Accounts Commission for Scotland
Care in the balance
DATA COLLECTION HANDBOOK

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EVALUATING THE QUALITY AND COST OF RESIDENTIAL AND NURSING HOME CARE FOR OLDER PEOPLE

Data collection handbook

FEBRUARY
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Care in the balance: evaluating quality and cost in residential and nursing homes for older people

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Contents

1. Introduction

1.1 Purpose and scope of the handbook

Best value requires councils to:

- achieve continuous improvement in services by comparing the performance of different providers, using benchmarking techniques where appropriate
- assess quality from a user's perspective
- develop cost effective services, which provide value for money
- be openly accountable to local communities for decisions made and services provided.

In order to meet these requirements, councils need access to valid and reliable information on both cost and quality.

The Accounts Commission collected a range of information from 39 residential care and nursing homes in order to develop the performance indicators used in the report '*Care in the balance'*. These homes came from all sectors: council, voluntary and private.

The main purpose of this handbook is to provide councils, and other providers, with guidance on collecting the same information in a consistent way. This should enable reliable comparisons of residential and nursing home care to be made at a local level.

Certain information, which we collected but which did not result in meaningful indicators, has been excluded from the handbook. For example, we collected the number of falls in each home over a 3-year period. However, it was not possible to tell whether the variation in falls was due to the quality of the building, the quality of care, the homes' differing approaches to risk assessment, the dependency level of residents or merely differences in recording accidents.

Over the course of the study we learnt from experience, and we have edited some of the data collection sheets for ease of use. Some, such as sheet ***11.2 Profile of residents***, offer the potential to collect a lot of information about residents. We shall be using some of this information for the second part of our study, for example source of admission. *We advise that you collect only what you need for the purposes of your own review.*

Finally, this is not the definitive set of performance indicators for residential and nursing home care. Our intention is that they should provide a starting point for the collection of valid and reliable information on these services. There are some areas, such as a review of the suitability of buildings for upgrading to single en suite rooms, which we did not consider.

1.2 Structure of the handbook

The handbook largely reflects the structure of the report *'Care in the balance',* so that the two can be used together.

Chapter 2 provides a brief summary of the indicators and the data sources needed. Cross references are made to the relevant data collection sheets and to the section of the main report where appropriate.

Chapter 3 discusses how we collected the staffing information and what to do if the data collected from different providers is not directly comparable.

Chapter 4 explains our approach to reviewing care plans.

Chapter 5 provides information on how we gathered the views of residents, and the value of this approach for best value reviews.

Chapter 6 explains the 'regime' questionnaire we used to assess management practices and caring policies in the homes. Professor Tim Booth of the University of Sheffield developed this questionnaire. A more detailed explanation of it is given in his book *'Home truths: old people's homes and the outcome of care'*. Unfortunately, this book is now out of print but Professor Booth has given us permission to reproduce the questionnaire (***11.10 Institutional regime questionnaire****)* and guidance for analysis.

Chapter 7 discusses the way in which we have analysed information on single rooms and en suite facilities.

Chapter 8 explains:

- the methodology for collecting costs from each home
- the assumptions we made in the allocation of costs between services
- how we have treated inter-sector differences.

There is also a detailed discussion of the treatment of capital and overheads.

Chapter 9 provides a checklist for home managers to use in assessing their own home's performance against the recommendations in the report '*Care in the balance'*.

Chapter 10 introduces the concept of measuring 'best in class' using benchmarking techniques.

All the data collection sheets are filed in **chapter 11** of this handbook. Comparative information from our study is provided on the enclosed disk.

1.3 Contacting the study team

Further information is available from the study team, who are Barbara Hurst (project manager), Carol Brown (project accountant) and Lucy Johnston.

Our switchboard telephone number is (0131) 477 1234. Our e-mail addresses are:

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2 Table of comparative performance indicators

2.1 Introduction

The indicators for which comparative data are available are listed below. They are cross-referenced to the data collection sheets included in chapter 11 of this handbook and to the relevant chapters in the report '*Care in the balance'*. The disk which accompanies this handbook has spreadsheets and graphs for each of these indicators (Excel for Windows 95, version 7.0). New information on other homes can be inserted as required and the graphs will automatically update. The costing template (***sheet 11.11***) includes the formulae needed to calculate the cost indicators.

Performance indicator	**Type of indicator**	**Data source** **(data collection sheets filed in section 11 of the handbook)**	**'*Care in the balance'* report reference**
Staffing (chapter 3 of handbook)			
Ratio of WTE care staff to residents (staff establishment; at 8.30 am, 4.30 p.m., 1am)	quality	11.2 'Profile of residents' 11.3 'Profile of staff' 11.4 'Rota information'	Chapter 2: *'Staffing and the quality of care'*
% of staff working less than 20 hours per week	quality	11.3 'Profile of staff'	Chapter 2: *'Staffing and the quality of care'*
% sickness absence - managers	quality	11.3 'Profile of staff' 11.5 'Sickness absence'	Chapter 2: *'Staffing and the quality of care'*
% sickness absence – care staff	quality	11.3 'Profile of staff' 11.5 'Sickness absence'	Chapter 2: *'Staffing and the quality of care'*
% of staff turnover	quality	11.3 'Profile of staff' 11.6 'Staff turnover'	Chapter 2: *'Staffing and the quality of care'*
Number of staff studying for, or with, relevant qualifications	quality	11.3 'Profile of staff'	Chapter 2: *'Staffing and the quality of care'*
Number of unqualified staff (excluding those studying)	quality	11.3 'Profile of staff'	*ditto above*

Performance indicator	**Type of indicator**	**Data source** **(data collection sheets filed in section 11 of the handbook)**	**'*Care in the balance'* report reference**
Care plans (chapter 4 of handbook)			
Care plans include all elements of good practice (as cited in report ' *Care in the balance'*	quality	11.8 'Care plan audit'	Chapter 3: *'Service quality'*
Each resident has a *known* key worker	quality	11.9 'Residents' questionnaire'	Chapter 3: *'Service quality'*
Obtaining stakeholders' views (chapter 5 of handbook)			
% of residents always called by their preferred name	quality	11.9 'Residents' questionnaire'	Chapter 2: *'Staffing and the quality of care'*
% of residents who describe staff as 'excellent' or 'good'	quality	11.9 'Residents' questionnaire'	Chapter 2: *'Staffing and the quality of care'*
% of residents who are very satisfied with the time staff spend with them	quality	11.9 'Residents' questionnaire'	Chapter 2: *'Staffing and the quality of care'*
% residents satisfied with trips or excursions	quality	11.9 'Residents' questionnaire'	Chapter 3: *'Service quality'*
% residents satisfied with food	quality	11.9 'Residents' questionnaire'	Chapter 3: *'Service quality'*

Performance indicator	Type of indicator	Data source (data collection sheets filed in section 11 of the handbook)	*'Care in the balance'* report reference
% residents satisfied with activities	quality	11.9 'Residents' questionnaire'	Chapter 3: *'Service quality'*
% residents satisfied with their room	quality	11.9 'Residents' questionnaire'	Chapter 4: *Quality of the environment'*
% residents satisfied with communal areas	quality	11.9 'Residents' questionnaire'	Chapter 4: *Quality of the environment'*
% residents satisfied with access to garden and grounds	quality	11.9 'Residents' questionnaire'	Chapter 4: *Quality of the environment'*
% residents satisfied with home overall	quality	11.9 'Residents' questionnaire'	Chapter 4: *Quality of the environment'*
Caring practices and routines (chapter 6 of handbook)			
Residents exercise choice in: • daily routines • the furnishing of their own rooms • use of grounds	quality	11.10 'Regime questionnaire' 11.9 'Residents' questionnaire'	Chapter 3: *'Service quality'*
Residents' privacy respected in practice	quality	11.10 'Regime questionnaire' 11.9 'Residents' questionnaire'	Chapter 3: *'Service quality'*
% residents who attend local clubs, societies or the church of their choice	quality	11.10 'Regime questionnaire'	*ditto above*

Performance indicator	Type of indicator	Data source (data collection sheets filed in section 11 of the handbook)	'*Care in the balance'* report reference
Availability of tea/coffee making facilities for residents and visitors	quality	11.10 'Regime questionnaire'	Chapter 3: *'Service quality'*
The environment (chapter 7 of handbook)			
% residents with single rooms	quality	11.1 'Profile of the home'	Chapter 4: *Quality of the environment'*
% residents with en suite facilities	quality	11.1 'Profile of the home'	Chapter 4: *Quality of the environment'*
Costs (chapter 8 of handbook)			
Weekly running cost per resident	cost	11.11 'Costing template' 11.1 'Profile of the home'	Chapter 5: *'Service costs'*
Annual care staff costs per resident	cost	11.11 'Costing template' 11.1 'Profile of the home'	Chapter 5: *'Service costs'*
Weekly catering costs per resident	cost	11.11 'Costing template' 11.1 'Profile of the home'	Chapter 5: *'Service costs'*
Weekly cleaning costs per resident	cost	11.11 'Costing template' 11.1 'Profile of the home'	Chapter 5: *'Service costs'*
Weekly energy costs per resident	cost	11.11 'Costing template' 11.1 'Profile of the home'	Chapter 5: *'Service costs'*

3 Staffing information

3.1 Introduction

The staffing indicators discussed in this section relate to care staff only. There is no reason, however, why the data collection sheets and principles outlined in this chapter could not be used to examine other staff groups, for example, domestic staff.

The comparative data we have collected on sickness absence and turnover are for the year 1997/98. We had hoped to relate these to the costing information we collected for the same year but unfortunately the available information systems did not allow us to do this for all homes. As performance indicators and for best value purposes they are of most use if they are examined as trend information. Targets can be set and monitored over time to determine whether continuous improvement is being achieved.

For any indicator involving residents take all residents in the home, including respite clients. Only one home had dedicated day staff for respite clients. We have, therefore, included respite clients as residents in the home. This provides a more reliable way of collecting the data than making a subjective apportionment of staff time.

3.2 Care staff establishment

Indicator: Number of residents per WTE member of care staff.

Collect information about care staff in the home on sheet ***11.3 Profile of staff.*** You will also need data sheet ***11.1 Profile of the home*** for this indicator.

