ways paperwork plays an active role in destabilising co-operation.

Subtraction 5: professional autonomy

Regulation can lead to regularisation. It can reinforce the mechanistic nature of some care practice, for example, regular bed-rail assessments. Everyone would agree it is good to check, but not if this checking and double-checking erodes professional autonomy. We need people to take action in a system of care because they recognise that it is the right thing to do at the time. We also need procedures to help to support elements of their role. Routine cannot be a substitute for thought – it cannot substitute for timely professional judgements and the danger is that, if it does this, it reduces the authority of the professional and their belief in their vocation.

Preventing poor care or promoting good care?

It is clear the balance between prevention of poor care and promotion of good care appears to be out of kilter. Care homes spend an inordinate amount of time attempting to cover themselves for fear of potential blame or litigation for poor care. Paperwork has become an industry in its own right, fuelled by a sense of fear and insecurity.

7 RECOMMENDATIONS

In conducting this study, we set out to explore the design of a more streamlined approach to paperwork that could help care homes respond to some of the inconsistencies and challenges this report identifies.

Our practical engagement with care homes has prevented us from making the somewhat naive assumption that sorting out paperwork would be a silver bullet. No one, in any of our interviews, thought that changing the paperwork would help if tackled in isolation from other factors that influence care practice – commissioning and regulation.

In addition, we found that while the idea of redesigning paperwork is an interesting one, paperwork doesn't currently exist in that way. There is an assumption among the different agencies involved that paperwork exists as a coherent and functional body of documentation, yet in reality this is far from the case. Different care homes apply different approaches to paperwork based on their own reading of what good care means and their own reading of the regulatory and commissioning requirements placed upon them. Paperwork is also a historically accreted mishmash of a wide range of legislative and regulatory drivers that have come about over many years. This affects the likelihood of redesigned paperwork being adopted across the board by care homes. In reality, in order to stand a chance of adoption, a redesign of the paperwork would either have to be so compelling that its simultaneous adoption by all of the players involved was assured, or it would need to be sufficiently flexible to enable care homes to interpret and use it in a way best suited to their circumstances and operation. Neither scenario is likely.

With this in mind, there are perhaps two ways of looking at recommendations for future paperwork. Firstly, there are some limited steps that could be taken to improve paperwork in the short term. Secondly, there are recommendations for longer-term systemic change (in terms of what is judged and how it is judged). This, in our view, provides more opportunities for improving the effectiveness, meaning and impact of paperwork in residential care.

Short-term recommendations

We identified some steps that could immediately improve paperwork processes. However, it should be noted that these tweaks to the system are unlikely to have a positive impact on care quality if they are not accompanied by longer term, system-wide changes (see below).

Incident reporting

Come to an agreement between the regulator (CQC) and safeguarding boards on the acceptance of one form for incident reporting. The CQC should take this on as part of addressing the government's red-tape challenge. This will help to prevent duplication of effort and of paperwork.

National inspection criteria/improved information sharing

Improve the alignment between the CQC, NHS and local commissioners about which areas are currently inspected (e.g. QAF and essential standards of care) and the paperwork that is requested and generated by care homes against these areas. Information produced by different regulators and commissioners appears to have no shared currency. Regulators and inspectors should be able to use reports that have not necessarily been generated by them as part of a joined-up process of assessing care.

Homes spend time preparing for inspection processes and produce information individually for each regulator. This can obviously be time-consuming and there may be opportunities for better alignment between inspectors as the CQC revises its inspection process.

Local geographical alignment

In the short term there would be merit in bringing together regulators, commissioners and care homes to identify some 'quick wins' at a local commissioning regime level that would help to reduce unnecessary duplication for care homes in that area.

This would demonstrate a model for co-operation across a range of regulators, commissioners and providers in a locality. It would increase clarity, save time and therefore have the potential to improve care quality within homes.

Organising the paper for different audiences

This study has shown that paperwork could be better organised to respond to the needs of different audiences. Firstly, a set of paperwork that residents can refer to and use, with basic information about their care needs and preferences, would be better owned by the resident. Secondly, a set of paperwork, which care staff need to use for daily care, risk or referral purposes, could be separated out for ease of reference. The Sue Ryder model is an excellent example of how paper could be organised along the above lines.

Long-term recommendations

In the introductory section of this report, we painted a picture of the environment in which care operates. It is an environment of major NHS reform, of system and process changes, of promises made to the consumer and of increased scrutiny and a strong belief that care may be in crisis. Attempts to improve paperwork in ways that improve quality must recognise this political environment. If they are to stand a chance of gaining wider

credibility, they must also respond to the frustrations and inconsistencies within the care system that many of the interviewees in this project have identified. But most importantly, this project has identified that approaches to judging high-quality care need to be more heavily informed by notions of relational care and what residents and providers think is important.

