Good and outstanding care

Transitional monitoring approach

Responsive

This resource includes good practice recommendations related to the Care Quality Commission's (CQC) Transitional Monitoring Approach focus being used by inspectors from October 2020.

Whilst the recommendations predate the COVID-19 pandemic, they provide insight from existing CQC inspection reports as what constitutes good and outstanding practice.

As part of their Transitional Monitoring Approach, CQC inspectors will look at some key areas of Responsive from their fuller inspection process. This includes reasonable adjustments, cultural / religious needs, decision making, raising complaints, and end of life care.

The document covers the following Key Lines of Enquiry:

R1. How do people receive personalised care that is responsive to their needs?

R3. How are people supported at the end of their life to have a comfortable, dignified and pain- free death?

Service type key:
A = Applicable to all services
C = Community based care, including homecare
R = Residential and nursing homes

For organisations who may be subject to a full CQC inspection, please refer to our main Good and outstanding care guide.

R1. Person-centred care

Person-centred care and effective and responsive care planning are key features of good and outstanding services. The involvement of people who need care and support or their family/advocates is central to shaping the care that they need. Staff see people as individuals, knowing their backgrounds, likes and preferences.

Recommendations from good and outstanding providers		Service type
✓	Work closely with people you provide care and support to (or their families/advocates) to understand what's important to them.	A
✓	Uphold and respect people's right to be involved in decisions about their own care.	A
✓	Provide consistent levels of person-centred care with everyone being able to live as independently as possible. Look to external endorsement and recognition for this (e.g. from local healthcare professionals, award schemes).	A
✓	Ensure time is provided to allow staff to get to know people and build relationships (including those not directly in care support roles). Focus on retaining staff and using the same carers to provide support to deepen relationships over time.	A
✓	Enable handover meetings to ensure staff have accurate and up-to-date information about people's needs. Where handover meetings are not possible, ensure documentation is available to inform the next care worker.	A
✓	Plan review meetings with people needing care and support in advance, ensuring they've had chance to prepare what they'd like to discuss.	A
✓	Ensure staff provide information clearly and honestly, enabling the person they care for to make an informed decision.	A

✓	When people needing care and support are making decisions, provide sufficient time to allow them to process and make informed choices.	A
✓	Where caring for people with sensory loss and/or disability, ensure the service complies at a minimum with the accessible information standard or exceeds where possible.	A
✓	Recognise and celebrate different religions and cultures, including key dates and events.	A

What to avoid		Service type
✕	People who need care and support aren't involved in the planning or review of their care and support.	A
✕	There is limited understanding, recording and monitoring of people's wishes and preferences.	A
✕	Decisions that are made for people based on the provider's convenience (e.g. people received bed baths because they were easier to manage than a shower or bath).	A
✕	The service has accepted to take on new people to care for despite knowing they cannot meet their needs.	A
✕	Staff didn't know the history or personal preferences of the people they cared for.	A
✕	Handovers are ineffective and information is either not provided, too limited or not recorded.	A
✕	Assumptions are made about what stimulation somebody needs (e.g. placed in front of a TV without being asked).	R

Available to help

Care Certificate workbook (standard 5) **(Skills for Care)**	Endorsed learning provider courses **(Skills for Care)**	Better Care in My Hands (CQC)

R1. Maximising independence

Good and outstanding providers help people to remain independent, often providing ways and means for them to achieve personal goals, maintain existing links or establish new links within the community. Whether delivering residential or community based care, the service helps to reduce social isolation and help people live meaningful lives.

Recommendations from good and outstanding providers		Service type
✓	Ensure all staff understand the importance of stimulation and that activities are an important part of motivating and engaging people.	A
✓	Empower people needing care and support to identify and undertake a range of hobbies, activities and interests (e.g. involvement in a local choir, computer course, running club).	A
✓	Provide regular activities for people needing care and support that are meaningful and fulfilling (e.g. ensure the activities are reflective of the diverse interests of those who need care and support). Understand their backgrounds and determine what is possible.	A
✓	Encourage and support people needing care and support to achieve their personal goals.	A
✓	Consider membership of the National Activity Providers Association (NAPA) who promote person-centred, meaningful and creative engagement supported by skilled staff.	A
✓	Promote a range of activities, including those helping to achieve better health and exercise.	A
✓	Document people's engagement in activities and review these to consider new ways and means to increase involvement.	A
✓	Capture feedback at the end of each activity and review to inform longer-term improvement.	A
✓	Draw on the talent across both staff and people needing care and support to offer a range of different activities (e.g. a staff member can play the piano / a person who needs care and support used to be an art teacher).	A

✓	Ensure those involved in activity provision are suitably experienced and trained. Consider the use of activity leads and champions to coordinate what is offered.	A
✓	Ensure staff respect people's own space and empower them (e.g. encourage and support people to prepare their meals, do their chores, access community facilities and to try new activities).	A
✓	Encourage people needing care and support to maintain their links with family, friends and external organisations (such as clubs and societies).	A

What to avoid		Service type
✗	Staff don't make any (or only very limited) attempts to engage people or offer activities (e.g. staff sit watching TV beside residents but make no attempt to interact with them).	A
✗	The activities provided are of a poor quality, not person-centred and not tailored to the needs and interests of the people needing care and support.	A
✗	Poor or meaningless records related to activities that have been provided (e.g. "she watched TV, walked around a bit, had a family visit, ate shortbread").	A
✗	Activities are limited to when a specialist member of staff is on duty only.	R
✗	Activities are related to the skills of the people delivering them rather than the needs of the people needing care and support (e.g. a staff member who previously worked in childcare promoted similar activities).	R
✗	The service excludes people from activities.	R
✗	The service doesn't monitor engagement in activities or review ways to improve this.	A
✗	The service fails to act upon scheduled activities (i.e. a published board of activities doesn't reflect what was actually delivered).	R

Available to help

Activities worker/co-ordinator role **(Skills for Care)**	Activity Provision **(Skills for Care)**

R1. Care plans

Care plans should be clear, up-to-date and person-centred. Most important of all is that the staff providing care and support follow the care plan. It should be easy to follow and contain all the information someone new will need to absorb quickly.