For the purposes of **this indicator**:

Exclude all temporary staff (unless they are covering a permanent post with a set number of hours), and relief and bank staff.

Include all managers. Initially we tried to strip managers out for this indicator. With the exception of the officer in charge it was extremely difficult to differentiate between managers' roles. For the sake of reliability of information we decided that including all managers (and owners if they had a hands-on role in the home) guaranteed a more robust indicator.

You need to calculate the number of care staff in whole time equivalents (WTE). This caused most difficulty in the private nursing home sector where the number of hours in a full time week varied considerably. We took an average of **39 hours** to represent a WTE.

If average occupancy in the home has been greater than 90% in the previous twelve months use the total number of places as the numerator and WTE care staff as the denominator.

N.B. If average occupancy in the home has been less than 90% in the previous twelve months this is not a robust indicator to use for comparison with other homes.

Example – calculating resident to staff ratio

Divide the number of places by the number of WTE care staff.

For example, in a home with 24 places and 17.5 WTE staff:

24/17.5

= 1.37 places per WTE member of staff.

This indicator establishes a baseline staffing ratio. It needs to be considered alongside an assessment of:

- staffing ratios achieved in practice (see section 3.3 below)
- the dependency levels of residents.

3.3 Rotas

Indicator: Number of residents per member of care staff on the rota.

For this indicator use data collection sheets ***11.2 Profile of residents*** and ***11.4 Rota information***.

We examined rotas for the whole of May 1998 in all the homes we visited. From this we calculated the average number of staff on duty at 3 times through the day:

- 8.30 a.m.
- 4.30 p.m.
- 1.00 a.m.

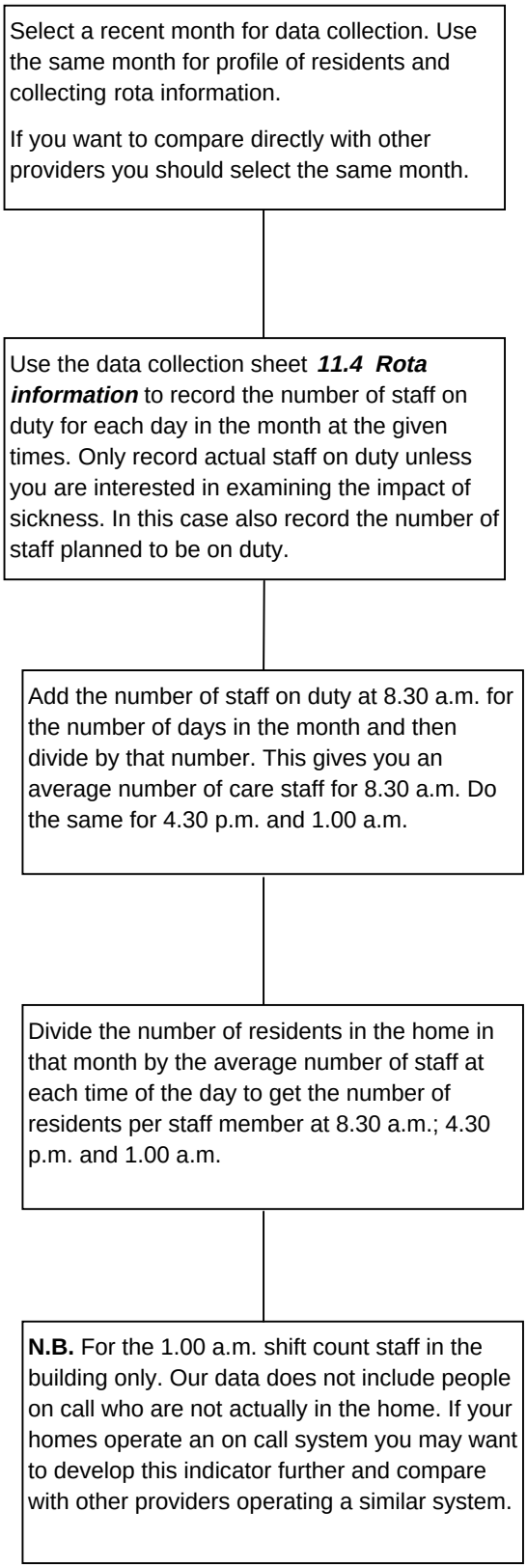
We chose these times as they were likely to cover all shifts in a home.

For the purposes of this indicator:

Include all care staff on duty. (In nursing homes this includes nurses). It is immaterial whether a member of staff is part time or full time - you are just measuring how many people were actually on duty at the given times.

Exclude the manager or owner unless s\he is acting as duty manager for the shift.

Procedure for collecting rota information



Example – calculating the number of staff on the rota

At 8.30 a.m. there are an average 6.2 WTE staff on during the month of May.

There are 32 residents during this month.

Ratio at 8.30 = 32/6.2 = 5.16 residents for each member of staff.

At 4.30 p.m. the average number of staff is 5.3 WTE.

Ratio at 4.30 p.m. = 32/5.3 = 6.04 residents for each member of staff.

At 1.30 p.m. the average number of staff on each night is 2 WTE with one senior on call (out of the building).

Ratio at 1.30 a.m. = 32/2 = 16 residents for each member of staff.

3.4 Part time staff

Indicator: the number of staff working < 20 hours a week

For this indicator use data collection sheet ***11.3 Staff profile***

It was difficult to decide what constituted 'part time' work in the context of residential and nursing home care. Technically speaking it is anyone working less than the standard working week. However, many night staff work different hours and to different rota arrangements than day staff. Any cut off point is going to be arbitrary. Eventually we decided to take 20 hours as close to half time working.

The indicator was an attempt to look at staffing arrangements from the perspective of the resident. We did not use this as a cost indicator although employing a large number of part time staff could reduce an employer's National Insurance contributions.

To calculate the percentage of staff working less than 20 hours a week simply divide the number of staff working less than 20 hours by the total number of staff and multiply by 100.

Example - calculating the percentage of staff working < 20 hours a week

Total number of staff = 23

Six of these work < 20 hours.

6/23 x 100 = 26%

3.5 Sickness absence

Indicators: % working year lost to sickness absence for managers (1997/98)

% working year lost to sickness absence for care staff (1997/98).

For this indicator use data collection sheet ***11.5 Sickness absence.***

Collect sickness absence figures for a whole year and record for the 4 quarters in the year as explained on the data collection sheet. We chose 1997/98.

Record sickness absence in working hours lost. Only hours which form part of an employee's normal working week should be counted for sickness absence. For this indicator we have worked with hours because of the variation in what constitutes a working day.

If you want to differentiate between long term and short term sickness complete the boxes for number of episodes of sickness in each quarter. Using these in combination with the matching boxes on hours lost will show the type of sickness absence in the home.

Completing data collection sheet 11.5

Include: all relevant care staff in the categories of managers and care officers. Treat depute and assistant managers as managers. Treat senior care officers and nurses in nursing homes as care officers. Treat care assistants as care officers.

Exclude: all authorised absences such as unpaid leave, maternity or paternity leave, compassionate leave.

We used an average of 1848 working hours as available in the working year. This excludes weekends, and 30 days annual leave and public holidays. For simplicity we suggest you use the same even though each staff member may have different leave entitlements. We did a sensitivity analysis on the impact of different working hours and it was very slight.

The numerator for this indicator is total sickness absence for each staff group in working hours; the denominator will be the working hours available per year i.e. 1848 hours x number of WTE staff in each staff group.

Example - calculating sickness absence amongst managers

In a home with 3.5 WTE managers the total working hours available for the year is 1848 x 3.5 = 6468 hours.

One manager has 55 hours sickness absence in the year; another has 120 hours; the other 2 have no sickness absence.

% sickness absence for managers = (175/6468) x 100 = 2.7%.

3.6 Staff turnover

Indicator: % staff turnover in year 1997/98.

For this indicator use data collection sheet ***11.6 Staff turnover***

There are a number of ways of measuring staff turnover. We chose to measure it on the basis of **actual** staff numbers who left during 1997/98 rather than on WTEs.

There is an argument that where the staffing of a home comprises a mix of whole time and part time staff a WTE basis gives a better indication than head count of the extent to which skills are being lost. We chose to use a head count, however, because we wanted the indicator to reflect the total number of new people a resident has to get used to rather than the more abstract WTE. The data collection sheet ***11.6 Staff turnover*** includes a column for hours worked against each person who leaves. This information is needed if additional analysis of turnover is required using WTEs rather than a head count.

To produce comparable information to that in the report *'Care in the balance'*, divide the number of leavers in a year by the total number of staff in post (including leavers) and multiply by 100. This was the simplest method to adopt given the number of different personnel systems in the homes and the varying quality of information on staff.

Example - calculating turnover

The staff group = 15 whole time and 8 part time.

During the year 1997/98 2 whole time and 1 part time members of staff left.

3/23 x 100 = 13% turnover

3.7 Qualifications and training

Indicators: % staff with relevant qualifications

% staff studying for relevant qualification

% staff unqualified.

For these indicators use data collection sheet ***11.3 Profile of staff (including qualifications).*** This sheet provides guidance on completion.

We have used a sub-set of the relevant qualifications for residential care as given in the Accounts Commission's *Local Government Act 1992 Publication of information (standards of performance) guide 1999/2000.* These qualifications are recommended as appropriate for this indicator by the Association of Directors of Social Work and the Central Council for Education and Training in Social Work.

To compare with Accounts Commission data

Treat:

- managers, depute and assistant managers as managers
- nurses in nursing homes (other than the matron and other managerial staff), senior care officers, care officers and care assistants as care staff.

Include: staff who are studying for further qualifications should be included in qualified staff.

Exclude: all pre-SVQ data.

The spreadsheet *3.7 qualifications master* on the enclosed disk provides data which allows analyses of number of staff with qualifications; number of staff studying for qualifications and number of unqualified staff. Simply add your home's data to the spreadsheet in the appropriate cells.

The numerator for the indicators is the number of staff with qualifications/studying for qualifications or unqualified. The denominator is the total number of staff.

Example - calculating the percentage of staff with relevant qualifications; studying and unqualified

A home with 15 staff (12.5 WTE) has 6 staff with relevant qualifications.

(6/15) x 100 = 40% qualified.

Of the remaining 9 staff, 4 are studying for SVQ levels 2 and 3.

