Care Home Quality Assurance in COVID-19

September 2022

Introduction

The COVID-19 crisis posed huge challenges to social care support in Scotland. The complex and serious issues faced by care homes in supporting residents to live well during a time of life changing restrictions; substantial risk and radical change and adaptation in the wider social work, health and social care support landscape cannot be underestimated.

During the pandemic efforts were made by the wider system to provide assurance and improvement support to care homes.

In 2020 NHS Boards were required to have daily contact with all the care homes in their area to ensure that homes had the support they needed to provide quality care and support.

In February 2021 the then Cabinet Secretary for Health and Sport requested via Chief Social Work Officers (CSWOs) that a further round of joint clinical and social work assurance visits be undertaken across Scotland.

About this report

This report sets out thematic findings from the 2021 round of assurance visits to care homes and includes practice examples, areas for development and lines of enquiry for the future. Materials received from areas varied in type, depth and degree of analysis, so the findings and recommendations are indicative, rather than conclusive.

Iriss, September 2022

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Key findings

Navigating dilemmas: The quality assurance visits highlight a sequence of dilemmas for care home and H&SCP/local authority staff as they sought to balance the tension between the risks of restriction to people's wellbeing and wider health and the immediate and substantial clinical risks of contracting COVID-19.

Maintaining connections was a major challenge for all care homes. A sensitive and emotive area of practice, managing isolation and restriction took a huge emotional toll on families, people and staff. Staff supported garden visits, letter writing, increased use of video calling, newsletters and increased social media use to support both individual and group contact with others. Effective and sensitive implementation of the open with care guidance was the current priority for most homes.

Reports noted the significant impact of **death, end-of-life support and grief** on both care home residents and the staff that support them. Although additional support was introduced during the pandemic it was noted more training and support for staff in this work is needed.

A decline in physical activity and an increase in social isolation had a significant impact on the **wellbeing of residents**. Where possible staff increased one-to-one activities and made more use of outdoor spaces and connecting residents digitally with families and friends. Making time for this was difficult given both staffing shortages and required COVID-19 related tasks. These tasks included additional cleaning, testing and Infection Prevention and Control (IPC) and Personal Protective Equipment (PPE) related tasks.

Restrictions had an additional impact on people with **cognitive impairment, dementia and those who walk with purpose.** Many homes put in place additional support to make walking safe through cleaning touchpoints; developing safe walking areas and accompanying residents as they walked. However this was only a partial solution and assurance visits found increased distress and stress amongst some people in some homes who were unable to walk safely due to COVID-19 restrictions.

IPC/PPE: Most areas showed good adherence to IPC/PPE procedures. Limitations due to the environment/building type were identified as the main factor in incomplete compliance, alongside lack of clarity of guidance and product usage advice. Areas took a pragmatic improvement approach to IPC/PPE issues following up with homes to check changes had been made. One area with poor compliance used external occupational psychology support to both understand and remedy the complex underpinning issues and found this resulted in significantly increased compliance amongst care home staff.

Environment was a key factor in both adherence to IPC/PPE procedures and maintaining safe social interactions and connection between people. Homes dealt with restrictions by removing furniture and making more use of gardens and grounds. Maintenance was largely halted during lockdown, and some homes were asked to focus on this as restrictions began to lift. In many areas homes older, adapted buildings which posed additional challenges for both infection control and social distancing.

Recurring tensions between **IPC compliance and maintaining a homely setting** for people living in care homes were noted. Care homes overall took a pragmatic approach, maximising freedom in personal spaces while keeping shared spaces tidy and free of objects. There was a broad difference in nursing and social work perspectives of tidiness and 'clutter' within the materials.

Support planning and documentation varied considerably from home to home, although it was unclear how direct a relationship there was between excellent documentation and quality of care. The assurance visits were seen as an opportunity to update paperwork and guidance and highlight where support planning could be more comprehensive and personalised.

There were overall concerns that Adult Support and Protection (ASP) issues would increase during lockdown. However, the two reports that considered this data in detail indicated no overall increase in ASP activity during lockdown.

The experience of assurance visits: Despite the anxieties of many care homes, joint social work and nursing visit teams tried to make the assurance visits collaborative and supportive. This was done through careful use of language, listening skills, production of the assurance tool and pre-visit self-evaluation.

