

# Kent Academic Repository

## Full text document (pdf)

### Citation for published version

Beadle-Brown, Julie and Towers, Ann-Marie and Netten, Ann and Smith, Nick and Trukeschitz, Birgit and Welch, Elizabeth (2011) ASCOT Adult Social Care Outcomes Toolkit: Additional Care Home Guidance v2.1 PSSRU Discussion Paper 2716/2\_1, University of Kent. Manual. Personal Social Services Research Unit, University of Kent, Canterbury

### DOI

### Link to record in KAR

<http://kar.kent.ac.uk/35172/>

### Document Version

Publisher pdf

#### Copyright & reuse

Content in the Kent Academic Repository is made available for research purposes. Unless otherwise stated all content is protected by copyright and in the absence of an open licence (eg Creative Commons), permissions for further reuse of content should be sought from the publisher, author or other copyright holder.

#### Versions of research

The version in the Kent Academic Repository may differ from the final published version.

Users are advised to check <http://kar.kent.ac.uk> for the status of the paper. **Users should always cite the published version of record.**

#### Enquiries

For any further enquiries regarding the licence status of this document, please contact:

[researchsupport@kent.ac.uk](mailto:researchsupport@kent.ac.uk)

If you believe this document infringes copyright then please contact the KAR admin team with the take-down information provided at <http://kar.kent.ac.uk/contact.html>



## Additional care home guidance v2.1

Julie Beadle-Brown, Ann-Marie Towers,  
Ann Netten, Nick Smith, Birgit Trukeschitz  
and Elizabeth Welch

---

PSSRU Discussion Paper 2716/2\_1 (supplement)  
September 2011



## Contents

Introduction .....	4
Guidance for making the ratings.....	4
Control over daily life.....	5
Personal cleanliness and comfort .....	6
Food and drink .....	7
Personal safety.....	8
Social participation and involvement .....	9
Occupation.....	10
Accommodation cleanliness and comfort .....	11
Dignity.....	12
ASCOT CH3: Observational schedule (CHOBS).....	13
Structured period of observation .....	13
Observer discipline.....	13
Procedure for observations .....	15
Preparation .....	15
During the observations.....	15
1) Engagement in meaningful activities and relationships.....	16
Social activity (SA) .....	16
Non-social activity (NSA).....	16
Negative behaviours and pastimes.....	17
2) Support quality and user experience.....	17
3) Opportunities and support for choice and autonomy.....	19
4) Physical wellbeing.....	19
Food and nutrition .....	19
Pain .....	19
Safety .....	20
5) Emotional wellbeing .....	20
6) Environment.....	20
Using the observation schedule and ratings.....	21
Care home interviews (CHResidentINT3/CHINT3).....	22
SCRQoL rating .....	22
Data entry tool.....	23
Further information .....	23

## Introduction

This document offers guidance on how to use ASCOT CH3 v2. ASCOT CH3 is for use within care homes and similar residential settings, and provides a way of measuring social care-related quality of life (SCRQoL). This guidance should be read in conjunction with the main ASCOT guidance:

[Netten, A., et al \(2011\) \*Adult Social Care Outcomes Toolkit v2.1: Main guidance\*, PSSRU Discussion Paper 2716/2, Personal Social Services Research Unit, University of Kent, Canterbury.](#)

In order to be able to complete the social care-related quality of life (SCRQoL) domain ratings identified in CH3, you will need to gather evidence from several sources, using a variety of methods. We highly recommend that anyone planning to use the ASCOT CH3 toolkit undertakes the 2 day training course offered by the research team.<sup>1</sup>

The data required to make informed and reliable judgements of residents' needs should be collected using the following tools/methods:

- 1) Interviews with residents using CHINT3
- 2) Interviews with staff and/or family using CHINT3
- 3) Structured period of observation using CHOBS
- 4) Conversations with staff and residents to fill in any gaps in knowledge identified by the prompts at the end of the CHOBS observation schedule.

## Guidance for making the ratings

This section concerns the social care-related quality of life domains, the needs levels within them, and real-life examples of evidence for ratings.

Before attempting to score residents using the ratings and guidance outlined later in this document, please make sure you have read through the domains and levels within the domains very carefully. In real life the attributes of the domains are very much interdependent, but it is important that, when rating a person's needs within any particular domain, you focus solely on that domain and do not let the person's needs in related domains influence your judgements. This is difficult to do and is partly why we **highly recommend** anyone planning to use this section of the toolkit (be it researchers, providers or commissioners) to undertake the training available.

Below are some examples of accurate ratings in each domain with relevant, good-quality evidence provided to back up each rating. The evidence provided to support your ratings is important because it enables others to validate your judgement and can help resolve disputes where there is more than one observer and a difference of opinion has arisen.

---

<sup>1</sup> Details of forthcoming training events will be sent to all those who have registered on the ASCOT website. Alternatively, email [ascot@kent.ac.uk](mailto:ascot@kent.ac.uk) for further details.

## Control over daily life

Optimal evidence would include: indications of staff and person's views of their level of control; observer's view of the situation; indications of opportunity for choice provided by the staff; the quality of the choice offered by staff – is it a basic choice or enabling; indications of the person's ability to choose and make these discernments; indications of what the staff say is provided and what the observer actually sees occur; does the person rely on others, if so what is the motivation for this? How would their situation differ without support from the service?