(4/15) x 100 = 27% studying

5 staff have no qualifications.

(5/15) x 100 = 33%.

The quality of training information available from the majority of homes was too poor to be included in the analysis. For those councils who wish to analyse this information for their own homes a basic information sheet is included at ***11.7 Training provided for care staff.***

4 Care plans

For reviewing care plans use data collection sheet ***11.8 Care plan audit - checklist***.

The checklist is based on accepted good practice and is designed to review both:

- process issues - for example, whether the key worker or named nurse is recorded on all plans
- care practice issues - for example, is there evidence that the care plan is unique to the resident?

We reviewed a small random sample of care plans in most of the residential care homes and a few of the nursing homes. There are widely different approaches to care planning. This was reflected in the range of care plans reviewed. They varied in length, style, content and methods of recording.

We do not believe that the information we collected is robust enough for direct comparisons of performance. However, we have included the checklist in this handbook to assist homes in auditing and developing plans at a local level.

Where councils have broadly similar care plans in their homes they may find the checklist useful in comparing performance.

5 Obtaining stakeholders' views

5.1 Introduction

It is widely recognised that the views of those who use services, their carers, and prospective users of services should be used to help plan and evaluate services[1]. Best value places a strong emphasis on this by requiring councils to assess quality from the perspectives of those who receive and pay for services. Consulting the wider public on service provision and priorities is also an important aspect of a council's role and many are setting up citizens' panels and other mechanisms for this purpose. There are a number of guides to good practice on consultation[2]. In addition, it is good practice to consult the staff who actually provide the service. Guidance on this is also available[3].

This chapter explains the development, use and analysis of the residents' questionnaire we used in the study. Home managers may want to use the whole questionnaire, use specific questions to target known areas of dissatisfaction, or add further questions. The questionnaire is available on disk.

5.2 The questionnaire

For the purposes of our study we focused on residents. An amended version of the questionnaire was also tested on a small sample of relatives. (Data collection sheets ***11.9a and 11.9b***). The questionnaire is suitable for use with both sets of respondents but should be analysed separately, reflecting their different perspectives and needs.

We chose to design our own questionnaire rather than use one 'off the shelf'. This was because we wanted to examine areas which linked specifically to our other investigations and data collection.

5.2.1. Open and closed questions

A 'closed' question only offers the respondent answers from a predetermined list. For example, in response to a question on whether the resident has a single room the answer must be given as a 'yes' or 'no'. An 'open' question allows for an open-ended response. For example, 'which things would you change about the home?'

Using only 'closed questions' in a survey of residents is quicker, cheaper and easier to analyse. However, the opportunity to identify small but important areas for continuous improvement is lost. Closed questions will only tell you how many residents are not satisfied, but not what is causing their dissatisfaction.

Our questionnaire uses a combination of open and closed questions. It provides quantitative information on the level of satisfaction (e.g. how many people are very satisfied with the communal areas) and qualitative information on the reasons for their satisfaction or dissatisfaction. This is important, as managers need to know what they are getting right as well as identifying areas for improvement.

[1] NHS and Community Care Act 1990; Narrowing the gap: improving customer services in local government; Accounts Commission (1994).
[2] See for example, 'Consulting your consumers: A handbook for public service managers. National Consumer Council (1994) and 'Service First (1998); "How to consult users: An introductory guide".
[3] See for example, Walters, M., 'Employee attitude and opinion surveys; Institute of Personnel and Development (1996)

The issues covered in the questionnaire are:

- bedroom
- communal areas
- use of grounds/garden
- meals
- staff
- activities
- excursions
- arrangements for visitors
- key working and care planning
- overall satisfaction.

As already indicated, the questionnaire can be expanded to target local issues. For example, our questionnaire does not cover the impact on residents of running other services from their home such as day centres; neither does it include any questions on laundry services. Both these could be important areas.

In addition to the specific areas listed above, the questionnaire also includes 2 general questions on:

- what residents liked best about the home
- what residents would change in the home.

These two questions are important and we would recommend that you keep these in any adapted version of the questionnaire. They allow residents to explain freely what affects their lives. They provide the opportunity for residents to comment on aspects of the home that service providers may not have identified as being important.

5.3 Conducting the survey

5.3.1 Who should you ask?

In the context of this study residents of the homes are the primary users of the service. However, their relatives and other carers also have a clear interest in the care provided and their views should be sought as well. Where residents are unable to articulate their views an advocate should be enlisted to assist them in completing the questionnaire. Care should be taken in interpreting the responses of groups who are likely to have different perceptions of life in the home. The sample used needs to be large enough to be representative, but it will be largely self-selecting as participation is voluntary. This should be borne in mind when interpreting results. In most homes we interviewed a quarter of the residents.

People with dementia should not necessarily be excluded from the survey. Current research indicates that even people with a Mini Mental State Examination (MMSE) score of 10 can still make relevant comments on their needs.

The interviews should be conducted in a private setting.

5.3.2 Who should ask the questions?

Ideally the interviews should be conducted by someone independent of the home and of the Social Work Department. Many councils have other departments, such as corporate services, which may employ suitable staff. For this process interviewers need to be sensitive to the particular needs of elderly people, some of whom have dementia. They should also be involved in the analysis of the data collected to ensure it is accurately interpreted.

5.3.3. Setting up the interviews

We wrote to the manager of each home outlining the objectives of the study and requesting that residents be informed about the survey. We gave a guarantee of anonymity and confidentiality and an assurance that participation was voluntary on the part of residents. The manager decided how the information in this letter was conveyed to residents. The best informed residents were those in homes where:

- each resident was given a copy of the letter
- the letter was displayed in a prominent place in the home
- the survey was discussed at residents' meetings
- key workers reminded residents about the survey and the date when it was due to take place
- staff and residents were reminded on the day of the survey

Relatives were invited to visit the home on a certain day and were given 30 minute appointments. Interviews were arranged in the afternoon and evening for people who worked and sufficient notice was given to enable people to make appropriate arrangements.

5.4 Analysing the responses

In order to analyse the results you need to translate the responses into numeric values through a system of coding. These then need to be entered into a spreadsheet or similar package.

5.4.1 Coding the questionnaire

Each home should be given a unique identifying number.

Each questionnaire should be numbered consecutively so that it can be identified during analysis if required (e.g. for checking data entry, or querying responses).

You also need to decide what 'profile variables' are to be used. These are variables which allow grouping of responses such as:

- the home name or unique identifier
- sector (council, voluntary, private)
- whether residential or nursing home provision.

Closed questions are already coded, mostly 1-5. However, coding the open questions is more complicated and may result in a large number of codes. Each unique response should have a numeric code assigned. For example, in question 7.1 where residents are asked to explain their level of satisfaction with the food, possible answers could be:

- quantity
- quality
- choice
- times of meals.

These could be then coded as quantity = 1; quality = 2; choice = 3; times of meals = 4. For more than one response either create codes for each combination or simply allow more than one response for each open question. You should decide the number of responses you want to gather. Two to three responses are generally regarded as sufficient for a 'multiple response' question. To make it manageable we suggest you limit responses to a maximum of three per open question. Most people will only mention one or two reasons for their level of satisfaction.

You should create a code list for every open question. However, it will save you time if you use a single code list for these questions:

- what do you like most?
- what would you change?

They should be analysed separately.

5.4.2 Data entry

Before designing your data entry spreadsheet you need to know:

- the profile variables you want to use
- the number of closed questions
- the number of open questions
- how many responses to each open question you want to use.

Each variable needs a separate column or entry box. Think through what you are going to enter before you start; for example, the question 'How long have you lived here?' will be answered in terms of years for some respondents, months for others. You need to decide whether to enter all responses as 'number of months', or round them all up to the nearest number of years.

5.4.3 Producing findings

Once the data has been entered, you can analyse the results and include them on the appropriate Accounts Commission graph to compare your home's position. The analysis of the open questions can be used for continuous improvement in the home.

6 Caring practices and routines

6.1 Introduction

This section uses a tool developed by Professor Tim Booth in the mid 1980s to examine the regimes in homes. His original work looked at the way in which the regime of a home can induce dependency in residents. We used it only to examine the management practices and caring routines in homes.

'*Home truths'*[4], the book which discusses his methodology and findings, is now out of print. However, the Accounts Commission for Scotland has bought the copyright to the tool, and it may be used without charge by Scottish local authorities and other providers of residential and nursing home care.

6.2 The questionnaire

The questionnaire is contained in data collection sheet ***11.10 The institutional regime questionnaire***. It investigates 33 different aspects of a home. Each aspect can be used as an individual measure, or the aspects can be clustered to give combination measures of:

- personal choice
- privacy
- segregation from the local community
- resident participation in the home.

Some of the individual aspects may be considered slightly dated. For example, in Booth's original sample only 28% of homes had no rules about when residents got up in the morning. In our sample 80% of homes offered this level of choice about morning routines. However, the aspects of care covered by the questionnaire still offer a valid starting point for investigating caring routines and philosophies.

The tool only provides information on what caring policies and routines are in place, and not how they are carried out and the impact they have on residents' lives. Homes with similar scores can be very different places in which to live.

6.2.1 Completing the questionnaire

The questionnaire can be used as a self assessment tool by the manager. Alternatively it can be administered by an independent person as a semi-structured interview with the home manager, and perhaps one or two care staff, to check for consistency of perception.

The questions should not be recited verbatim by the interviewer; a good approach is to ask general questions about each aspect. For example you could ask: 'What happens in the morning?' This is likely to get a more honest description than the questions 'Are there any rules about bedtime?' or 'Do residents go to bed at a time set by staff?'

The interviewer will also need to record his or her impressions of the interviewee and their responses. Although it is unlikely that any managers or members or care staff would deliberately mislead, their answers may not be completely accurate. In particular, interviewees may describe what would happen in the home under ideal circumstances, for example if there were no sickness absence, rather than what actually happens day to day.

[4] Tim Booth, *Home Truths: old people's homes and the outcome of care*. Gower, 1985.

The interviewer should bear in mind the aspects covered by the questionnaire, and record any relevant observations during their visit. We visited two homes where we rang the bell to gain admission, yet we were told during the interview that 'the front door is not locked during the day'.

6.2.2 Analysing the questionnaire

The questionnaire is very simple to analyse, but care is needed to include any observations by the interviewer and to correct any inconsistencies.