The wider assurance/support context: Assurance visits were only part of local frameworks of oversight and support for care homes. In some areas these structures were thoughtfully designed and well-integrated; in others this appeared more reactive. There was no relationship between size of local authority/HSCP and degree of integration of support and oversight.

Support for staff and care home leadership featured frequently in the more analytical materials received. Staff and care homes were described as 'valuable partners' and praise was given for their commitment to the people they support. Additional support for staff to deal with their experience, as well as compassionate support for care home leaders were identified as areas for future focus.

Experience of care home leaders and staff: All materials noted that assurance visits were intended to be supportive, collaborative and focussed on best practice. Feedback from care

home staff varied here, with some experiencing the visits as supportive and others seeing the additional oversight as a sign of lack of trust in their leadership and practice.

Staffing levels: Several areas implemented shared staffing approaches to cover self-isolation and absence. Despite this many areas reported ongoing staffing shortages throughout the pandemic.

Structural factors: Several reports noted confusion about national guidance, guidance versions and the very short time available for implementing revised guidance in practice. This both reflects the fast moving and changing situation faced during COVID-19 and the rapid changes in national guidance and policies.

Method limitations: Materials received from areas varied in depth, analysis and type. This means conclusions are indicative rather than conclusive.

Navigating dilemmas

COVID-19 presented a huge range of dilemmas for care home and H&SCP/local authority staff as they sought to balance the tension between the risks of restriction to resident's wellbeing and wider health and the immediate and substantial clinical risks of contracting COVID-19.

This core dilemma is raised repeatedly in almost all the assurance visit materials received, expressed and explored across areas as diverse as Infection Prevention and Control (IPC) compliance, the home environment, documentation, staff resilience, support practice, and dealing with death and grief.

Maintaining connections

The most difficult dilemma, and one that was noted in all materials received, was how to keep residents connected with their families, carers and friends.

The impact of visiting restrictions on people and their families has been significant and the deep distress and anger felt has been clearly expressed across public, policy and media settings. Reports generally acknowledged the significant impact on residents and their families. One, in particular, clearly and compassionately articulated the cognitive, social and emotional effects on people and their families in what was described as 'an impossible situation'.

Both leadership and support staff in care homes reported high levels of personal distress at having to manage visiting restrictions. For support staff key stressors included explaining restrictions to families and friends; dealing with an increased number and intensity of phone calls from families; and managing visits sensitively as restrictions were lifted. For care home leaders the stressors included how best to support their staff, clarity on how to practically implement guidance, and dealing with the rapidly changing situation.

Practice examples- maintaining connection

Care homes took a range of creative approaches to maintaining connection. These included supporting residents to make video calls, taking and sharing digital photographs, and letter writing. Some care home leaders set up regular newsletters and increased their use of social media to connect with families, friends of people living in the home and raise awareness with the wider public. Several homes reported investing in additional hardware (iPads) to make calling easier for people; some homes found this more difficult in terms of lack of infrastructure, stable Wi-Fi and staff digital confidence.

End-of-life and grief

End of life care and working through personal grief was a recurring theme across reports. Losing friends and acquaintances, coupled with COVID-19 restrictions had a significant effect on resident's wellbeing and distress levels. One report movingly described the distress experienced by a woman whose room was next to the care home front door where she saw several friends and acquaintances being taken out of the home for burial.

While reports noted excellent end-of-life care and support for residents, several saw the need for additional support for both people and staff in grieving for their losses throughout the pandemic.

Development areas- end of life and grief

Support and listening spaces for staff to help them work through their personal grief.

Training and support for staff in end-of-life care and support.

Training for staff in how to support residents to grieve for their lost friends and acquaintances, particularly where the person is non-verbal or has a significant cognitive impairment.

Maintaining social and physical wellbeing

Reduced opportunities for both non exercise related daily activity (NERA) and organised exercise was noted as a key challenge in keeping residents mobile, and physically well. This was challenging to maintain where people were restricted to their rooms or shared spaces in care homes were too small to accommodate people safely. Some reports noted an increase in falls, attributing this to reduced physical activity, reflecting the reduction in activity seen in the general population during lockdown.

Practice examples- maintaining wellbeing

Homes with visiting activity coordinators were not able to make use of this support in the early stages of the pandemic, reducing opportunities for organised group activities. The impact of staff shortages, additional cleaning and testing duties and the need to provide additional support to residents who were ill meant support staff had considerably less time available for supporting social and physical activities.