Rating with service	Rating without service	Exemplar evidence
<b>High needs</b>	High needs	Profound LD would not be able to make choices and in particular realise those choices without support. Observed the service user refuse to do things she doesn't want to but other than that no real evidence of choice/control. Staff say she has control, but evidence suggests otherwise: e.g. apparently wanted to buy expensive handbag; family happy for her to have and meet the costs, but staff wouldn't buy it. Service restricting person's control.
<b>Some needs</b>	High needs	Was offered some choice and seen to exercise that choice by either joining in or not, although some vocals were taken as 'yes/no' by staff. Could have been offered more choice over what he was involved in; e.g. helped by staff to chop a carrot but not given opportunity to be involved in any other part of making dinner. Without help and support, service user would not be able to put choices into practice and so would have little or no control over daily life.
<b>High needs</b>	No needs	Fairly independent. Will make own hospital appointments, etc. Staff say he is not able to do as much as he thinks he can - mainly from a safety perspective. He does have sight and hearing impairment, but is cognitively able. He clearly feels that he has no control over his life within the service and rating reflects his views.
<b>No needs</b>	No needs	Service user (SU) is elderly but completely lucid and capable. She does not do very much in the way of activities but to quote what she said, 'I couldn't be bothered'. Service seems to respect her right to choose and in this domain she would be fine without support.

## Personal cleanliness and comfort

Optimal evidence would include: indications of staff and person's views of his/her personal cleanliness, grooming and clothing; observer's view of the situation; indications of what the staff say is provided and what the observer actually sees occur; description of the quality and appropriateness of grooming, clothing and cleanliness; *how* is the person helped, what is the person capable of, specifically in their grooming and cleanliness; awareness of or concerns regarding this aspect of his/her life.

Rating with service	Rating without service	Exemplar evidence
<b>High needs</b>	High needs	Person appears dirty, dishevelled and is inappropriately dressed for weather. When staff challenge, major CB [challenging behaviour] is reported to occur. Odours apparent. Service provides daily prompts and support with complex aspects, when allowed by SU due to severe MH problem
<b>Some needs</b>	High needs	Staff report he is unable to wash or dress himself and that he is kept clean by service. However, observed evidence suggests some needs. Clothes were not service user's; family member came in and pointed out and asked for person to be changed. Said this happens a lot. Also, <i>slight</i> body odour present when close to resident. Needs total staff support to wash and dress so would be high without service.
<b>No needs</b>	Some needs	SU able to wash and dress independently, but needs supervision and occasional verbal prompts to make sure is actually clean. Staff feel he does sometimes need some help and he would occasionally be less clean if help were not provided. Observation supports staff view.
<b>No needs</b>	No needs	Staff report SU is able to wash/dress independently. SU looks clean and tidy. SU reports that he does not require help with personal care.

## Food and drink

Optimal evidence would include: indications of staff and person's views of the food and drink available; observer's view of the situation; degree of concern or awareness shown by person regarding their access to and choice over mealtimes/snacks; a person's/family's view of the quality of food; indications of what the staff say is provided and what the observer actually sees occur; food philosophy (e.g. preference for organic food) of home (if there is one); whether the home is sympathetic to health-related or religion-based provisions; detail of what the person can/could provide in this area for himself/herself/without help; what access to food and choice does the person have; what is his/her feeding ability and are there specific feeding issues?

Rating with service	Rating without service	Exemplar evidence
<b>High needs</b>	High needs	Very dependent nursing home resident who relies entirely on staff for all nutritional needs to be met. No evidence of a menu in place or that residents are offered choices. All residents given same food at meal times and not enough staff to ensure they all ate as much as they needed to. This person's plate was cleared and it looked untouched. Person looks thin.
<b>Some needs</b>	High needs	Menu in place but not accessible to clients - unsure how food is chosen, staff say SU chooses, but no common system observed that would make that possible. Meal times were quite uncomfortable and silent - not inclusive although she fed herself appropriately and seems well nourished. Would be much worse if no staff present - would become malnourished and underweight.
<b>No needs</b>	High needs	Healthy balanced diet provided for residents by staff. Respect cultural/religious specifications. Access to drinks and snacks as required. Would not be able to plan/shop for food. Could prepare some food (i.e. ready-made snacks). Weight control an issue so likely to overeat the wrong foods and would be at risk quite rapidly if on own.
<b>Some needs</b>	Some needs	SU would be able to engage in some aspects of meal provision that would ensure he was fed if no services were provided. He isn't keen on the food provided at home, and only likes it "sometimes". Does not say that he gets a choice. Staff seem to limit portions as a means of weight control, definitely some needs here.



## Personal safety

Optimal evidence would include: indications of staff and person's views of his/her level of safety; observer's view of the situation; degree of concern or awareness that the person presents regarding their safety; indications of what support the staff say is provided and what the observer actually sees occur: whether the staff seem too concerned (or not enough) about physical safety; whether there are indications of abuse; whether the person is able to assess danger; whether the person has their safety assured outside the home; whether the home appears safe from a health and safety or psychological environment perspective; what is the staffing ratio?