The best way to do this is at the end of the review, when all homes have been visited. Review all the questionnaires again, and make consistent decisions about ambiguous aspects. For example, in the two homes where we had to ring for admission, we recorded this as 'the door is locked during the day', even though this is not what we were told during the interview. In another home where we were told that residents chose when to have a bath but a bath rota was pinned to the office wall, we recorded this as 'staff choose when residents have a bath'.

You can collate the responses to individual aspects of the regime and relate them to other findings, as we do in *'Care in the balance'*. You can also group the responses into the four combination scales:

- personal choice
- privacy
- segregation from the local community
- resident participation in the home.

1. Personal choice scale

Flexible routines have a minimum of ten of the following characteristics:

Bedtimes	either some residents go to bed at a time set by staff while others choose their own bedtimes OR there are no rules about bedtime
Getting up	either some residents are allowed to get up when they want but others are not or there are no rules about getting up
Breakfast	either residents can have breakfast when they like or within some set time period.
Menu choice	there is always or sometimes a choice of main dishes on the menus for the midday meal
Menu planning	residents are consulted over the planning of menus or efforts are made to meet their requests
Bathing	residents choose when they have a bath
Access to grounds	residents may use the garden or grounds of the home when they wish
Furniture	residents may either bring large or small items of their own furniture into the home
Decorations	residents occupying single rooms may have them decorated at their own expense or would generally be asked to choose the decor when the room is redecorated
Refreshments	facilities are available for residents to make their own snacks or drinks
Alcohol	residents can buy alcohol in the home
Clothing	residents are either taken to the shops to buy new clothes or they choose from a selection brought to the home
Personal allowance	one half or more of the residents directly receive the full personal allowance
Meetings	staff and residents meet together formally on a regular basis to discuss common affairs

Structured routines have a minimum of ten of the following characteristics:

Bedtimes	all residents are expected to be in bed at a time set by staff
Getting up	residents are expected to be up in the morning by a time set by the staff
Breakfast	there is a set time for breakfast
Menu choice	there is no choice of main dish at the midday meal
Menu planning	menus are normally planned entirely by staff
Bathing	staff decide when residents are to have a bath
Access to grounds	residents may use the garden or grounds only with the agreement of a member of staff or if supervised
Furniture	residents' own furniture cannot be accommodated
Decorations	residents normally have no say about decorations in their room
Refreshments	residents do not have facilities for making their own snacks and drinks
Alcohol	residents cannot buy alcoholic drinks in the home
Clothing	staff generally buy new clothes for the residents
Personal allowance	less than half of the residents receive the full personal allowance
Meetings	there are no formal meetings involving residents and staff

Intermediate routines - have any other combination of characteristics on the fourteen variables.

2. Privacy scale

Responsive regimes have the first two and any three of the next four variables**:**

Personal valuables	all residents have somewhere to lock personal valuables
Access to bedrooms	all resident are allowed to use their own bedrooms during the day
Access to grounds	residents may use the garden or grounds of the home when they wish
Access beyond grounds	residents may normally come and go as they please
Locking bedrooms	all residents occupying single rooms may lock their own doors
Privacy	there are facilities for residents to receive visitors in private

Unresponsive regimes have the first two and any three of the next four variables:

Personal valuables	not all residents have somewhere to lock personal valuables
Access to bedrooms	residents are either not allowed to use their bedrooms during the day or they may do so only sometimes
Access to grounds	residents may go into the garden or grounds only if supervised
Access beyond grounds	residents are usually accompanied when leaving the grounds of the home
Locking bedrooms	not all residents occupying single rooms may lock their bedroom doors
Privacy	there are no facilities for residents to receive visitors in private

Intermediate regimes - all other combinations of characteristics on the six variables

3. Segregation scale

Open environments - minimum of seven of the following characteristics:

Access beyond grounds	residents may normally come and go as they please
Locking front door	the front door is not locked during the day
Visitors	visitors are welcome at any time of the day or evening
Overnight accommodation	overnight accommodation is sometimes provided for visitors
Telephone	residents have access to a pay-phone in the home
Away visits	half or more of the residents sometimes stay with family etc. for weekends or holidays
Social activities	half or more of the residents regularly attend meetings of clubs and societies outside the home
Holidays	holidays are arranged for groups of residents

Closed environments - minimum of the seven of the following characteristics

Access beyond grounds	residents must either have permission from a member of staff or be accompanied before leaving the grounds of the home
Locking front door	the front door is kept locked at all times or is sometimes locked during the day
Visitors	visitors may call at set times or by prior appointment
Overnight accommodation	there is no overnight sleeping accommodation for visitors
Telephone	there is no pay-phone provided for residents
Away visits	few or no residents spend weekends or holidays with family etc.
Social activities	few or no residents attend meetings of clubs and societies outside the home
Live entertainment	outside groups or artists visit the home not more than once every two or three months
Outings	day or evening outings are arranged not more than once every two or three months
Holidays	holidays are not arranged for visitors

Intermediate environments - all other combinations of characteristics of the ten variables

4. Participation scale

Democratic regimes - all homes with regular staff-resident meeting plus any two of the following characteristics:

Menu planing	residents are regularly consulted about the planning of menus or staff make an effort to meet special requests
Domestic tasks	most residents do small domestic jobs in the home or grounds
Home entertainment	staff themselves provide some form of entertainment or recreation in the home for residents monthly or more often

Autocratic regimes - all homes without regular staff-resident meetings plus any two of the following characteristics:

Menu planing	menus are normally planned entirely by staff
Domestic tasks	residents do not help about the home
Home entertainment	staff themselves only provide entertainment or recreation for residents once or twice a year or not at all

Intermediate regimes - all other combinations of characteristics on the four variables - meeting, menu planning, domestic tasks and home entertainment.

7 The environment

7.1 Introduction

The physical environment of a home is to a certain extent determined by the type and size of the building itself, and whether or not it is purpose built. It is also affected by the amount of repair and maintenance work carried out.

Increasingly, single en suite rooms are becoming the standard for accommodation in residential and nursing homes. Best value will require councils to consider their own provision against this standard. In doing so many will face the question of whether it is cost effective to upgrade their own homes.

This section deals with two quantitative indicators of a home's environment. These are:

- proportion of residents with a single bedroom
- proportion of residents with en suite facilities.

The environment of a home is made up of more than bedrooms and adjoining bathrooms. The other indicators we have used to investigate the environment (such as satisfaction with bedroom) are collated through different means and are discussed in *Chapter 5 Obtaining stakeholders' views* and *Chapter 6 Caring practices and routines*.

7.2 Percentage of residents with single and en suite rooms

The data you need to collect for this indicator is detailed in data collection sheet ***11.1 Profile of the home***.

In calculating this indicator we used **all** rooms in the home, including respite. For those homes with a high percentage of respite places this may have slightly overstated their position. The data collection sheet provides a space for you to differentiate between places if you choose to make a more detailed analysis of single rooms.

It is also important that you differentiate between the percentage of single and en suite rooms a home has, and the percentage of residents who occupy these rooms. If you decide to look at the percentage of bedrooms:

- you will be over-stating the quantity of the provision for residents (see box below)
- you will not be able to compare your indicator with the Accounts Commission's.

Percentage of single rooms or percentage of residents with single rooms?

In a residential home which can accommodate 60 residents and has 50 single rooms and 5 double bedrooms the indicator for single rooms can vary, depending on the way in which you calculate it.

For example:

The % of single bedrooms in this home is calculated by:

Number of single rooms / total number of rooms = (50/55) x 100 = **90.9%.**

The % of residents in single rooms is calculated by:

Number of residents not sharing/total number of residents = (50/60) x 100 = **83.3%**

8 Costs

8.1 Introduction

Councils require full and accurate information on relevant costs for both strategic and operational decisions. Strategic decisions about the mix of internal and external provision require all costs to be taken into account, including appropriate capital costs. For decisions about the day-to-day operation of individual homes revenue costs are more appropriate. Ideally, these costs should include overheads and an element of capital costs, albeit probably on a different basis than for strategic decisions. There is some debate about which are the most relevant capital and overhead costs.

8.2 General approach

The study team drew up a preliminary costing template, using the standard classification set out in the CIPFA publication '*Accounting for Social Services in Great Britain'*(1993). The template was refined, in the course of the study, to provide information on key cost drivers without including an unnecessary degree of detail. The template is intended to act as a starting point for identifying areas of expenditure which would benefit from more detailed examination by individual providers.

Providers were requested to supply a ledger print or accounts for the last available financial year. In the case of councils this was the year to 31 March 1998. Some of the other providers in the study had earlier year ends. No adjustment has been made for inflation as we did not consider that the effect would be material. For a copy of our costing template and notes on completing it see ***Data collection sheet 11.11.***

We collected information on the following categories of expenditure:

- care staff
- premises
- supplies and services
- overheads
- capital.

Capital and overheads have been omitted from our cost data to enable comparisons to be made between providers and across sectors. The issues associated with these categories of expenditure are discussed below. Councils will be aware that they are required by statute to include full costs in their standard charge calculation[5]. It should be noted that the addition of capital and overhead costs to the figures quoted in our report will significantly increase costs for most providers.

[5] S22(2) of the National Assistance Act 1948.

8.3 Allocating costs to different services

Council homes differ from those of most other providers in that they are often used to provide other services in addition to residential care; for example, day care, home support administration and meals on wheels. We had hoped to be able to isolate these costs from our running costs for residential care. However, whilst we were able to identify and remove costs relating to staff engaged on other services, insufficient information was available from councils to enable premises costs (such as cleaning and energy costs) to be satisfactorily apportioned between the different user groups. As a result these costs are overstated for some of the council homes in our sample.

This issue must be addressed by councils. Setting up systems to capture information may require additional computer resources or divert staff from other activities. Management must decide whether the benefits derived from implementing systems to capture additional information justify the cost of obtaining it. It may be that estimates based on a mixture of reasonable assumption and easily obtainable data (such as floor area) are an acceptable and more cost effective substitute for fully accurate information.

8.4 Staff costs

In general, it is unlikely that councils' financial ledger systems will provide an analysis of employee costs by grade. We used year-end payroll prints, together with information collected from each home[6], to ensure that all relevant employee costs were identified. The payroll print was then reconciled to the ledger. There were generally discrepancies between the ledger and payroll figures. We understand that these arise from different methods of paying allowances and expenses and from year end accruals. For the purposes of the study, ledger totals were used and differences allocated to the care staff category.