What follows are recommendations for the types of high level, systemic, behavioural and attitudinal changes required to create the kind of environment in which compliance and monitoring activities in care homes work to support the type of person-centred, relationship-based care residents value and care staff want to provide. We have limited ourselves to the three changes that we think would have most impact on the residential care system as currently configured.

Resident/provider-driven definitions of quality

There were more than 100 domains of quality, health and safety recorded through the paperwork we reviewed. Yet when we spoke to residents, carers and their relatives they relayed a relatively small range of domains of quality that they valued above all others. The development of a resident/provider-led approach to defining quality would be a useful step towards prioritising and ultimately reducing some of the domains of quality that are recorded through paperwork on a day-to-day basis.

The Sue Ryder example (included in this report) involved a process that enabled residents to identify what is important to them, and for staff to respond to the standards of care created on that basis. Staff and volunteers were trained to deliver against this model. This was well received by residents and staff alike, and staff said they felt clearer about what they were expected to do to achieve high-quality care.

There is a huge opportunity for care homes to engage in a similar process, identifying the 'moments that matter' to residents, relatives and staff in the provision of care. Consultation with staff, residents and relatives will help to create a shared (and negotiated) agreement about what good-quality care looks like – but perhaps more importantly, it would also help to emphasise that care is and should be a shared endeavour.

This bottom-up vision of care quality should then form the basis of how care homes are judged by inspectors and commissioners alike. This will require inspectors and commissioners to take an approach to assessing quality that engages more with a care home's own mission and vision for delivering high-quality care. Common standards of care quality would still be used to assess a care home, but assessors would also look at how a home demonstrates its fit with these universal standards of care, thus ensuring a meaningful and personalised assessment.

The need to judge what we value

Assessment is usually based on a very narrow definition of compliance. Translated, this often means using the right forms and completing them in the right way. This version of compliance gives no weight to the meaning of choice, participation, dignity or respect. These are observable in the day-to-day transactions between residents and staff. Observing and judging the quality of those transactions is one way of thinking about judging the relationship between care staff and residents.

The CQC is planning to focus more on the observation of care in the future. Any observed assessment would need to focus on understanding transactions in care homes. This project has identified different dimensions of those transactions – of the relationships between care staff and residents – that people living and working in a care home really value. These include:

- There should be a recognition that people – residents, relatives, care-givers – have a shared interest in shaping and defining what is meant by good care. Inspectors should be able to observe a mutual understanding of what good care looks like across all residents, relatives and care-givers.
- Inspectors should also be able to observe the everyday give and take between people in a care home. This involves the equal and effective negotiation between care-givers and residents about what people can and can't do in a home. It involves a shared understanding and acceptance about why particular decisions have been made about the provision of care.
- High-quality relationships exist when care-givers and residents have a shared understanding of tolerable risks. Good care would see the primary role of risk management as enabling residents as opposed to defending the home from potential litigation or reputational loss. Inspectors should be able to observe an asset-based approach to care. This takes as its starting point 'what can a resident do?' as opposed to 'what support does a resident need?'

While clearly not exhaustive, this framework goes some way towards understanding how a positive ethos of care can be supported and encouraged. It would require strong leadership in homes to promote the kind of mutuality, trust and positive risk-taking required for relationships within care homes to improve.

We are not suggesting that the quality of each transaction is recorded by staff using this framework. Instead, we are recommending that principles from this framework could be used to train staff to understand how they practise transactional care.

In the observation process, inspectors could use a framework like this to develop more sophisticated questions for residents and care staff about how residents have a choice, how they participate in decisions about their care, and why particular care decisions are made by staff.

In addition to being guiding principles for the provision of relational care, these principles should also be echoed in the relationship between providers, regulators and commissioners.

Risk enablement and collective accountability

As suggested above, care relationships should begin by asking what residents are able to do, rather than what they can't do. This enables risks to be taken, rather than focusing on protectionist strategies that may make homes more risk averse. Yet if this is to happen in practice, a number of changes are required in the way that care staff are supported and in the way that the system as a whole perceives and responds to risk.

At a care-home level this requires support and professional development for staff to understand: how to identify risks, how to discuss them with residents and/or relatives and friends, and how to discuss and negotiate the management of those risks in a fair, open and proportionate way based on the principles of relational care (described above).

Current approaches to risk-assessment paperwork require care homes to report in a way that can be mechanistic and repetitive, with staff asked to complete regular assessments even though a resident's situation has not changed. There are arguments for the introduction of exception reporting on some of these types of risk assessments, such as bed-rail assessments.