Rating with service	Rating without service	Exemplar evidence
<b>High needs</b>	High needs	SU fears outbursts aggression another SU (don't get on). Has epilepsy, had an attack when we there - another SU had to come and call a member of staff as one wasn't present. Autism and LD mean no concept of danger. Epilepsy is health risk.
<b>Some needs</b>	High needs	Resident says <i>sometimes</i> worries about being safe and staff agree with this and say this is because of personal history (cannot disclose details). Staff also indicate that this person is unaware of possible dangers. In the home. Person appears safe and secure around staff and other residents but 'some needs' rating to respect the fact resident told me they sometimes feel unsafe.
<b>No needs</b>	High needs	Constantly with staff owing to physical needs of resident. No apparent environmental dangers and did not seem uncomfortable with any particular staff members or residents. Blind with autism and non-verbal - making her vulnerable and unable to get help should she need it.
<b>No needs</b>	Some needs	It appears that SU feels safe and secure in her environment and the home is ensuring she has support to prevent dangerous situations, i.e. falls and keep her safe when doing community activities. Risk of falls if did not have this support, so some needs without services.

## Social participation and involvement

Optimal evidence would include: indications of staff and person's views of his/her level of social participation and involvement; observer's view of the situation; degree of concern or awareness that the person presents regarding their social involvement – with staff, peers and visitors; indications of what the staff say is provided and what the observer actually sees occur; what opportunities does the home provide and whether social interaction is encouraged. Is the person able to go out, and what is the extent of activities available? Is the person isolated, and if so is this due to choice, circumstances or resources? Is there a language, cultural or social barrier? How social is the person: do they initiate contact or are they socially inept, withdrawn? How active is the person: is this a barrier? Is the person's condition a barrier? Does the person have hobbies?

Rating with service	Rating without service	Exemplar evidence
<b>High needs</b>	High needs	Observed very limited interactions within the home - often sat for long periods of time with no interaction despite always being near a member of staff. Interactions that did happen were typically very brief and around self care or meal times. Virtually constant repetitive behaviours observed. Had very limited expressive communication
<b>Some needs</b>	Some needs	Goes to day centre and college. Sister visits weekly. Social contact in the home is with staff, not other residents. Resident says he sometimes feels lonely and can't always see people when he wants, which indicates some needs in this domain. Situation would be broadly similar without support from the service.
<b>No needs</b>	High needs	Participates in horse riding and trampoline club. Attends cookery classes at college. The family insist and pays for him to go on a weekly day out of town trips. He is taken shopping and is visited by family. Was observed interacting numerous times with staff, talking, dancing, sitting on outside swing. SU is autistic and is reliant on others to initiate - he has no social skills so would be high needs without all this support.
<b>No needs</b>	No needs	Person fully capable of organising own social activities, appears very independent: i.e. arranged and goes out into community with son. Observed to be speaking to other residents independently. Also stated she chooses when to take part in activities in the home.

## Occupation

Optimal evidence would include: indications of staff and person's views of his/her level of occupation and employment; observer's view of the situation; degree of concern or awareness that the person presents regarding their opportunities for occupation and employment; opportunities the home provides and whether external employment/activity is encouraged; whether there are resources to support both internal and external occupation; how active/able the person is, and whether this is a barrier. Is the person's health a barrier? Where relevant, does the person have skills which could be easily employed – such as ability to act as gardener etc? Are there opportunities for voluntary work?

Rating with service	Rating without service	Exemplar evidence
<b>High needs</b>	High needs	Observed to sit in chair all day - very minimal interaction with staff. Only activity was throwing/catching ball and eating/drinking. Appeared saddened and withdrawn and I think would have liked to be more involved and active. Reliant on staff for occupation.
<b>Some needs</b>	High needs	Service user struggles to self-occupy in constructed/positive ways rather than revert to passive sitting or self stimulating. Entirely dependent upon staff for this so would have high needs without service. Rated some needs as staff sometimes more concerned with other tasks and fail to re-organise to provide opportunities to include service user.
<b>No needs</b>	Some needs	At college every day. Likes to go to some of the youth clubs on campus and has a lot of activities she enjoys around the house. Has help to access community activities. Staff feel she would not be able to access many activities without support.
<b>Some needs</b>	No needs	Occupies himself in absence of services. Feels like the home 'restricts' him somewhat - says he is bored sometimes.

## Accommodation cleanliness and comfort

Optimal evidence would include: indications of staff and person's views of the condition of his/her accommodation; observer's view of the situation; degree of concern or awareness that the person presents regarding their accommodation. What is the state of the home itself, including equipment? Is the accommodation sanitary and clean? Is the home homely and comfortable? Does the person participate in the cleanliness or decoration of their room? Is the room personalised and appropriately decorated? What tasks in upkeep is the person allowed to do or is capable of doing? Do the staff seem concerned and actively aware of comfort and cleanliness standards desired by the person? How are these issues responded to?