We separately identified the costs of care staff, domestics, cooks, handymen and administrative staff. This should facilitate consideration of how best to provide ancillary services. Our definition of 'domestics' includes kitchen domestics and laundry staff and may also include some staff involved in food preparation. This was due to limitations in the source data available to us. We consider that food preparation staff should be classified as 'catering staff' and that laundry staff should be separately identified under 'supplies and services'.

Information on allowances and expenses was not held in a form which enabled full analysis. This area would merit further consideration by councils to determine the significance of the sums involved and to identify whether anomalies exist between, or within, councils.

[6] ***Sheet 11.3: Profile of staff.***

8.5 Premises costs

Premises costs comprise repairs and maintenance, energy, and other property related costs such as buildings insurance. As discussed above, we have separately identified the cost of caretakers or handymen to enable full consideration of staffing issues and the related costs. Repairs and maintenance costs will include renewals below a threshold determined by each provider. In general the private and voluntary sectors use significantly lower thresholds for capitalising expenditure than councils. This means that repairs and maintenance expenditure in the private and voluntary sectors may appear lower than in the council sector, and the situation is correspondingly reversed in relation to capital expenditure.

8.6 Cleaning costs

Although cleaning costs would normally be considered as part of premises costs we have isolated them as this was an area where our study highlighted significant cost differences. The main reasons for the differences were the higher rates paid to staff in the council sector and higher costs associated with the use of DSOs.

8.7 Catering costs

As with cleaning, the study highlighted significant cost differences, with the use of DSOs being a major factor. One difficulty faced by many councils is that kitchens in residential homes are often used to provide meals on wheels and meals for day centre clients. We recommend that steps are taken to identify the costs associated with meals supplied by residential kitchens to the different client groups. This will enable only those costs relating to residents' meals to be included in the home's costs.

For the purpose of the study we made an apportionment based on an assumption that lunch was the main meal of the day and represented 50% of the total food costs. We also assumed that lunch was the meal provided by the meals on wheels service and to users of day centres within homes. Food costs were apportioned between residents and other groups on the basis of the estimated number of lunches provided. Catering staff costs were apportioned on the basis of relative expenditure on food.

8.8 Supplies and services

Our study did not identify a significant amount of expenditure relating to client services. Practice varied as to the services for which clients were charged and which costs were met from the proceeds of fundraising by individual homes. The relevant costs for inclusion in the template are those borne by the council, i.e. the cost of providing the service net of contributions from residents or fundraising. Costs associated with transport for residents should be included here.

The category 'other supplies and services' includes expenditure on contents and public liability insurance, professional fees and, for the private and voluntary sectors, registration and inspection fees. For private sector providers running a single home the cost of services such as accountancy and audit will be included. For other providers these costs will be classified as overheads.

8.9 Medical supplies

We attempted to identify and capture additional costs associated with nursing homes in contrast to residential homes under the category 'medical supplies'. Many medical supplies and services are provided by the NHS. It is possible, however, that there may be some additional capital costs associated with specialist equipment for nursing homes. We did not examine this area.

8.10 Capital and overheads

One of the aims of this study was to compare costs across sectors. However, because of the different bases of accounting for capital costs and the lack of uniformity in the treatment of overheads, both within sectors and between providers, these costs have been excluded from our consideration of comparative costs. It should be borne in mind that the inclusion of these costs will significantly increase the overall costs. Councils should be aware that they are legally required to calculate standard charges on a full cost basis i.e. including relevant capital and overhead costs.

8.10.1 Overheads: identifying relevant costs

For the purposes of this study, the term 'overheads' is used for both central support services and departmental overheads. For councils, the recommended treatment of overheads is set out in the CIPFA *Statement on Accounting for Overheads in Local Authorities in Great Britain*, issued in 1994. The Statement's requirements apply only to the service and divisions of service level. The CIPFA publication *'Accounting for Central Services in Great Britain'* (1995) specifies that 'the basis used and the level to which costs are allocated, apportioned or charged is at the discretion of the local authority' (para 2.09). The Statement is based on the underlying principle that end users should invariably pay for the support services they use.

Clearly the definition of the end user of any particular service is open to debate. In the context of residential care for older people there are several levels to which overheads can be charged. At the higher level cost centres, such as *'Services for the Elderly'* or *'Residential Care of the Elderly'*, the cost is ultimately borne by the taxpayer. At the lowest level, i.e. the individual home, the cost is borne by individual residents.

In deciding where to charge overheads councils should determine whether the cost legitimately falls to be borne by the general or local taxpayer or by direct users of services. It seems reasonable that residents should only bear the cost of those overheads which directly relate to the running of the home. One way of determining this is to consider whether specific costs would be borne by a home run by an external provider.

In addition, where high overhead costs arise from inefficiencies or from the complex administrative needs of councils it seems inequitable that these should be borne by residents of care homes. It is, nevertheless, important to maintain a downward pressure on high overheads.

When the relevant overheads have been identified, councils should examine the nature and volume of the central services required by each home and draw up service level agreements (SLAs) specifying the charge to be levied for specified volumes of service. This would ensure that homes bear the costs directly related to services provided to them. We saw no evidence that SLAs are widely used by councils, although consensus exists that they are the most satisfactory method of monitoring, controlling and allocating central costs.

The advantages of SLAs are:

- monthly accounts can be raised, rather than the year end allocation which generally occurs in councils
- service managers have greater control over costs and accountability is increased
- comparison with the cost of externally purchased support services is made easier
- cost comparisons with external providers of residential care would be facilitated
- only relevant overhead costs would be borne by residents.

In practice, at individual home level, councils appear to take an all or nothing approach. That is to say, either no apportionment is made to the home, or full apportionment is made of all overheads whether or not they are relevant to the operation of the home. Commonly the apportionment is based on relative expenditure. This leads to a situation where it is likely that the overheads for individual homes are either understated (where no allocation is made) or overstated. This is clearly unsatisfactory.

The private sector providers included in our sample were either single homes run by a partnership, in which case there are no central overheads, or were companies running several homes. The companies set prices to ensure sufficient profit was made by each home to cover overheads, but practice varied over whether overheads were apportioned to individual homes in the group. Practice in the voluntary sector varied between apportioning all overheads on the basis of expenditure by the homes and making no allocation of overheads to individual homes, taking any profit from the home as a contribution to overheads. To ensure full cost recovery, providers should include relevant overheads when calculating unit costs for each home.

8.10.2. Capital costs

The annual charge for capital which appears in the accounts of providers in the three sectors varies because of the different accounting conventions in force. In addition, the cost of financing capital expenditure in the three sectors varies because of the nature of their access to capital markets. Generally the council and voluntary sectors have access to capital at lower rates than those available to the private sector.

For the purposes of their published annual accounts councils are required to account for their fixed assets using a form of current cost accounting. Their fixed assets are regularly re-valued and shown on the balance sheet at their current value. Service accounts are charged with notional capital charges consisting of a financing charge and depreciation based on current values. The financing charge is designed to reflect the cost of tying up financial resources in a particular asset, and depreciation represents the extent of 'wear and tear' which has reduced the value of the asset during the year.

However, it is significant to note that these notional capital charges are removed from the consolidated revenue account and replaced with actual loan charges (mainly interest) and capital repayments for the year. This is because councils are required by law to set council tax levels to provide sufficient money to meet the estimated 'expenses to be incurred' during the year, taking account of any other sources of funding[7]. Since notional charges do not fall within the definition of expenses to be incurred they must be replaced with actual payments of loan interest and repayments of loan debt.

[7] S93, Local Government Finance Act 1992.

Private sector providers charge depreciation and interest on loans used to purchase assets to their revenue accounts. Voluntary sector providers using donated assets or assets funded by donation make no charge to the revenue account by way of depreciation, but charge for assets funded by external loans in the same way as the private sector. The practice of not charging for donated assets has implications for future provision by the voluntary sector because of a decrease in the level of charitable donations. This issue falls outwith the scope of our current study but it will be examined in the next phase which will look at commissioning and related strategic issues. Some voluntary sector providers have access to loans for the purchase of assets from a central fund for which they are charged a notional rate of interest, below the normal commercial rate. In general the private sector borrow at normal commercial rates.

In effect the repayments of loan debt, which appear in councils' accounts, are analogous to depreciation in the accounts of the private and voluntary sectors in that they result in the cost of assets being spread over a number of years. The length of the repayment period will obviously affect the annual charge to the revenue account. Councils are permitted to take loans for residential homes over a maximum term of 40 years which is considerably longer than the term which would be available to the private sector. The longer period available to councils is because of the lower risk of them defaulting on loans.

In summary, **annual capital costs** which appear in the accounts of providers in the three sectors are:

- ***Private sector*** - loan interest and depreciation
- ***Council sector*** - notional capital charges based on current asset values, replaced by loan interest and repayments.
- ***Voluntary sector*** - no charge for donated assets, loan interest and depreciation for assets financed by loan.

Different materiality levels are used by providers to determine whether expenditure should be capitalised or charged to revenue in the year of purchase. The private and voluntary sectors tend to capitalise expenditure on furniture and equipment which councils would generally charge to revenue in the year of purchase. We encountered thresholds as low as £100 for capitalisation in the private sector, whereas councils use a higher materiality level, around £6000.

Uniquely amongst the three sectors, councils have the ability to finance significant capital expenditure from income raised in the current year, where surplus funds are available. This is discussed below.

The variation in accounting practice for the treatment of capital costs across the three sectors makes inter-sector comparison on a full cost basis impracticable.

8.10.3. Relevant capital costs

For the purpose of monitoring the achievement of best value and establishing baseline costs for commissioning purposes there are two types of capital cost which councils need to consider. These are:

- the cost of acquiring fixed assets
- the cost of using them.

The primary asset involved in the provision of residential care is the home itself, and the acquisition cost consists of the construction costs or purchase price (including fixtures, fittings and remedial work required to make the building fit for its purpose as a residential home) together with any financing cost (such as loan interest). These costs require to be charged to revenue over the life of the asset.