Later in the pandemic some homes were supported by redeployed allied health professionals (AHPs) who were able to provide additional activities and specific expertise in e.g. occupational therapy. Other homes reported increasing one-to-one, rather than group activities to maintain both safety and social connection.

Homes reported making greater use of outdoor spaces, gardens and grounds for socially distanced walking and exercise classes. They also looked to remove and re-arrange furniture in shared areas like dining and sitting rooms to make room for both safe exercise and socialising. Homes with smaller spaces used 'staggering' activities and mealtimes to maintain social distancing.

One home focussed on marking and celebrating milestones such as birthdays, specific holidays, changes of season etc to help residents remain orientated to the passage of time.

Development areas- maintaining wellbeing

A return to usual home activities as COVID-19 restrictions lift, ensuring people's rights and social wellbeing are prioritised as infection risk decreases.

Supporting people who walk with purpose

Normally the movement of people who walk with purpose[i] in care homes would not be restricted, rather they would have a supportive personal care plan in place to minimise risks and promote safe movement. However, infection control requirements, and restrictions in movement within homes during COVID-19 posed a substantial challenge to how best to support these residents.

Homes sought to support residents to walk safely by putting in place additional staffing to both accompany people as they walked and provide additional cleaning at 'touchpoints' around the home, recognising that restricting people's movements was likely to cause distress and stress and, as one report noted, be a breach of human rights.

Practice examples- supporting people to walk with purpose

Best practice described supporting people to walk safely by putting in place additional staffing to both accompany people as they walked and provide additional cleaning at 'touchpoints' around the home, recognising that restricting people's movements was likely to cause distress and stress and, as one report noted, be a breach of human rights.

Where weather permitted, greater use was made of gardens and grounds both to socialise and to provide safe spaces for people to walk. More difficult to resolve, were situations where the person had been diagnosed with COVID-19 and thus posed an infection risk to others.

One area made increased use of specialist psychological services for people with cognitive impairment and/or dementia to develop more bespoke support during the pandemic.

Environment

Several areas noted the environment as a primary issue in maintaining good IPC procedures, maximising safe social interactions, and maintaining physical activities for people.

They saw particular challenges for homes located in older buildings with narrow corridors and limited grounds and gardens. These reduced the opportunities for socially distanced interactions, made it difficult to locate PPE and handwashing stations within corridors, and gave residents fewer options for walking and staying active.

Restrictions on routine maintenance meant non-essential work was not completed during the pandemic. In most reports this was not seen as a critical issue but was flagged for addressing once homes moved out of restrictions.

A number of homes in two areas were required to address essential maintenance issues (such as worn surfaces) as this was making cleaning (and therefor infection control) difficult for staff.

Infection control and a homely setting

Much of the material received focussed heavily on compliance with IPC and PPE procedures in substantial detail.

General issues identified included staff understanding of, and compliance with, procedures; the physical setup of PPE and handwashing/sanitising stations; management of laundry; and the frequency of cleaning throughout the home.

A point of tension emerged here. Many responses expressed concern about 'clutter' and the impact this has on infection control. Particular concerns were expressed about personal items in shared spaces and bathrooms. Social work input however held more to the view that it is the person's right to have familiar objects to hand as "this is their home after all" taking a strong human rights perspective on the issue. These contrasting views largely reflected the professional background of the assurance visit leads and their specific remit for the visits.

Most of the reports paint a picture of homes responding pragmatically trying to keep shared spaces tidy to facilitate IPC compliance and underlining people's rights to as homely an environment as possible in their own rooms and spaces.

Compliance with IPC and PPE procedures

Good compliance with IPC and PPE procedures was noted in the majority of reports although there was variation between care homes. Some areas noted difficulties with PPE supply early in the pandemic but that this had been resolved at the time of the current round of assurance visits.

Where there was incomplete compliance with IPC and PPE procedures issues included:

- Partial understanding of requirements.

- The provision and siting of PPE and handwashing stations.

- Lack of 'quick reference' laminated posters and guides and variation in cleaning schedules[ii] (from once every 2 hours to twice a day).

- Problems with laundry[iii], laundry storage and uniform requirements (e.g., bare below the elbow) were also highlighted.