Rating with service	Rating without service	Exemplar evidence
<b>High needs</b>	High needs	His room is too small and he shares a bathroom with everyone else, which was not particularly clean when I observed the service. The communal areas look old and shabby and there are stains on the carpet with an odour of urine in the hallways. Person doesn't have cleanliness skills or awareness so would be high needs without support.
<b>Some needs</b>	Some needs	Currently doesn't clean own room but does have some capability in this regard so would have some but not high needs in absence of services. Own room fairly clean, could do with dusting in places and is sparse with little personalisation. Communal areas clean but rarely used by SU.
<b>No needs</b>	High needs	Home and room is kept clean and tidy for her by domestic staff. She has personal items with her. Probably could assist a little in cleaning but doesn't. Says that home/hired help would clean anyway and is too confused to follow the activity through without support.
<b>No needs</b>	Some needs	SU can clean own room apart from vacuuming and changing bedding, but does not clean other areas of the home. Doubt would know how to clean bathroom as probably never done it, but would continue to clean room without support - was proud of room.

## Dignity

Optimal evidence would include: indications of staff and person's views of his/her dignity; observer's view of the situation; degree of concern or awareness that the person presents regarding their maintenance of dignity; indications of staff or peer abuse or lack of positive interaction; balance with positive aspects of dignity observed – what do the staff do well, how do they ensure dignity through respect; do the staff appear to care?

Rating	Exemplar evidence
<b>High needs</b>	Staff consistently call resident by incorrect name. Staff imitate verbal utterances in mocking tone and laughed within earshot of resident. Staff said 'stop that noise and eat your dinner'. Very little respect shown towards resident in this service.
<b>Some needs</b>	Mostly treated with warmth and respect. However, manager talking about the resident on the bus and also asked loudly if he had remembered to flush toilet.
<b>No needs</b>	Appears staff treat service user with dignity. She has choice over whose help to receive, appears clean and tidy, and her decisions are respected. Interactions with staff are friendly/warm in tone.

## ASCOT CH3: Observational schedule (CHOBS)

### Structured period of observation

The amount of time required for this activity depends upon the size and nature of the care home. Our general recommendations are as follows:

Single resident	1 hour period of observation
Small services (5 residents or fewer)	2 hour period of observation involving all service users for whom consent is available
Larger services	2 hour period of observation for every 5 people observed (this may have to be spread over more than one day)
Care homes with 'hubs'	At least one hour in each hub of the home.

Ideally the structured observation should be completed just before the evening meal – e.g. 1600 to 1800 as this period allows most opportunity for interaction and engagement and means that those who have been out at work, college or day centres will be returning home. In home for older people, who are unlikely to be leaving the service during the day, then observing of the two hours leading up to and including the start of the lunchtime would also be possible. It is essential to ensure you observe at least part of a meal time – if this doesn't happen during the structured observation then stay a bit longer and informally observe what happens during the meal time. The observation schedule attached provides a template for conducting the observation in each service. Those who are doing research should consider completing a more structured observation using momentary time sampling, which will give more information about how much time people are spending engaged.

During the course of the observation you will collect information about:

- 1) Whether people are spending time engaged in meaningful activities and relationships
- 2) Support quality and user experience.
- 3) Opportunity and support for choice and autonomy
- 4) Physical wellbeing
  - a. food and nutrition
  - b. pain
  - c. safety
- 5) Emotional wellbeing
- 6) Environment

This is accomplished by spending time observing the individuals concerned, regularly noting down what they are doing and what is happening to them. This is done as unobtrusively as possible. Observers have to strike the right balance between being a guest in someone's home, and not unduly influencing what is going on.

### Observer discipline

The aim is to observe as unobtrusively as possible. However, it is important that the observer is placed where they can see everything that could affect how domains are coded (e.g. if looking through a window at a client in the garden, the observer must be able to see whether, if the client speaks to another person, that person is reciprocating). If two observers are present (e.g.

for the purpose of estimating inter-rater reliability) this will usually mean entering the area which the person occupies because it is important that both raters have the same view-point.

Generally, the observer should walk into the room to a position where they can observe the client, avoid eye contact with anyone, stand as still as possible and concentrate on making their observations. When two observers are present, they should not talk to or distract each other (or anyone else).

Wear flat, soft-soled shoes that will not sound loud on stairs or hard floors. Close doors carefully – some doors with automatic closers may shut with a loud slam. Do not handle materials, move objects or otherwise intervene in the environment unless someone's safety is directly threatened.

Do not go into rooms where a person might reasonably be expected to be asleep in bed, undressed, or working with a member of staff on a programme which might be disrupted by another person coming in. Generally, this means not entering toilets or bathrooms, or bedrooms at the beginning and end of the day. The observer should enter these rooms if, for example, the person is doing housework.

In order to help clients and staff discriminate when they can talk to observers, make it clear at the outset of the session and put the observational schedule away when completed. If the observer has been talking to clients or staff before the start of the session, they should make it clear to everyone that they are going to start observing. Further contacts should then be ignored (reducing clients and staff communicating with observers will be helped if the observers avoid eye contact as far as possible). At the end of the session (when no more observations are being taken), put away checklist and tell everyone that observations are finished, and spend a few minutes socialising.

If the person you are observing (or anyone else in view) seems likely to come to serious harm unless you intervene immediately, do so. You can either re-start observations or go another day if need be.

If at any time the presence of the observer seems to cause difficulties or embarrassment for the person being observed or they indicate that they do not want to be observed, stop observing and either re-start later or reconsider whether the observation can proceed.

Confident, unobtrusive observers will rapidly blend in to the background and need not be a critical imposition in the lives of the people observed.