The capital charge established under the revised capital accounting system for councils is intended to cover both the cost of acquiring the asset and the cost of using it. However, in some cases the revised capital charge will be more than the actual costs incurred (for example, older properties in areas where the property market is buoyant and where the loan debt is fully discharged). For this reason it may be more appropriate to use capital repayments and interest as the cost of acquiring capital. [8] For assets where the loan debt is fully discharged, it is likely that increased repairs and maintenance costs will be incurred to compensate for the absence of any loan charges. The cost of assets purchased from current revenue needs to be spread over a suitable period to prevent a disproportionate increase in running costs in a single year.

We acknowledge that there are difficulties associated with this approach. In the course of the study we found that the introduction of the new system of capital accounting, together with the reorganisation of local government, has given rise to a situation where some authorities are unable to identify information relating to the loan repayments and interest charges relating to individual assets. This obviously has implications for stewardship.

The cost of using an asset is the amount incurred in maintaining its value (i.e. repairs to the fabric of the building), together with any amount by which the value of the asset has diminished due to its being used over the accounting period (depreciation), plus the cost of general repairs. Since residential care homes should be maintained to the high standard appropriate for dwelling places, it could be argued that the costs of repairs and maintenance are sufficient to represent the cost of using the building without charging depreciation. Some private sector providers do not charge depreciation on buildings on this basis.

Generally speaking, councils and other providers will have a cycle of structural repairs and improvement works which will be undertaken over a period of three to five years. For this reason it is considered appropriate that these costs are averaged over a rolling period of five years, or more, to ensure that the costs are not unreasonably distorted by the cost of a major structural repair. One council in our study had adopted this type of approach using a repairs and renewals fund. This is only appropriate for the purposes of management accounts, since ACOP[9] requires the actual cost of repairs in the year to be charged to the revenue account.

[8] For the purposes of this study it is assumed that councils will continue to own and operate their existing homes. Decisions on whether to close homes and out-source the provision will, of course, require different costs to be considered.

[9] The Code of Practice on Local Authority Accounting in Great Britain.

The treatment of capital costs by providers in the private and voluntary sectors are for them to determine. However, for the reasons summarised above, their capital costs, particularly in the early years of operation of a home, are likely to be higher than in the council sector. Conversely, their initial loan debt on the home itself will be fully repaid within a relatively short period. This will increase profitability in later years for the private sector. Councils will have to consider whether these are relevant factors when making commissioning decisions.

For the purpose of establishing the 'standard charge' for residential accommodation for older people guidance issued by COSLA, and endorsed by LASAAC[10], recommends the use of capital charges calculated under the revised capital accounting system. The problems discussed above mean that councils may need to engage in a debate about the most suitable method for taking the costs of capital into account. It would be desirable to reach a consensus on a common approach to facilitate comparisons, and to ensure equity of treatment among residents of homes in different council areas.

[10] Local Authority (Scotland) Accounts Advisory Committee

9 Good practice checklist

9.1Introduction

This handbook concentrates on providing tools and guidance for the collection of comparable quantitative data from residential and nursing homes. These data and the good practice we identified in our study site homes have been used in the report ' *Care in the balance'* to make a number of recommendations.

Other homes may find it useful to compare their own practice against these recommendations and develop an action plan covering areas for development. The following checklist has been devised for this purpose.

9.2 Reviewing a home against good practice

Home_____

Good practice questions to ask of the home. ***Does your home or council*:**	**Report reference**	**Achieved yes/no/partially**	**Action required**
Increasing effectiveness and residents' satisfaction			
Ensure that residents are fully involved in: • assessing and planning for their own care needs • planning and evaluating all aspects of life in the home.	Chapter 3: *'Service quality'*		
Ensure that care plans are based on individual needs and preferences.	Chapter 3: *'Service quality'*		

Good practice questions to ask of the home. ***Does your home or council*:**	**Report reference**	**Achieved** **yes/no/partially**	**Action required**
Increasing effectiveness and residents' satisfaction			
Undertake regular audits of care planning.	Chapter 3: *'Service quality'*		
Ensure all residents understand the role and identity of their key worker.	Chapter 3: *'Service quality'*		
Have single en suite rooms for all residents.	Chapter 4: *'Quality of the environment'*		
Maximise the arrangements for privacy, providing all residents with: • keys to their doors if they want them • a personal lockable drawer for valuables • alternative meeting place for residents who share rooms to meet with visitors.	Chapter 3: *'Service quality'*		
Provide facilities for residents or their visitors to make tea or coffee.	Chapter 3: *'Service quality'*		
Develop and sustain links with the local community for the benefit of residents.	Chapter 3: *'Service quality'*		
Regularly review the effectiveness of residents' meetings and use other methods for gathering residents' views and keeping them informed.	Chapter 4: *'Quality of the environment'*		

Good practice questions to ask of the home. ***Does your home or council*:**	**Report reference**	**Achieved** **yes/no/partially**	**Action required**
Increasing effectiveness and residents' satisfaction			
Closely match staffing levels to the care needs of residents.	Chapter 2: *'Staffing and the quality of care'*		
Ensure that the home's policy on the use of part time, relief and bank staff does not affect the quality of care. Consult with residents on the impact of the policy on them.	Chapter 2: *'Staffing and the quality of care'*		
Ensure that staff have adequate channels of communication to raise concerns about care practice in the home.	Chapter 2: *'Staffing and the quality of care'*		
Involve residents in identifying gaps in staff skills.	Chapter 2: *'Staffing and the quality of care'*		
Have an overall staff development plan linked to the home's objectives.	Chapter 2: *'Staffing and the quality of care'*		
Develop individual staff development plans which directly reflect the home's objectives and link to regular staff supervision and appraisal sessions.	Chapter 2: *'Staffing and the quality of care'*		
Provide comprehensive induction training for new staff.	Chapter 2: *'Staffing and the quality of care'*		

Good practice questions to ask of the home. ***Does your home or council*:**	**Report reference**	**Achieved** **yes/no/partially**	**Action required**
Increasing effectiveness and residents' satisfaction			
Provide domestic and other non-care staff with training in: - the values of the service - promoting the maintenance of residents' skills and independence.	Chapter 2: *'Staffing and the quality of care'*		
Improving efficiency			
Develop sound financial and other information systems which provide reliable information for management and comparative purposes.	Chapter 5: *'Service costs'*		
Compare performance on selected indicators with other providers to target areas for improvement.	*'Care in the balance'*		
Benchmark with other providers to identify areas of better practice which can be adapted into their own service delivery.	*'Care in the balance'*		
Ensure that home managers have clear job descriptions which recognise the importance of: - training and developing new staff - sustaining links with the local community - monitoring the effectiveness of care planning - promoting and monitoring the involvement of residents in all aspects of life in the home.	Chapter 2: *'Staffing and the quality of care'*		

Good practice questions to ask of the home. ***Does your home or council*:**	**Report reference**	**Achieved** **yes/no/partially**	**Action required**
Improving efficiency			
Ensure that adequate administrative and information technology support is available.	Chapter 2: *'Staffing and the quality of care'*		
Monitor sickness absence. Compare performance with other providers. Set targets to reduce these if they go above an acceptable level.	Chapter 2: *'Staffing and the quality of care'*		
Monitor staff turnover. Compare performance with other providers. Develop an action plan to improve performance if necessary.	Chapter 2: *'Staffing and the quality of care'*		
Assess the benefits of managing care and ancillary staff in the same teams.	Chapter 2: *'Staffing and the quality of care'*		
Managing or reducing costs			
Consider consortium arrangements to share the cost of SVQ training and workplace assessment.	Chapter 2: *'Staffing and the quality of care'*		
Review the delivery of catering and cleaning services to their residential care homes, particularly where DSOs are involved.	Chapter 5: *'Service costs'*		
Review the management structure in the home to maximise the number of front line care staff. Ensure that adequate management controls remain in place.	Chapter 2: *'Staffing and the quality of care'*		

Good practice questions to ask of the home. ***Does your home or council*:**	**Report reference**	**Achieved** **yes/no/partially**	**Action required**
Managing or reducing costs			
Share with other councils different approaches to service delivery which improve staffing levels within current resources, or achieve cost savings.	Chapter 2: *'Staffing and the quality of care'*		
Compare costs with other providers as a way of identifying areas to target for cost reductions.	Chapter 5: *'Service costs'*		
Being accountable			
Provide clear comprehensive information for prospective residents on the home and care provided.	Chapter 3: *'Service quality'*		
Make copies of inspection reports available to residents, families, and prospective residents.	Chapter 3: *'Service quality'*		
Provide each resident with a contract which clearly outlines the resident's rights and responsibilities.	Chapter 3: *'Service quality'*		

10 Best in class?

Benchmarking is a structured approach to finding ways to improve your organisation's performance so that it conforms to - or moves towards - best practice. 'Best in class' benchmarking focuses specifically on those organisations that are judged to be the best in terms of a particular process or function[11].

This study has identified performance indicators - or data benchmarks - for residential and nursing home care. It has not developed an approach to benchmarking. This will require councils and other providers to identify:

- the most appropriate providers with whom to compare performance
- the processes by which better performance is achieved.

It is not easy to identify the key performance indicators which show that one home is better than another. However, for **illustrative** purposes, we have taken eleven indicators and scored each residential care home against them in the table overleaf.

The main problem with this approach is that no weighting is given to the different indicators. For example, it may be more important to have 100% single rooms than less than 6% sickness absence amongst care staff.

Such data benchmarks are really just the start of benchmarking for performance improvement. Whilst such data will help you identify performance gaps - for example, my home's staff turnover is significantly higher than other homes' turnover - they do not in themselves help to identify the cause of differences in performance, or indicate how to improve performance. Indeed they are likely to raise more questions than answers - questions that other types of benchmarking try to answer.

Councils that wish to improve their services using benchmarking techniques can contact the Accounts Commission's Management Studies Unit on (0131) 477 1234 for further advice and guidance.

[11] A recent publication available from the Management Studies Unit (MSU) of the Accounts Commission provides a more detailed guide to benchmarking. *'Measuring up to the best: a manager's guide to benchmarking'* January 1999. Another useful MSU publication on measuring performance is *'The measure of success: developing a balanced scorecard to measure performance'* June 1998.