A number of areas noted variation in guidance and advice on use of hand sanitiser, cleaning materials and PPE. Again, assurance visits provided an opportunity to clarify these across areas.

In some homes clinical uniforms have been phased out to create a more homely setting for residents. During COVID-19 unforms were re-introduced by some care homes to improve infection control. While this was a practical response to the situation this again highlights the difference in clinical and social perspectives on care homes and the difference between a clinical setting and a person's home.

Development areas- IPC

Increased consistency of IPC and PPE guidance at HSCP level.

Re-introduction of framing of the care home as a homely setting (not primarily clinical space) in both practice, leadership and future assurance activities.

Practice examples - IPC

Good IPC practice was highlighted in a number of homes where improvements were made in signage, guides, and supporting staff and visitors to follow IPC and PPE procedures.

Some homes (re) introduced uniforms to improve IPC compliance. In other points of good practice staff who were required to launder uniforms or work clothes at home were given payments for their increased laundry costs to assist staff with compliance.

One area took a psychologically informed approach, bringing in external expertise to properly understand why staff were not complying with procedures. The intervention included listening compassionately to staff, understanding and developing shared motivation for complying with IPC, and developing and implementing a practical plan.

Support planning and documentation

The approach to quality assurance visits relied on observing practice (most common) review of a sample of documentation (care plans, medication charts, cleaning charts, and handover notes) and speaking to people, staff, and care home leaders. Many reports noted a wide variation in care plan documentation, from the highly personalised and easy to follow to the generic and minimal.

Reports did not discuss care plan implementation in detail, so it is difficult to draw conclusions about the relationship between the document quality and the care and support received.

Several areas noted that Anticipatory Care Plans (ACPs) were not in place for everyone or had been developed quickly at the beginning of the pandemic and required review. This was particularly the case for people who did not have capacity and required family/guardian consent to make changes to their ACP.

Some areas noted out of date documentation was in use relating to Power of Attorney (PoA), welfare guardianship, and Adult Support and Protection. The assurance visits gave an opportunity to address and update this across all the homes in their area.

Development areas- documentation

Better understanding of care plan variation and to what degree this actually reflects support in practice.

Better understanding of, and a plan to address, how key documentation, forms, and guidance are distributed to care homes and kept up to date on a national or local basis.

Adult support and protection

During the acute phase of COVID-19 there were significant general concerns about an increase in Adult Support and Protection concerns. In response to this several areas made this a focus of the social work aspect of assurance visits. This included reviewing ASP data for homes ahead of visits and ensuring that documentation reviews included ASP related materials.

Two areas provided analysis of ASP data that suggested no pattern of increase in reported concerns. However, given the small numbers of people involved, and the variance in ASP referral processes and thresholds across Scotland, this pattern cannot be generalised to the national level.

In the two areas:

- The number of initial Duty to Inquire (DTI) referrals did not appear to increase during the COVID-19 period.

- However, during COVID-19 a greater number of DTI referrals progressed to a full assessment.

- Progression from assessment through to further ASP activity (e.g. an initial case conference) remained at the same level pre and during the COVID-19 period.

- The increase in DTI assessments did not lead to an increase in further ASP activity overall.

It is not clear what led to the increase in DTI referrals moving through to the assessment stage during this period. Potentially the lack of in-person contact with care homes and residents may have been a factor, making threshold and risk judgements at the DTI referral stage more difficult. One area suggested that the difficulty in obtaining full information at the DTI referral stage was the likely factor leading practitioners to move referrals on to assessment at a higher rate to allow for a complete exploration of the risks to the person.

DNA CPR

Concerns about the use of do not attempt cardiopulmonary resuscitation notices (DNA CPR) were expressed by quality assurance visit teams, families, and staff alike. Lack of consultation with families and guardians[iv] was noted, and a concern that a 'blanket' approach had been taken, or perceived to be taken, to people living in care homes.

Practice examples- DNA CPR

Some areas prioritised strengthening connections between GPs and care homes. Other areas requested reviews of DNA CPR decision making approaches with a view to increasing consultation with families and guardians in the process.

Assurance visits- methods and approach

It was clear from the material received that several areas made significant efforts to be supportive and collaborative in their approach to quality assurance. One area co-produced their quality assurance review tool with care homes and several sought self-evaluation ahead of the review visits, setting a clear improvement and support (rather than inspection and oversight) approach. Where feedback from care homes had been received, most described the visits as 'helpful' and the advice as 'useful.'