## Procedure for observations

### Preparation

Gaining consent: it is important to ensure that consent is sought for the observations to happen, especially in a research context. However, even in an internal audit, it is still good practice to gain consent from each resident for the observations to go ahead. This should be done in accordance with the Mental Capacity Act, involving a best-interests consultation if necessary. However, even if consent is gained, observers should ensure that they monitor each individual's reactions to the observation and presence of the observer. If necessary, take guidance from staff if the individual seems to be upset or clearly uncomfortable with the observer's presence.

Before commencing the observation, you will need to speak to the home manager (or equivalent) about the residents you intend to observe. It is sensible to have an understanding of any potential issues that may arise during the observation, and you have a responsibility to make yourself aware of ways in which non-verbal residents might communicate that they no longer want to be observed. You also need to make sure that you can clearly recognise each of the residents you are observing.

Make sure the people you have come to observe and their staff know who you are and why you are there and tell them that, while observing, you will not usually be able to interact with them. Allow sufficient time for this before the start of the observation session. Make it clear to everyone when you intend to start observing and start as close as possible to the times you have planned. Make a note of the exact time you start and finish (including any breaks). We recommend that you include at least part of meal time during the observation period, as there are issues relating to food and nutrition that you need to observe and make judgements about.

### During the observations

When you are observing more than one resident, you will need to divide your total observation time (usually 2 hours) between them as evenly as possible. How you do this will depend upon the nature of the home and the residents' proximity to one another. The ideal approach is to systematically rotate around each resident, spending 5 minutes observing each individual in order, adding people in and dropping people out as necessary. This allows you to achieve a more representative sample of time for each resident observed. However, this is sometimes hard to achieve and so we recommend that you at least ensure that you watch each person more than once during the observation period. So, for example, if you are observing 4 people, you would aim to spend 30 minutes observing each person in total – you should break this into three 10 minute slots. So you would observe Resident 1 for 10 minutes, then Resident 2 for 10 minutes, then Resident 3 for 10 minutes, then Resident 4 for 10 minutes, then Resident 1 for 10 minutes and so on. Obviously, if someone leaves the premises or it is clear that they will not emerge from their room for some time, then you drop them out of the observation and add them in again later should they become available again.

In large homes, you may find it is better to find out where the residents you are observing are and divide your time proportionally between areas of the home. So, if you are planning to observe five residents, two of which are in the lounge and three are in the garden, you might decide to watch the people in the garden for the first 75 minutes and the people in the lounge for the last 45.

In hubs, we have recommended an hour per hub, but this is a minimum recommendation and, if you find you have more than two/three people in any one hub, it is sensible to increase your



observation time. Ideally you want to achieve at least 20 minutes per person, preferably at least 30 minutes.

Stay with each resident as far as possible during the observations and record what they do and what happens to them. If it is not possible or appropriate to continue observing for a few minutes, move on to the next person. If the delay is going to be for longer – e.g. because all service users have gone to their rooms for a sleep – then stop and re-start the observation when one of the service users returns. Make a note of the length and reason for any delays in observation, as this might help feed into your judgements later on.

Do not observe where your presence might embarrass the client or if they appear to be uncomfortable with your presence. If serious problems occur (e.g. the individual you are observing displays serious challenging behaviour or is taken ill), stop observing and rearrange another session later on.

Write notes about each resident throughout the observation, focusing as much possible on the areas identified below.

## 1) Engagement in meaningful activities and relationships

Make notes on what the people you are observing are doing: how are they spending their time? Evidence collected in this section of the toolkit will help you make ratings in several domains but especially occupation and social participation. The following headings are to be used as prompts for your notes/coding.

### Social activity (SA)

Are residents engaged in some form of communication with someone else? If so, make a note of with whom (e.g. a member of staff or another service user) and briefly what about. What is the tone and nature of the communication (friendly/warm/familiar or impersonal/hostile)? Are staff good at noticing residents trying to communicate? Do they adapt their own communication to suit the resident (e.g. signing).

Note that if the person is clearly attending to a demonstration or listening to instructions from staff about a task, then that would be considered non-social activity (see below).

### Non-social activity (NSA)

This category includes any form of meaningful activity that might come under the headings of:

**Leisure/recreational/unstructured educational:** Such as using recreational or leisure materials: e.g. embroidery, puzzles, hobby materials, books, playing computer games, etc. It can also be participating in an activity that does not involve materials, such as swimming or going for a walk. Getting out or putting away materials, switching on TV or radio, walking carrying leisure materials between place of storage and place of use.

**Personal/self-care:** Getting ready for or doing a self-help activity. For example, feeding (appropriately) or drinking. Also involves movements to furniture in the act of sitting down or standing up, providing action is completed within the three-second gap.

**Practical tasks/activities:** Getting ready for or doing any practical tasks around the house, garden or in the community (e.g. getting ready for shopping). This can be simple, fetching and

carrying-type activity, washing up, opening and closing doors and windows, turning light switches off and on etc (providing this is not repetitive stereotyped behaviour). It can also be more complex, such as using electrical or gas equipment, stirring food on the cooker.

Some residents may have profound and multiple learning disabilities meaning it may be difficult to judge how engaged they are in a task or whether they are enjoying it. However, if staff are taking the time to assist people, perhaps using hand-over-hand guidance, make a note of this because it adds to the evidence you are collecting about the residents, staff and their interactions. It will also feed into the section below about the *quality of the support* residents receive.