Yet perhaps the most pervasive threat to effective risk enablement is the lack of collective accountability in the system. Providers, commissioners and regulators need to get to a point where they have a shared investment

in achieving high-quality care. Currently, one of the reasons this does not happen is a fear of being blamed for failure. The more distance providers, commissioners and regulators can create between themselves and blame for poor care, the better.

To understand how we generate that shared investment and collective accountability may mean looking to other industries. In the aviation industry, for instance, there is a much clearer and definable sense of collective responsibility. Yes, individual accountabilities do exist – a plane manufacturer constructs the plane, its suppliers make the parts, the pilot flies the plane and an airline hires the pilot. Yet at the same time, everybody in this industry has recognised that it is in nobody's interest for planes to fall out of the sky. There is collective accountability and sharing of cost too – people within the industry directly fund the aviation industry's regulator, for instance. The risk management for the strategy is mutually agreed across people working in the industry.

In practice, this means that at a care-home level, additional training and activities to specify what a care home means by risk enablement will need to be undertaken. At a commissioner and regulator level, inspectors should be supported to understand how to observe risk enablement in transactions between care staff and residents. In addition, exception reporting of risk assessments should be introduced for topics where providers are expected to undertake continual and repetitive risk assessments (that produce the same result each time). At a system-wide level, a national discussion is required to identify barriers to the development of collective accountability in the residential-care sector for older people. This paper has identified some of them, but more dialogue and openness is required from key stakeholders (government, regulators, providers and the media) about how to move beyond a culture of fear and blame in this sector.

A final word

A fascination with paperwork as a way of judging quality perhaps points to the wider culture of literacy within our society – a mistaken belief that if what is written is written well, it can be trusted; a belief that what is written is a form of assurance. A frontline care worker we interviewed said:

"It's all a bit silly really, anyone can write a good care plan."

Frontline careworker

She was describing her belief that writing a good care plan was something that anyone could be taught to do and didn't necessarily mean that good care resulted from this as a consequence. But we have also discovered that writing a good care plan is not something anyone can do, and there are different views about what a good care plan reads like.

It isn't that paperwork has no value – many people spoke about how it is required in order to understand the administration of medicine or to record when things have been done, because memory alone cannot be relied on. But paperwork is only a tool, and an imperfect one at that.

If paper is to be of value then we must be clearer about the values we can attach to it. And our preoccupation with getting the paper right detracts from where the real effort should be placed. Without a clearer view of how we account for what we value in care, paper can and will continue to offer us false assurance in the care process.

Without a clearer view of how we account for what we value in care, paper can and will continue to offer us false assurance in the care process.

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APPENDIX 1

Table 1: CQC outcomes and their relationship to the regulations in Part 4 of the Health and Social Care Act 2008

Regulation	Outcome	Summary of Outcome
17	1	**Respecting and involving service users** Awareness of choice available to them, involvement in decisions about care, privacy and dignity respected
18	2	**Consent to care and treatment** People give consent and understand how to change decisions if necessary
9	4	**Care and welfare of people who use services** Effective, safe, appropriate care that meets needs/protects rights
14	5	**Meeting nutritional needs** Encouragement/support to have sufficient food and drink, and to have choice
24	6	**Co-operating with other providers** Safe and co-ordinated care when moving between providers/receiving care from multiple providers
11	7	**Safeguarding people who use services from abuse** Safeguarding and protection of rights
12	8	**Cleanliness and infection control** Cleanliness of environment/protection from infection
13	9	**Management of medicines** Timeliness and safety of providing medicine and information about medicine
15	10	**Safety and suitability of premises** Residents, care staff, visitors are in safe environment that promotes wellbeing
16	11	**Safety, availability, suitability of equipment** Equipment is properly maintained, suitable for its purpose, used correctly and promotes independence/comfort of service users
21	12	**Requirements relating to workers** Protection for staff and deployment of appropriately skilled/experienced staff for the job
22	13	**Staffing** Sufficient numbers of appropriate staff
23	14	**Supporting workers** Competent staff that are properly trained and supervised
10	16	**Assessing and monitoring the quality of service provision** High-quality and safe care due to effective decision-making and good management of risk
19	17	**Complaints** Effectively listening to and responding to complaints and not victimising those that make complaints
20	21	**Records** Personal records (and other records required to protect safety and wellbeing) are accurate, fit for purpose, held securely and remain confidential