	Resident to care - staff ratio <2	sickness absence - care staff < 6%	care staff turnover - < 10%	100% residents called preferred name	100% residents think staff are excellent or good	overall satisfaction >50% very satisfied, remainder quite satisfied	100% residents single rooms	100% residents with en suite rooms	care staff qualified or studying - upper quartile	50% + residents attend external clubs	weekly running cost < £306 (average for residential care homes)	/11
1v	√			√							√	3
2c			√								√	2
4c			√		√		√				√	4
5c			√	√							√	3
6c	√					√	√		√	√		5
7v	√	√	√			√		√			√	6
8v	√	√							√		√	4
9c	√			√							√	3
10c									√		√	2
11v	√	√	√	√		√			√	√	√	8
12c	√		√	√			√					4
13c	√		√									2
14c	√		√	√		√	√	√	√	√		8
15c	√	√				√	√			√		5
16v	√	√	√	√	√	√	√				√	8
17c		√	√				√	√			√	5
18p	√			√							√	3
19c		√	√			√					√	4
20c	√		√	√	√	√						5
21c	√		√	√			√		√			5
22p	√	√	√	√							√	5
23c			√								√	2
24c		√	√	√							√	4
25c	√		√			√	√		√	√		6
26c		√	√							√		3
27v			√				√				√	3
28p	√	√			√		√			√	√	6
29c		√	√	√			√	√	√			6
30p	√	√		√	√		√				√	6
31p	√	√		√	√	√					√	6
32c	√	√	√	√	√	√	√	√				8
38c	√		√	√	√	√	√					6

11 Data collection sheets

11.1 Profile of the home

11.2 Profile of residents

11.3 Profile of staff (including qualifications)

11.4 Rota information

11.5 Sickness absence

11.6 Staff turnover

11.7 Training available for staff

11.8 Care plan audit – checklist

11.9(a) Residents' questionnaire

11.9(b) Relatives' questionnaire

11.10 'Institutional regime' questionnaire

11.11 Costing template and notes for completion

These data collection sheets along with the data from this study are provided on the disk supplied with this handbook.

11.1 Profile of the home

Home:

This is all the information about the home itself that you need for comparative purposes. You may wish to build up a more detailed profile on age of building, other uses etc. for your own best value review.

Question	Answer
How many **total** places are available?	
How many of these are **permanent residential** places?	
How many are **dedicated respite** places?	
How many **single** rooms are available?	**Total:** *which is made up of …* Permanent residential: Respite:
How many **en suite** rooms are available?	**Total:** *which is made up of …* Permanent residential: Respite:
Average occupancy for <specify year> related to your other data collection	
What other services are provided from the home? *Describe these services in detail as it will be used to apportion food and other costs between residential care and the other services.*	

11.2 Profile of residents

Home:

Complete a line for each resident who was living in the home on *<insert your census date>*.

Only collect items of information which you will use. If collecting information on place from where the resident was admitted use one of the following codes for speed:

1.	From own home.
2.	From relative's or carer's home.
3.	From sheltered housing.
4.	From hospital.
5.	Other (specify exactly where).

No.	Age	Sex	Date of admission	Admitted from:
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

11.3 Profile of staff (including qualifications)

Name of Home _____

Use the table on the next page to record all staff working in the home. You should use a new line in the table for each member of staff. If reliable estimates can be given include estimated split of duties between services in the home. Include all kitchen, domestic and clerical staff, handymen etc. if you want to do analysis on different staff groups.

The table overleaf lists a number of qualifications your staff may have. You should record all the qualifications each staff member has. Use the key number when writing on the sheet. For example if a staff member has an SVQ Level 2 and a Nursing Qualification RGN you should record - 7a and 8a. If a member of staff has a qualification that is not on the list, write out the name of the qualification in full. If the member of staff has no qualifications enter this too.

Key Number	Qualification
1	Diploma in Social Work
1a	Studying for Diploma in SW
2	Certificate in SW
3	Certificate in Social Service
4	HNC incorporating SVQ3
5	HNC in social care
5a	Studying for HNC
6	SVQ Level 3
6a	Studying for SVQ3
7	SVQ Level 2
7a	Studying for SVQ2
8a	Nursing Qualification - RGN
8b	Nursing Qualification - RMN
8c	Nursing Qualification - SEN
8d	Studying for nursing qualification incl. EN conversion
9	Occupational Therapist
10	Workplace assessor
11	Other

For example:

Position	Standard hours (per week)	Estimated split of duties.	Qualifications
Manager	39	80% residential and 20% respite	8a and 2
Senior care officer	19.5		3
Senior care officer	39		7 and 6a
Care officer	22		No qualifications
Care officer	39		7a

Position	Standard hours (per week)	Estimated split of duties.	Qualifications

11.4 Rota information Home:

Date in month	8.30 a.m.		4.30 p.m.		1.00 a.m.	
	Planned	Actual	Planned	Actual	Planned	Actual
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
Total						

11.5 Sickness absence

Home:

The table below should be completed to show the level of sickness absence for care staff and managers for the 12 month period *<insert chosen year>*. Sickness absence should be recorded by quarter within the 12 month period. (e.g. April – June; July – September; October – December; January – March). The year we used was April 1997 to March 1998.

Position	**Hours lost through sickness absence**				**Number of episodes of sickness absence**			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Managers*								
Care officers#								

Note: * include managers, deputy and assistant managers. # include nurses (in nursing homes), senior care officers, care officers and care assistants.

11.6 Staff turnover

Use this sheet to record information on manager and care staff turnover for comparative purposes with data in the report *'Care in the balance'*. We collected the information for the year 1997/98.

The sheet can also be used to collect information on the turnover of any category of staff.

Home:

For *<insert year >*:

No.	Member of staff and job title	Hours worked (*for optional analysis)*
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

11.7 Training provided for care staff

Home:

The information below covers the year <insert year>. The cost column should record the fee paid or the recharges made from a different council department to the home. Adapt the form for use with different staff groups as required.

Course	Number of staff attending	Number of hours per person	In-house; council or other	Cost of course per person

11.8 Care plan audit – checklist

Home:

Question	Answer and comments (Yes/No delete as appropriate)
Is the key worker recorded?	Yes/No
Have review dates been entered into case notes?	Yes/No
Have the last **3** reviews been carried out according to planned review dates?	Yes/No
Was the resident present at the last review? *If not present, is it clear why?*	Yes/No
Has the resident signed his or her care plan?	Yes/No
When was the resident's case file last updated?	
Have the resident's physical and personal care needs been clearly identified?	Yes/No
Are the actions planned to meet these needs clear and measurable? *(i.e. capable of being monitored, **not** vague).*	Yes/No
If appropriate, does the care plan give target dates? e.g. provision of a zimmer frame by end of February 1999.	Yes/No
Have the resident's emotional and social needs been clearly identified?	Yes/No
Are the actions planned to meet these needs clear and measurable? *(i.e. capable of being monitored, **not** vague).*	Yes/No

Question	Answer and comments (Yes/No delete as appropriate)
Have the resident's mental health needs been clearly identified?	Yes/No
Are the actions planned to meet these needs clear and measurable? *(i.e. capable of being monitored,* ***not*** *vague).*	Yes/No
Is there evidence that the resident's daily personal care and social activities are unique to them? *(note whether verbal or documentary evidence is available)*	Yes/No

11.9(a) Residents' questionnaire

Name of home :

Name of interviewer:

1.How long have you lived here?

2.What do you like staff to call you?

2.1Do you get called .....?

(1)always
(2)sometimes
(3)never

3.Do you have a single bedroom?

(1) yes
(2) no

4.How satisfied are you with your bedroom?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

4.1 What makes you …… with your bedroom?

5.How satisfied are you with the areas you share with other residents e.g. lounge, bathroom and dining rooms?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

5.1What makes you …….. with these areas?

6. How satisfied are you with the way you can use the garden?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.
(6) do not use the garden

move on to Q6.1 or Q6.2 as appropriate.

6.1 If you do not use the garden, why is this?

6.2 What is it that makes you …. with the garden?

7. How satisfied are you with the food?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

7.1What is it that's …….. about the food?

8.Does each resident have a staff member assigned to them individually by the home (some homes call it a key worker) ?

(1)yes
(2)no
(3)don't know

9.Thinking about how much time staff spend with you, how satisfied are you?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

9.1What makes you ……. with this?

10.What do staff do that you most value?

11. Who makes decisions about when you can do things like, for example, get up, go to bed, have your meals?

(1)you
(2)staff
(3)joint decision

12.Does the home review each residents care needs?

(1)yes
(2)no
(3)don't know

13.If you were asked to describe staff here which word would you use?

(1)excellent
(2)good
(3)adequate
(4)poor

14.How satisfied are you with the organised activities in your home?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

14.1What makes you …… with them?

15.How important are outings for you?

(1)very
(2)quite
(3)not important

If answered 'not important' move on to Q17. Otherwise continue with Q16.

16. How satisfied are you with the outings arranged?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

16.1What makes you …… with the outings?

17.How satisfied are you with the arrangements for visits by friends and relatives?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4) quite dissatisfied
(5) very dissatisfied
(6) not relevant.

If answered 'not relevant' move on to Q18.

17.1What makes you ……. with the arrangements?

18.What are the things you really like about the home?

19. What things would you change about the home?

20. Overall, how satisfied are you with <*home name*>?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

11.9(B) Relatives' questionnaire

Name of Home:

Name of interviewer:

1.How long has your relative lived here?

2.What does s/he like staff to call them?

2.1 Do you know whether they get called (their preferred name).....?

(1)always
(2)sometimes
(3) never
(4) do not know

3. Does your relative have a single bedroom?

(1) yes
(2) no

4.How satisfied are you with their bedroom?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

4.1What makes you …… with the bedroom?

5.How satisfied are you with the areas people share with other residents e.g. lounge, bathroom and dining rooms?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

5.1What makes you …….. with these areas?

6.How satisfied are you with the way your relative can use the garden?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.
(6) does not use the garden

Move on to Q6.1 or Q6.2 as appropriate.

6.1 If s/he does not use the garden why is this?

6.2 What is it that makes you ….. with the use of the garden?

7.How satisfied are you with the food?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

7.1What is it that's …….. about the food?

8.Does each resident have a staff member assigned to them individually by the home (some homes call it a key worker) ?

(1)yes
(2)no
(3)do not know

9.Thinking about how much time staff spend with your relative, how satisfied are you?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

.