Whenever you see residents involved in an activity, make a note of whether that activity is:

- Age appropriate: are older adults watching children's television or being given dolls to play with?
- Real: there should be a purpose to non-leisure activities and tasks. For example, if a resident is engaged in peeling vegetables, those vegetables should be used in the cooking, not just thrown away.
- Being done as a solitary activity, with other residents or visitors or with staff.

### Negative behaviours and pastimes

Making a note of negative behaviours and pastimes will help you decide how the person feels about their environment, their level of activity and social interaction. It may also be helpful when trying to rate the safety domain. Are residents staring into space or sleeping in their chairs during the whole or much of the observational period? Why? What are staff doing? Make note of any unpurposeful activities such as fiddling with buttons, tapping a pencil, repeatedly wiping nose on hand or sleeve, making minor adjustments to clothing once dressed, talking to oneself quietly etc. You may even see self-injurious behaviour (SIB) (such as head banging, eye poking etc), challenging behaviour (threatening vocalisations, swearing etc), destructive behaviour (to property) or aggressive (to people) behaviour, all of which ought to be recorded in detail as evidence for your ratings later on. Serious aggressive behaviour is rarely observed, but if you do see this sort of behaviour be aware of your own safety and that of others and stop observing if necessary, especially if you think your presence is aggravating the situation.

## 2) Support quality and user experience

Evidence collected here can be particularly informative for making ratings in the dignity domain and can also help you make judgements about level of need within individual domains and whether the service user is being helped or hindered by the service. There are a number of elements here that need to be observed:

- Do staff provide direct assistance to people to be engaged in meaningful activities and relationships?
- Are staff available and at least interacting with people and providing contact?
- Do staff have a warm and respectful approach?
- Do staff adjust their communication to the individual they are supporting as necessary: e.g. using adapted communication to help people understand and communicate?

The first element we want to look at here is whether residents are receiving any direct assistance to be engaged in meaningful activity and relationships. This should be distinguished from support from staff that does things for or to people. So, washing someone's face, pushing

them around in a wheelchair, helping them walk down the corridor, feeding them, talking to them etc. would be contact rather than assistance in the sense applied here. For people who are more able, they may be able to be engaged quite a lot without staff assistance, but many people will only be engaged in activities with staff assistance. The exceptions to this are activities such as watching TV, but it is sometimes difficult to be sure that the person is actually watching the TV or listening to music rather than the TV or radio just being on in the background. Note if people receive contact as well as assistance from staff, and listen to how staff speak to and about people and how they interact with them. Are their approaches warm and respectful? Do they treat people with dignity? Do they use positive language (e.g. encouraging rather than telling people not to do things)?

Examples of good quality assistance and support by staff:

- ◆ Involving residents in tasks and activities around the home by providing the help and assistance they need
- ◆ Holding materials or equipment in the right position (e.g. holding a bowl while the service user mixes the contents; holding their coat while they put it on)
- ◆ Reminding, prompting or asking the person (e.g. saying “Is it ready?” or “Shall we go and get the bread?”)
- ◆ Directions or instructions (e.g. saying “Put it on the top” or “Push it a bit harder”)
- ◆ Demonstration or modelling (e.g. showing the person what to do)
- ◆ Guiding or helping (e.g. putting their hand on the person’s forearm to help them position their hand over the correct dial on the washing machine)
- ◆ Offering residents choices about which activities they want to be involved in or what meals they want to eat
- ◆ Preparing materials, activities and tasks ahead of time so that residents can be involved and engaged immediately at the level which is right for their own ability
- ◆ Being on hand to provide verbal and/or physical assistance, as well as contact and interaction throughout activities and the day
- ◆ Using non-verbal communication methods where appropriate to help people with communication difficulties. This is most likely to be seen with people with learning disability or autism, but using objects of reference and visual prompts can also be helpful for people with dementia
- ◆ Providing positive interactions and using positive language; being aware of people’s dignity when dealing with personal care

Examples of poor quality assistance or support:

- Instructions or actions which are intended to stop people doing meaningful activity (ie not “do nothing”, “sit down”, “stop it”, “go away”, “wait a minute”...)
- Restraint intended to stop the person from doing something positive or make them do no activity (e.g. strapping them into a chair, not for their own safety but so they can’t get out)
- Help/support that is not matched to the needs/ability of the resident – e.g. verbal prompts to a person who needs a demonstration to understand the instructions or hand-over-hand guidance to a more able person who would benefit from having a go on their own
- Staff predominantly use verbal language with someone who clearly does not speak and does not appear to understand what is said to them
- Staff do not treat people with dignity and respect – they talk about people in front of them or other residents, they discuss personal care loudly, they call people nicknames or talk to

them in pejorative or demeaning language; they move them or approach them without warning

- Contact is negative – correcting people or criticising rather than encouraging them
- People tried to communicate, to get staff’s attention, but no one noticed or their attempts were ignored
- People are clearly in pain or discomfort, perhaps needing to be changed or toileted, but staff are doing other things and do not notice or do notice but don’t respond, perhaps saying “I’ll be with you in a minute” but never coming back (or coming back much later)

### 3) Opportunities and support for choice and autonomy

This has already been highlighted in the sections above, relating to staff support and engagement in activities. We have recommended that you observe around meal times and this will give you the opportunity to see whether residents are given choices around food - e.g. what to eat, how much to have, what to drink, when to eat etc. You might also witness choices around which activity to do in preparation for meal times or when tidying up after meals. You might also see evidence of choice within activities – e.g. people making decisions about how to do a task or activity or what order to do things in. You might see staff encouraging people to make decisions about holidays, or activities to do next week etc. In addition to noting whether choices were offered in the course of activities (e.g. which part of a task to do, which order to do a task in, when to stop, etc), it is important to note whether these choices were respected.