APPENDIX 2

Table 2: Key CQC regulations and corresponding paperwork requirements

	Does the regulation explicitly refer to paperwork?	Would paperwork be useful or required to ensure compliance?	What do the CQC guidelines say regarding best practice? Is paperwork mentioned?	What paperwork do care homes currently use to respond to each regulation?
Health and Social Care Act 2008				
Regulation 17 Respecting and involving service users	Not explicitly	Yes	Assessments and care plans would be used to comply with this regulation	Assessment of care, care-plan agreement record, care-plan action record, care plan, care-plan guidance
Regulation 18 Consent to care and treatment	Not explicitly	No, but arrangements must be in place for obtaining and acting in accordance with consent of service user	System must be in place for consenting, explaining benefits, risks, alternatives, refusal etc.	Record of consent form and update as situation changes
Regulation 9 Care and welfare of service users	No	Yes, more difficult to adhere to without paperwork	Care plans, risk assessments and personal emergency evacuation plans (PEEPs)	Care plan, risk assessment, PEEP, staff handover sheets
Regulation 11 Safeguarding service users from abuse	No	Yes, more difficult to adhere to without paperwork	Systems to monitor and review incidents, act on concerns and complaints	Incident reporting forms, action/implementation plans, review plans, records of incidents that occur, bespoke forms to report safeguarding concerns, Criminal Records Bureau (CRB)
Regulation 14 Meeting nutritional needs	Not explicitly	Yes	Written risk assessment and care plan	Malnutrition Universal Screening Tool (nutritional risk assessment) care plan
Regulation 13 Management of medicines	Yes	Yes	Arrangements for obtaining, recording, handling, using, safekeeping, dispensing and disposal of medicines	Recording of medicines, Medication Administration Record (MAR) chart
Regulation 10 Assessing and monitoring the quality of service provision	Not explicitly	Yes	Systems for gathering, recording and evaluating information about the quality and safety of care and managing ongoing risks	Feedback information, recording of adverse information

Table 2 continues on page 42

	Does the regulation explicitly refer to paperwork?	Would paperwork be useful or required to ensure compliance?	What do the CQC guidelines say regarding best practice? Is paperwork mentioned?	What paperwork do care homes currently use to respond to each regulation?
Health and Social Care Act 2008				
Regulation 20 Records	Yes	Yes	Verbal communication is documented as soon as possible	All records relevant to the service (safety: gas, electricity, water, Deprivation of Liberty Standards, purchasing mechanical devices and medical equipment, money, staff employment, duty rosters)
Care Quality Commission (Registration) Regulations 2009				
Regulation 18 Notification of other incidents	Yes	Yes	CQC must be informed of a variety of incidents that impact on the service user (death, abuse, investigation by the police)	Notification form

APPENDIX 3

Table 3: An overview of paperwork used in care homes

	STAFF COVERAGE		REQUIREMENT			FREQUENCY OF USE		
	Frontline carers	Managers	Funding	Legal	Best practice	Daily	Regular	Infrequent
Risk assessments/handling medicines		✓		✓				✓
Risk assessments/medicine access and security		✓		✓				✓
Risk assessments/administering meds		✓		✓				✓
Risk assessments/ordering meds		✓		✓				✓
Risk assessments/disposing of meds		✓		✓				✓
Risk assessments/storage of meds		✓		✓				✓
Risk assessment/data protection regarding meds		✓		✓				✓
Risk assessments/storage, administering and disposal of controlled drugs		✓		✓				✓
Risk for medical equipment		✓		✓				✓
Risk assessment/self-medication		✓		✓				✓
Training documentation for using equipment		✓		✓				✓
Training documentation for administering meds		✓		✓				✓
Documentation for key holders/ access to meds		✓						✓
Temperature checks/records for medicine fridges		✓		✓	✓	✓		
Copy medical paperwork for transferring residents		✓		✓	✓			✓
PRN charts	✓				✓	✓		
Record of patient consent	✓			✓	✓	✓		
Audit of MAR charts		✓			✓	✓	✓	
MAR chart	✓			✓		✓		
Controlled drug records/book		✓		✓		✓		
Controlled drug witnesses	✓				✓	✓		
Records for self-administration of meds						✓		
Records of meds in/out		✓			✓		✓	