Recommendations from good and outstanding providers		Service type
✓	Ensure staff are effectively inducted, trained and supervised so they understand their responsibilities around completing, using, reviewing and updating the care plan.	A
✓	Provide staff – including volunteers and temporary workers - with enough time to read and ask questions about an individual's care plan before they visit.	A
✓	Ensure care is planned with the people who need care and support (and/or their families) rather than for them.	A
✓	Record how all contributors to the care plan are involved in the process.	A
✓	Ensure every care plan is detailed, person-centred and clearly describes the care, treatment and support needs of the person who needs care and support. Where appropriate, ensure health action plans are produced.	A
✓	Ensure the care plan is clearly laid out, ensuring staff and others using it can easily find the relevant information.	A
✓	Keep the care plan regularly updated and adjust levels of support as requirements change. Clearly document any changes that have been made and ensure these are signed off by person (and/or their families).	A
✓	Include information about people's capacity in their care plan and detail how they should be involved in their care and lifestyle choices (including making decisions for themselves or where best interest discussions may be needed).	A
✓	Check care plans are produced in a way that everyone who needs to use or review them understands the resource.	A

✓	Consider using technology and electronic forms to support care planning and enable staff to update and review changes. Additional benefits include setting automatic alerts and prompts to update.	A
✓	Ensure risk management and mitigation is effectively reflected in the care plan. Document clear procedures for staff to follow to minimise risk.	A
✓	Include peoples interests, preferences and things that are/were important to them in the care plan.	A

What to avoid		Service type
✗	People who need care and support (and/or their family/advocates) aren't involved in the care plan and didn't reflect their needs and preferences.	A
✗	Care plans are incomplete or inconsistent, out of date and infrequently reviewed.	A
✗	Care plans aren't easily accessible, depriving staff from being able to review and update.	A
✗	Staff aren't provided with the opportunity to read the care plan before they are expected to provide care.	A
✗	Care isn't provided in-line with what is stated within the care plan.	A
✗	Care plans for new users of the service take too long to develop.	A

Available to help

Mental Capacity Act (MCA) and care planning (SCIE)	Endorsed learning provider courses **(Skills for Care)**

R3. End of life care

Supporting people at the end of their life is something many good and outstanding services see as a privilege. From adapting care to meet changing and spiritual needs to effectively managing comfort, the service should prioritise a dignified death that draws on expertise available from within and outside of the service.

Recommendations from good and outstanding providers		Service type
✓	Ensure advanced plans, which record people's preferences when they near the end of their lives, are in place, well documented and regularly reviewed. These include adaptable activities suiting someone's changing needs and wishes.	A
✓	Where appropriate, involve the person's family, friends, power of attorney and advocates to discuss decisions about their end of life care.	A
✓	Ensure end of life plans take into account the person's language, ability to communicate and capacity to ensure it's as accessible to the person who needs care and support (and/or their family/ advocates) as possible.	A
✓	Ensure end of life care plans take into account people's protected equality characteristics.	A
✓	Where appropriate, ensure all staff, including managers and leaders, are trained in appropriate levels of end of life care and resilience. These skills are refreshed to reflect latest practice.	A
✓	Establish close links with end of life care professionals to ensure the support reflects good and best practice. If the organisation has had an end of life care programme, use an expert external organisation to review this.	A
✓	As people approach the end of their life, regularly monitor people who need care and support and assist them with symptom and/or pain management.	A
✓	Ensure the service is appropriately staffed to ensure people at the end of life receive additional support and accompaniment.	A

✓	Ensure specialist equipment and medicines are consistently available at short notice.	A
✓	Expand care during this difficult time to include support needed by family, friends and advocates of those at the end of their lives and following their passing.	A
✓	Provide opportunities for people nearing the end of their life to engage in adaptable activities that suit their changing needs and wishes.	A
✓	Provide opportunities for people's religious beliefs and associated priorities to be respected and adhered to as part of their end of life care.	A
✓	Regularly review your end of life care approach as part of staff supervisions, team meetings and document what went well and plans for any areas of improvement.	A
✓	After the person has passed, ensure the body is cared for in a dignified and culturally sensitive way.	A
✓	In addition to caring for the person at the end of their life, the provider also supports other people who need care and support, staff, family, friends and advocates to deal with the death of a loved one.	A
✓	Consider offering innovative new approaches to end of life care drawing on best practice and external expertise where needed.	A

What to avoid		Service type
✕	People at, or nearing the end of their life didn't have plans in place.	A
✕	Staff hadn't received training on end of life care (or it's not in-line with the latest practice).	A
✕	Staffing levels limited the opportunity to provide additional care and support.	A
✕	Capacity isn't assessed and/or consent isn't obtained to end of life care and treatment.	A
✕	Support, medicines and equipment aren't promptly available to help people nearing the end of their life.	A

Available to help

Common core principles and competences for social care and health workers working with adults at the end of life **(Skills for Care)**

Working together to improve end of life care training pack **(Skills for Care)**

Training on end of life care for domiciliary care staff **(Skills for Care)**