Despite this, several areas reported care homes being anxious about further quality assurance activity due to previous experience of deficit focussed and risk adverse approaches. Quality assurance was also undertaken against a backdrop of public and media criticism of care homes, and this was a factor in how assurance activity was received.

All of the templates and guidance received were clear that the assurance visits were intended to be partnership orientated, supportive, and focussed on good practice and 'supportive improvement' i.e., the provision of training, coaching, further information and specialist advice to resolve any issues identified.

A few areas demonstrated their partnership approach by fully co-producing the assurance process and template with the sector. In contrast most areas relied on statements of intent/reassurance in their guidance and templates coupled with a self-evaluation approach to communicate a partnership approach to the homes involved. Some H&SCP areas shared their templates giving a degree of consistency both to the areas focussed on in the assurance visits and the methods used.

Assurance visit focus

There were some minor variations in the areas assigned to the different professional leads during assurance visits. There was considerable overlap between nursing and social work in reviewing health and wellbeing, and the care home environment. Many areas included an IPC professional to cover this aspect of the visit.

Social work led aspects included statutory responsibilities (e.g., Adult Support and Protection), care plan reviews, and attention to resident's spiritual, wellbeing and cultural needs.

Most templates used a simple Red/Amber/Green (RAG) approach with supporting narrative to determine areas of good practice and areas for improvement.

The majority of areas covered the following areas in their templates

Resident wellbeing, experience, and quality of care:

Mental and physical health and wellbeing
Social care support practice
Spiritual/cultural needs
End-of-life care and support
Maintaining contact with friends and family
Supporting residents with cognitive impairment

Documents and records:

Care plan documentation
Adult Support and Protection documentation
Anticipatory Care Planning (ACP) documentation
DNA CPR notices
Risk assessments

Environment

Environment (generally the clinical focus here is on cleanliness and the social work focus on homeliness/personalisation)
Infection Prevention and Control processes
Leadership and staffing

Leadership and staffing

Staffing levels
Staff wellbeing
Leadership/culture

Assurance visit process

All areas took a similar approach to the assurance process:

Document review: The assurance visit team first reviewed existing information about care homes in their area. This included contract monitoring information, information from daily huddles, notifications of COVID-19 outbreaks, occupancy information, previous Care Inspectorate inspections, and social work data about Adult Support and Protection issues.

Self-evaluation: The team then provided a self-evaluation template and guidance to care home leadership for completion.

Visit: The team made the joint assurance visit to gather information against the key areas in the following ways:

Assurance visit methods

All areas used these assurance methods during the visit:

- Observation of social care support practice e.g. how residents were being supported.

- Observation of IPC processes and practices (e.g. donning/doffing of PPE.)

- Observation of the physical environment, signage etc.

- Reviewing a sample of care plans and other documents.

- Reviewing IPC and cleaning procedures.

Some areas also used

-Feedback from care home staff.

-Feedback from residents and families- either through an online survey or conversations during the visit.

Discussion and action planning: The assurance team discussed the self-evaluation and information gathered with the care home manager. Most areas sought to give feedback face-to-face as soon as possible, both in recognition of the urgency of the situation, and the pressures that care home leadership and staff were under. The team then agreed a set of actions with care home leadership, with an emphasis on identifying good practice and supportive improvement.

Formalisation and Reporting: The assurance visit team then formalised their feedback and action plan in a variety of formats. The outcomes of the visit and the agreed actions were then shared with the care home and internally to the oversight group(s) in the HSCP.

Follow up: In most areas the action plan was then followed up, either by phone or through additional visits.

One area integrated their assurance visits closely with local authority contract monitoring, matching assurance areas with contractual clauses and requirements. There was no discussion of the effectiveness of this approach within the material received.

The requirement for assurance visits and care and support reviews required additional staffing from both local authority social work and the NHS in each area. Some areas sought volunteers from existing teams; one area recruited student social workers (with appropriate support and training) with several other areas using Scottish Government funding to recruit additional staff to resource the work.

Practice examples- assurance methods

One area sought formal feedback from care homes about how supported they felt during the COVID-19 pandemic. This was thoughtfully analysed to provide quality information about the care home experience and clear recommendations for recovery and future work.