Table 3 continues on page 44

	STAFF COVERAGE		REQUIREMENT			FREQUENCY OF USE		
	Frontline carers	Managers	Funding	Legal	Best practice	Daily	Regular	Infrequent
Records of ordering/delivery/ returns of meds		✓			✓		✓	
Stock checks controlled drugs		✓			✓		✓	
Record of prescription requests		✓			✓		✓	
Care plans	✓		✓	✓	✓	✓	✓	
Risk assessments for equipment		✓		✓				✓
Risk assessments for hazardous chemicals		✓		✓				✓
Risk assessments for lifting		✓		✓				✓
Training register for lifting/ equipment/chemicals		✓		✓				✓
Maintenance of equipment paperwork		✓		✓				✓
Paperwork for equipment repair/ call-outs		✓			✓			✓
Cleaning paperwork		✓			✓	✓		
Hazard Analysis and critical control point (HACCP) paperwork		✓		✓				
Food and food storage temperature checks		✓		✓		✓		
Laundry cleaning/collection/self-service		✓			✓	✓		
Valuables storage and receipt paperwork		✓		✓				✓
Staff rotas		✓			✓		✓	
Payroll		✓			✓		✓	
Fire drills, training and equipment maintenance		✓		✓	✓			✓
1–1s/disciplinaries		✓			✓		✓	
Death, injury, infectious disease reporting paperwork		✓		✓				✓
Burglary, misconduct paperwork		✓		✓				✓
Risk assessment for latex exposure		✓		✓				✓
Clinical waste paperwork		✓		✓			✓	
Risk assessment for work-related stress		✓		✓				✓
Communications/staff meetings		✓			✓		✓	
Risk assessments for hot water and bathing/showering		✓		✓				✓
Risk assessments hot surfaces		✓		✓				✓
Risk assessments electricity/gas		✓		✓				✓
Risk assessments asbestos		✓		✓				✓
Risk assessments floors/stairs/ windows/doors/lifts		✓		✓				✓
Toilet inspection paperwork		✓		✓		✓		
Risk assessment for residents that smoke		✓		✓				✓
Risk assessment for outdoor areas		✓		✓				✓

Table 3 continues on page 45

	STAFF COVERAGE		REQUIREMENT			FREQUENCY OF USE		
	Frontline carers	Managers	Funding	Legal	Best practice	Daily	Regular	Infrequent
Maintenance and lighting checks		✓		✓			✓	
Risk assessment ventilation		✓		✓				✓
Night workers' health assessment		✓		✓				✓
Admission and discharge of residents paperwork	✓			✓				
Risk assessment for transport (minibuses, etc.)		✓		✓				
Maintenance paperwork for transport		✓		✓				
CQC notifications		✓		✓	✓		✓	
Malnutrition Universal Screening Tool	✓			✓	✓		✓	
Waterlow form (for pressure sores)	✓			✓	✓		✓	
Turning chart	✓			✓	✓		✓	
Life story	✓				✓		✓	
Bed-rail assessment	✓			✓				✓
Behaviour record	✓				✓			✓
Fluid balance and stool chart	✓				✓		✓	
Pre-admission assessment	✓				✓			✓
Monitor charts for weight, blood pressure, temperature, glucose, respiration, epileptic seizure, pain assessment	✓				✓			
MUAC BMI (Screening tool for malnutrition)	✓				✓			
Local council monitoring documents			✓		✓		✓	
Primary Care Trust paperwork			✓		✓		✓	
Forms to safeguarding boards		✓			✓		✓	
NHS Continuing Healthcare paperwork			✓		✓		✓	
Hygiene chart	✓				✓		✓	
Daily log/record of care	✓			✓	✓	✓		
Local council contract paperwork		✓	✓				✓	
Preferred regulator documentation		✓						✓
Action plans		✓		✓	✓			✓
CQC registration paperwork		✓		✓				✓
Quality Surveillance Group paperwork		✓		✓				✓
Commissioning for Quality and Innovation (CQUIN) paperwork		✓	✓		✓		✓	
CRB paperwork		✓		✓	✓			✓
Complaints/service-user feedback/meetings	✓			✓	✓		✓	
List of bedrooms where smoking is permitted		✓		✓				✓
Activities plan for residents	✓				✓		✓	

Table 3 continues on page 46

	STAFF COVERAGE		REQUIREMENT			FREQUENCY OF USE		
	Frontline carers	Managers	Funding	Legal	Best practice	Daily	Regular	Infrequent
Pain assessment	✓			✓				✓
Breathing assessment	✓			✓			✓	
Mobility assessment	✓			✓	✓		✓	
Falls assessment	✓			✓	✓		✓	
Communication assessment	✓			✓	✓		✓	
Sleep and rest plan	✓			✓	✓		✓	
Spiritual needs	✓			✓	✓		✓	
Continence assessment	✓			✓	✓		✓	
Manual handling	✓			✓	✓		✓	
PEEPs	✓			✓	✓			✓
Mental capacity checklist	✓			✓	✓			✓
Care-plan reviews	✓			✓	✓		✓	

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