Part of giving residents choices involves using appropriate methods of communication. It is no good if a resident is offered a choice in such a way that they do not understand or cannot actually make that choice. Are staff using adapted communication (perhaps objects, signs or photos) to enable choice-making? This would help you judge whether the service is really assisting a person with their needs and whether they treat their residents with dignity and respect.

## 4) Physical wellbeing

### Food and nutrition

This domain is about eating nutritionally well-balanced meals and having access to enough snacks and drinks in-between times so that residents are not hungry, thirsty or, in the extreme, suffering from malnutrition or dehydration. It is also about whether people have food that they appear to like. As you watch people eating their meals, note down whether the food is tailored to their tastes or whether everyone has the same meal. Is there variety in what people are eating, perhaps indicating some form of choice? Is the food blended/liquid for those who need it? Are people given assistance to eat and drink if they need it or are plates left full because staff are too busy to help people? You may need to ask questions outside of meal times to find out if and how residents access drinks and snacks between meals. Is there a policy and if so does it seem to be in practice? You may also need to ask to see the menu, and if someone is eating something different you might need to ask staff whether that is out of choice, dietary requirement or cultural need. Bear in mind that evidence gathered in this area might inform ratings in other domain, such as control over daily life, safety and dignity.

### Pain

During the course of the observation, make note of any evidence of pain that residents may experience. People express pain in different ways: rubbing, vocalising (moaning/groaning), complaining (verbal), facial expressions (grimacing), crying and restlessness. Do staff notice

and/or react appropriately? Are people given some sort of treatment to relieve their pain (it may be moving their position or giving medication)? Do staff offer sympathy and explain why more medication cannot yet be given if that is the case? Are other residents upset by this? How is that dealt with? As well as telling you about the standard of care, taking notes about pain can help you make judgements about the dignity and safety domains, and may assist your understanding about how involved the service user is with social and non-social activities.

### **Safety**

This is an issue that needs to be considered throughout the observation and is relevant to many of the areas outlined above. Safety here refers to how safe residents are in their physical environment (no wires to trip them up or become entangled in) but also in relation to other residents, staff and visitors. Is there any evidence that residents are being intimidated or frightened? Are residents a risk to themselves and, if so, how is this being dealt with?

## **5) Emotional wellbeing**

Are any of the focal residents observed to be in distress? What is the mood like in the home, and especially for the residents you are observing? Do residents appear sad (crying) or withdrawn (staring into space, standing in the corner, refusing to join in)? Alternatively, are residents content (smiling, talking, making eye contact)? Is there evidence of humour amongst residents and staff (that is being enjoyed by all, not at the expense of another resident, as this would be negative and disrespectful)?

Presence of challenging behaviour would be seen as an indication of lack of emotional wellbeing. This includes both aggressive or destructive behaviour but also lots of time spent in self-injurious or self-stimulatory behaviour. If people are engaging in activities and interacting with others, even if they aren't necessarily smiling all the time, then they are likely to be relatively well adjusted and happy. Evidence about emotional wellbeing is important in helping you judge whether residents are happy with their levels of occupation, social interaction, control over daily life and so on. It will also help you judge whether residents feel they are treated with dignity and respect.

## **6) Environment**

This is about what you see as you walk around the service. There are some particular aspects of the environment to make note of:

- Is there a smell? If so, is it in particular rooms or areas or throughout the home?
- Are the communal areas clean and tidy?
- Are the bedrooms clean and tidy?
- What is the furniture like? It should be appropriate for the needs of the residents and not dirty, soiled or stained. Chairs should be comfortable – not so soft that residents cannot get out of them (older adults in particular) and not so hard that people cannot relax (armchairs in the living room, dining chairs in the dining room).
- Is the environment institutional or homely? Homely would include photographs, pictures, live plants, soft furnishings and lamps. Institutional would include health and safety signs on the walls, overhead strip lighting, blinds and no curtains.
- What is the temperature like in the home? It should be appropriate for the level of activity of the residents – so expect older adult homes to be warmer because they are generally less active. Any evidence that people are too cold or too hot?

- Who is keeping the environment clean? Is there a domestic team or do residents do it themselves and, if so, do they get adequate and appropriate support from staff?
- Is it easy for residents to get around the home (easy-access lifts, corridors wide enough for wheelchairs, flat and even surfaces) or are there barriers to their freedom of movement (such as locked doors, no access to outdoor space, stairs that mean residents can only go up and down with staff support)?
- Is there suitable and sufficient lighting?
- Any pets or plants?