Some areas co-produced their assurance visit template, guidance and approach with care homes. Several areas prioritised self-evaluation approaches and the use of existing information (e.g., Care Inspectorate reports) thus reducing the burden on both assurance teams and care homes. Two areas included feedback from residents, their families and friends as part of the assurance process.

Smaller HSCP areas were able to have regular supportive conversations with care homes in their area. This relationship building was critical to care home leadership experiencing the visits as collegiate and partnership based.

One area took a trauma informed approach to the assurance process, listening carefully to the experience of both people and staff. Given the detailed data that this approach yielded , and the positive feedback from staff and people, the area intends to continue using this approach to improvement.

Development areas- assurance methods

One report noted that the word "assurance" itself created a barrier to learning and improvement and suggested more careful messaging around this in the future.

Assurance teams faced challenges in explaining the nature of the visits and how they related to service inspection, contractual monitoring, and other COVID-19 oversight activities.

Taking a long term focus on relationship based, collaborative work with care homes builds strong foundations for working effectively together in a crisis.

Supporting care home staff

Most material submitted noted the substantial pressure on care home support staff and leadership, expressing concerns about exhaustion, stress, and burnout. This was compounded for many staff by the wider personal anxieties faced by everyone during the pandemic. The effects of this exhaustion was seen in some areas in reduced willingness to support people with behaviours of concern due to the additional emotional and physical demands of this part of care home work.

Several reports noted pressure and distress for staff required to give more end-of-life support than usual and in particular handling family and friends' distress at not being physically present at end-of-life. Some reports noted staff were themselves grieving for people they had developed close relationships with and that this was having a real impact on their levels of distress.

Reports expressed high appreciation for staff resilience and commitment to the wellbeing of the people they support. In the early phase of the pandemic staff were described as going 'above and beyond', with some even moving into homes to reduce the risk of infection. A number of reports were concerned that care home staff and leadership felt valued and appreciated as 'real partners' and seen as a pivotal part of the care and support environment in their area.

Some areas noted the financial hardships faced by staff due increased expenditure on transport and lack of meal provision at work. This is a complex issue related both to structural funding during COVID-19[v] and Fair Work issues in the care home sector which is beyond the scope of this review.

The care home manager/leader role was noted in a number of reports as being subject to enormous pressure during the pandemic as they sought to balance national and local requirements, changing guidance, support for staff and people, and as well as effective support to families and friends.

Several reports identified that having a supportive and organised manager was key to a supportive home environment for people and staff. This suggests a useful focus on maintaining and developing care home leadership in terms of future recommendations.

Practice examples- supporting staff

Care homes and H&SCPs put in a number of supports for staff during this period. These included:

- Increasing the frequency of 1:1 supervision.

- Focussing supervision sessions on wellbeing.

- Online Supportive Conversations and Reflective Sessions (OSCaRs).

- Case reviews/lessons learned analysis: Case reviews were set out in an accessible anonymised short format (Description, Impact, Solution and Action) and regularly highlighted and discussed at multidisciplinary meetings.

Development areas -supporting staff

There is a need for additional training and support for care home staff in dealing with their own distress, loss and grief and supporting residents with their own distress, loss and grief from the pandemic period.

There is a need for compassionate support for sector leaders as we move out of the acute crisis phase of the pandemic.

Guidance implementation

A number of areas noted changing messaging and lack of clarity relating to the national and local guidance on COVID-19 as significant barriers to practice during lockdown. Care home

leaders identified key challenges in implementing guidance on visiting restrictions, IPC, and navigating financial support for care home workers and care homes as employers/businesses.

Some areas saw different areas of guidance as periodically conflicting and noted the very short time window for implementing guidance following issue. This reflects the fast moving and changing situation faced during COVID-19, and the difficulties with both dissemination and understanding of complex guidance during a crisis.

Practice examples -guidance implementation

Beyond specific requirements (e.g., safety huddles/daily contact) areas took different support approaches including manager/leader forums, regular online catch ups with care home leadership, and district nursing advice and support to homes.

One area delivered partner webinars and care home leadership discussion groups with Scottish Care demonstrating partnership with the sector.

Development areas -guidance implementation

Future crisis planning at national or local level should include what was learned from COVID-19 about the need for guidance from different policy areas to be coherent, effectively cross-referenced, and released with enough lead-time for all partners to implement changes effectively.