## Using the observation schedule and ratings

The first part of the schedule asks you to record the date and time of the observation, and it is also useful to record how many residents were present in the unit at the start of the observation and how many staff were present. This will allow you to calculate observed staff to resident ratio. There is space to write any additional information, such as the order in which you observed different areas of larger homes or different hubs. You might also want to record here some identifying information for each person – it is good practice to use a numerical code or at least an initial for each person you are observing, rather than writing their full names on the form. However, you might need to make a note such as “AB – man in green jumper with glasses”, just to make sure you that can identify people quickly during the observation.

The second section provides space for you to record what you see and hear during the observation for each individual. Enough space is provided for five people, but you can copy. Additional note space is left on the back of each page to record additional information. For example, you might see something relating to a different resident or you might want to record, for example, that a group of residents and staff have just left to go bowling. We suggest that you record everything to do with that individual in one box, but that you clearly note the start and end times for observing that individual – remember there should be more than one observation of each person. It is really useful to record the detail – right down to what people say. Our experience is that you may spend a lot of time not being able to write very much because the person is still watching TV or staring at the walls or fiddling with a sock, but then there will be a flurry of activity. It is important to keep things in perspective and not let one flurry of activity colour what might otherwise be a long period of no activity. You have to look at the observation overall when making your ratings. Sometimes it is easy to be sympathetic to staff and think “Well, they are doing the best they can in the circumstances (not enough of them, difficult clients etc)”. However, you need to be as objective as possible doing these observations and record what you see and hear, not why you think you saw what you saw or heard what you heard. You are observing the reality of the individual’s life, whatever the reason for it being the way it is.

The third section includes a checklist as a reminder of things you need to make sure you have seen or asked. Most of these things you should have seen during your structured observation, but the checklist will help you make sure that you have gathered all the evidence necessary.

The fourth section asks you to draw out from the observation the relevant information for each of the areas described above, which you will then use to make your SCRQoL ratings on the final CH rating document (CH3). You should complete one of these for each person observed. These sections and the SCRQoL ratings should be completed within 48 hours of the visit so that all the information is still fresh.

## Care home interviews (CHResidentINT3/CHINT3)

You may choose to supplement your observations with interviews. There are two separate interview schedules CHResidentINT3 for use with the care home resident themselves and CHINT3 for use with either a member of staff at the care home or with one of the resident's relatives or friends. The difference between the two schedules is that the one for relatives/friends and staff members is more highly structured, whereas the resident one allows for a less structured interview. It still contains tick boxes to indicate which level a resident feels their SCRQoL is in each domain, but large sections available for the interviewer to write notes can be used if the resident finds such as highly structured interview difficult. Here, a more qualitative approach to interviewing can be taken, allowing the resident to express their feelings about their quality of life in their own words. These notes should then be used in conjunction with other data gathered (observational data, other interview data) to arrive at a final score. The resident interviews only explore current SCRQoL, so ratings of expected SCRQoL should be drawn from other data.

Depending upon appropriateness or availability, you can interview the resident themselves, one of their relatives/friends (referred to as carer on the interview schedule) or a member of staff at the care home. Obviously, before embarking on any interview you should make a judgement as to whether the interviewee will be able to provide useful information on the topics included in the schedule

## SCRQoL rating

The final stage is using the Care Homes version of ASCOT. The judgements you make here should be based on all the information you have collected during your time in the care home. This includes:

- 1) Interviews with residents using CHResidentINT3
- 2) Interviews with staff and/or family using CHINT3
- 3) Structured period of observation using CHOBS
- 4) Conversations with staff and residents to fill in any gaps in knowledge identified by the prompts at the end of the CHOBS observation schedule.

Assimilating all this data, you need to rate each resident's needs in the needs in the **presence of services** and in the **absence of services** for each quality of life domain.<sup>2</sup> You may find that different people have different perspectives concerning the resident's level of need within a domain. We recommend that you follow the following rule of thumb to decide how to make your final rating:

- 1) The service user's own view of their needs in the presence of services takes precedence above all others
- 2) The observer's view based on the evidence collected in the toolkit takes precedence above any other singular view (be that family or staff)
- 3) Family and staff opinions should be collected and used to inform the observer's judgement in conjunction with what was recorded in the observational schedule.

---

<sup>2</sup> Dignity is the only domain where you are not required to rate people's needs in the absence of services. Dignity is all about being treated with respect, and so it would not make sense to measure this in the absence of the people doing the caring.

## The domains:

The SCRQoL rating is divided into the following domains:

1. Control over daily life
2. Personal cleanliness and comfort
3. Food and drink
4. Personal safety
5. Social participation and involvement
6. Occupation
7. Accommodation cleanliness and comfort
8. Dignity

Each domain has detailed guidance to help you code residents' needs. You will be required to make the following judgements:

Needs in the presence of services:

- No needs
- Some needs
- High needs

Needs in the absence of services:

- No needs
- Some needs
- High needs

Details on both the general principle behind these levels and what that means in each domain can be found on the Care Home Ratings form and earlier in this guidance.

## Data entry tool

Included in the ASCOT toolkit CH3 is a data entry tool. More information about data entry tools can be found in the main guidance.

## Further information

Further information on ASCOT can be found on the ASCOT website. In particular, the frequently asked questions section will address common questions, and the future developments section will highlight ongoing work on ASCOT. The ASCOT team can also be contacted via email ([ascot@kent.ac.uk](mailto:ascot@kent.ac.uk))