Conclusion

The findings from the assurance visits reflect how the COVID-19 crisis highlighted existing tensions, challenges, and structural issues within care homes and their relationship with the wider health and social care support sectors.

The findings highlight the significant tensions between social work/social care support and clinical perspectives on wellbeing, risk, and safety. This tension recurred across almost all identified themes from the care home environment, accommodating people who walk with purpose, maintaining social connections and being, through to seemingly minor decisions such as the reintroduction of uniforms in otherwise homely settings.

Working effectively with this tension will be key to recovery from COVID-19; with the recognition that the balance between social and clinical 'safety' may need to be reset, most urgently where human rights concerns come into play.

This tension is also expressed in how different assurance visit partners view care homes and their purpose. Across the materials, homes were viewed as anything from an extension of a hospital ward through to a person's home. The latter focus is most likely a result of the intense pressures of the pandemic but overall reframing of care homes as resident's homes will be a key part of recovery.

Several reports spoke eloquently of deep distress across residents, families, staff teams, and care home leadership. Some materials also noted strained relationships and the difficulty of communicating positive intent to support and improve care home practice against the wider context of blame, loss, and distress.

Findings highlighted specific support needed for residents and staff to process and integrate their losses and experiences during COVID-19. Particular attention was given to end-of-life care and grief as homes experienced both resident and staff deaths during the crisis.

Restrictions on visiting and movement had a huge impact on residents and their families and their relationship with care home staff and leadership. Rapidly changing guidance, staffing shortages and perceptions of excessive oversight also placed strain on relationships between care home staff, leadership, and HSCP/local authority staff. A focus on (re)building trust and relationships at all levels will again be fundamental to recovery.

The experience of assurance and oversight during the COVID-19 pandemic has implications for Scotland's approach to regulation, inspection, accountability and improvement in social work and social care support. Findings from the materials highlight the gap between what is intended in assurance and what is experienced by those being assessed.

Several approaches created the conditions for a collegiate, partnership approach to working with homes during the crisis. These included co-production of assurance materials, use of existing measures and data, self-evaluation, on the day feedback, and solution-focussed improvement support conversations with supportive follow-up.

Annex A: Responses and method

Materials

Seventeen (17) responses were received from Chief Social Work Officers (CSWOs) or members of their team. In recognition of the pressure that senior management is currently under we did not require respondents to complete a standard template.

This means there are substantial limitations inherent in the information collected, and the conclusions that can be drawn at this stage are at best indicative. Materials ranged from primary data, to in depth analysis, and to general reports. Some reports focussed on data and numbers and others were wholly thematic.

- Thematic/summary reports - 3 areas
- Individual assurance reports- 2 areas
- Method/approach statements- 4 areas
- Blank assurance templates- 17 areas
- Assurance visit guidance - 13 areas
- Personal reflections- 2 areas
- Bespoke report - 1 area

Statements and key points from the materials were clustered and analysed against the below categories.

Examples of good practice and areas for development (where identified) were also organised against these categories:

Impact on residents	Impact on staff and leadership	Social work and nursing assurance focus areas	Approach to assurance visits
Maintaining connections and communication End-of-life and grief Maintaining social and physical wellbeing Supporting people with cognitive impairment Infection control and a homely setting	Supporting staff Guidance implementation	Support planning Documentation Adult Support and Protection DNA CPR	Approach Methods Focus of assurance activities Wider assurance/support context in the area. Assurance visit paperwork

[i] Sometimes referred to as 'wandering' or 'pacing'. Some people with dementia 'walk with purpose' for a range of reasons. They are looking for someone or something, walking off pain or stiffness, taking some exercise, or recollecting lifelong habits of being an active person.

[ii] Across the material submitted, cleaning schedules ranged from once every 2 hours to twice a day. However it was noted in at least two reports that some of the variation was acceptable and related to the different home settings reviewed.

[iii] Additional funds were, in principle, available to providers for IPC compliance via the Social Care Sustainability Payments mechanism see the Health and Social Care Scotland/COSLA guidance.

[iv] Although medical professionals can make a DNA CPR decision in the best interests of their patients without requiring a decision from the person or their family, good practice requires consultation and input to the decision making from these groups.

[v] See the H&SCS and COSLA guidance on sustainability payments to the sector and the Scottish Government 2021 Fair Work Action Plan.