9.1What makes you ……. with this?

10.What do staff do with your relative that you most value?

11. Who makes decisions about what your relative can do, things like, for example, get up, go to bed, have meals?

(1)you
(2)staff
(3)joint decision

12.Does the home review each residents care needs?

(1)yes
(2)no
(3)do not know

13.If you were asked to describe staff here which word would you use?

(1)excellent
(2)good
(3)adequate
(4)poor

14.How satisfied are you with the organised activities in this home?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

14.1What makes you …… with them?

15 How important are outings for your relative?

(1)very
(2)quite
(3)not important

If answered 'not important' move on to Q17. Otherwise continue with Q16.

16 How satisfied are you with the outings arranged?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

16.1 If outings are very/quite important what makes you …… with the outings?

17 How satisfied are you with the arrangements for visits by friends and relatives?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

17.1 What makes you ……. with the arrangements?

18.What are the things you really like about the home?

19. What things would you change about the home?

20. Overall, how satisfied are you with <*home name*>?

(1)very satisfied
(2)quite satisfied
(3)neither satisfied nor dissatisfied
(4)quite dissatisfied
(5)very dissatisfied.

11.10 Institutional regime questionnaire

Complete by circling the letter which corresponds to the practice in the home. Write any comments or observations you have during the interview and after visiting the home.

NAME OF LOCAL AUTHORITY	
NAME OF HOME	**(residential/nursing)**
NAME OF INTERVIEWER	
NAME OF RESPONDENT	
DATE OF INTERVIEW	

1. BEDTIMES	Comments
a) All residents go to bed at a time set by staff.	
b) All residents are expected to be in bed by a set time, but they may choose to go earlier if they wish.	
c) Some residents go to bed at a time set by staff, but others are allowed to choose their own bedtimes.	
d) There are no rules about bedtime, residents do as they please.	

2. GETTING UP	Comments
a) All residents get up in the morning at a time set by staff.	
b) Residents are expected to be up by a fixed time but they may choose to get up earlier if they wish.	
c) Some residents are allowed to get up when they choose but others are not.	
d) There are no rules about getting up, residents do as they please.	

3. BREAKFAST TIME	Comments
a) There is no set time for breakfast.	
b) Residents can have breakfast when they like within a set time period of one hour or less.	
c) Residents can have breakfast at what time they choose or when they choose within a set time period of more than one hour.	

4. MENU CHOICE (excluding special diets)	
a) There is always a choice of main dishes on the menu for the midday meal.	
b) Sometimes there is a choice of main dishes on the menu for the midday meal, but not every day.	
c) It is not practicable to offer a choice of main dishes at the mid day meal.	

5. MENU PLANNING (excluding special diets)	
a) Menus are normally planned entirely by staff.	
b) Menus are normally planned by staff though efforts are made to meet special requests from residents.	
c) Arrangements have been made for regularly consulting residents over the planning of menus.	

6. BATHING	Comments
a) Generally speaking residents choose when they have a bath.	
b) Generally speaking staff decide when residents are to have a bath.	

7. ACCESS TO GROUNDS	Comments
a) Generally speaking residents may use the garden or grounds of the home when they wish.	
b) Generally speaking residents may go into the garden or grounds with the agreement of a member of staff.	
c) Generally speaking residents may go into the garden or grounds only if supervised.	

8. ACCESS BEYOND GROUNDS	Comments
a) Generally speaking, no residents go outside the grounds of the home unaccompanied.	
b) Residents may leave the grounds of the home with the agreement of a member of staff.	
c) Residents may normally come and go as they please.	

9. LOCKING THE FRONT DOOR	Comments
a) The front door of the home has to be kept locked at all times.	
b)The front door is sometimes locked during the day.	
c)The front door is not locked during the day.	

10. LOCKING BEDROOMS **May residents occupying single bedrooms lock their own doors?**	Comments
a) All may lock their doors.	
b) Some may lock their doors.	
c) None may lock their doors.	
d) No single bedrooms.	

11. VISITORS	Comments
a) Generally, visitors are welcome at any time of the day or evening.	
b) Visitors are welcome at any time by prior appointment only.	
c) Visitors are welcome to call at set visiting times only.	

12. PRIVACY

Do you have facilities for residents to receive visitors in private (including residents' own bedrooms)?

a) Yes	
b) No	

13. OVERNIGHT ACCOMMODATION

Is overnight sleeping accommodation sometimes arranged for visitors?

a) Yes	
b) No	

If yes, please state how many occasions a visitor stayed overnight in the past year.

14. PERSONAL VALUABLES

Do residents have somewhere of their own where they can lock small items of personal value?

a) All do.	
b) Some do.	
c) None do.	

15. FURNITURE	**Comments**
a) Residents may bring to the home some large items of their own furniture (eg bed, wardrobe, chest of drawers).	
b) Residents may only bring smaller items of their own furniture (eg chair, TV, occasional table).	
c) The accommodation is not suitable for residents' own furniture.	

16. DECORATIONS	Comments
a)Residents occupying single bedrooms may arrange to have them decorated (papered or painted) at their own expense to suit their own tastes.	
b) (if not a) Residents would generally be asked to choose the decor when their room is redecorated.	
c) Residents normally have no say about the decorations in their room.	
d) No single bedrooms.	

17. TELEPHONE	Comments
a) Residents have access to a pay-phone provided for them in the home.	
b) There is no pay phone but residents are allowed to use the office phone on request.	
c) Only in exceptional circumstances is there a phone available for use.	

18. REFRESHMENTS	Comments
a) Facilities are available for residents to make their own snacks or drinks when they want.	
b) There are no facilities in the home for residents to make their own snacks or drinks.	

19. ALCOHOL

Can residents buy alcoholic drinks in the home?

a) Yes	
b) No	

20. CLOTHING	Comments
a) Generally residents are either taken to the shops to buy new clothes or they choose them from a selection brought to the home	
b) Generally residents are willing to accept new clothes chosen for them by staff.	

21. ACCESS TO BEDROOMS	Comments
a) Residents are allowed to use their own bedrooms during the day.	
b) Residents are sometimes given permission to use their own bedrooms during the day.	
c) Residents may not use their bedrooms during the day.	

22. DOMESTIC TASKS	Comments
a) Most residents do small domestic jobs in the home or grounds.	
b) A few residents do small domestic jobs in the home or grounds.	
c) Residents cannot undertake domestic jobs.	

23. PERSONAL ALLOWANCES

It is accepted by the DHSS that it might be desirable to limit the amount of cash directly received each week by a resident who has become unable to safeguard or manage the full personal allowance.

In your home do:

	a) More than three quarters of the residents directly receive the full personal allowance?	
	b) Between one half and three quarters of the residents directly receive the full personal allowance?	
	c) Less than one half of the residents directly receive the full personal allowance?	

24. MEAL TIMES		**Comments**
	a) All care staff on duty normally eat with residents at the main mid day meal.	
	b) Some care staff on duty normally eat with the residents at the man mid day meal, though others eat separately.	
	c) Generally, care staff do not eat with residents at the main mid day meal.	

25. AWAY VISITS

Roughly what proportion of your long-term residents sometimes stay with family, relatives, etc. for weekends or holidays?

a) Most.	
b) About half.	
c) A few.	
d) None.	

26. SOCIAL ACTIVITIES

Roughly what proportion of your residents regularly attend meetings of clubs, societies and associations outside the home?

a) Most.	
b) About half.	
c) A few.	
d) None.	

27. LIVE ENTERTAINMENT

How often is some form of live entertainment by outside groups or artists organised in the home for residents (eg show, talks, concerts, etc.)?

a) Monthly or more often.	
b) About every two or three months.	
c) Once or twice a year on special occasions (e.g. Christmas).	
d) Practical problems prevent organised entertainment.	

28. HOME ENTERTAINMENT

How often do staff themselves provide some form of entertainment or recreation in the home for residents (e.g. talks, bingo, other games, etc.)?

a) Monthly or more often.	
b) About every two or three months.	
c) Once or twice a year on special occasions (e.g. Christmas).	
d) Practical problems prevent organised entertainment.	

29. OUTINGS

How often are day or evening outings arranged for groups of residents?

a) Monthly or more often.	
b)About every two or three months.	
Once or twice a year.	
Practical problems prevent organised outings.	

30. HOLIDAYS

Are holidays arranged for groups of residents?

a) Yes	
b) No	

31. MEETINGS

a) Staff and residents meet together formally on a regular basis to discuss matters concerning the home.	
b) Only care staff hold regular formal meetings.	
c) There are no regular formal meetings of any sort.	

11.11 Costing template for residential and nursing homes for older people

A	B	C	D	E	F	G	
5		Home 1	Home 2	Home 3	Home 4	Home 5	**Notes**
6	**Care Staff**						**1**
7	Manager/Owner						**2**
8	Care Workers						**3**
9	Relief Staff						**4**
10	***Total***						
11	Premises Costs						
12	Repairs and Maintenance						**5**
13	Caretaker/handyman						
14	Energy						
15	Other						**6**
16	***Total***						
17	**Cleaning**						**7**
18	Staff						
19	Materials						
20	Contract						**8**
21	***Total***						
22	**Catering**						
23	Staff						
24	Food						
25	Contract						**9**
26	***Total***						
27	**Supplies and Services**						
28	Client Services						**10**
29	Activities officer						
30	Admin staff						
31	Other Admin						
32	Other						**11**
33	***Total***						
34	***Medical Supplies***						**12**
35							
36	***Total Direct Running Costs***						**13**

37							
38	**Income**						
39	Fees						
40	Sales						
41	Other						
42	***Total***						
43							
44	***Total Net Direct Running Costs***						
45							
46	**No Of Places**						**14**

Calculation of Costing Indicators

Weekly cost per resident

Running cost=(C36/C46)/52

Cleaning=(C21/C46)/52

Catering staff=(C23/C46)/52

Food=(C24/C46)/52

Energy=(C14/C46)/52

Annual Cost per resident

Manager=C7/C46

Care staff=C8/C46

Relief staff=C9/C46

Total care staff=C10/C46

Note: A version of the template incorporating working formulae is available on disk.

11.11 Costing Template – Notes

Note 1

Salaries are stated gross, including employer's NI, employer's pension contribution and all allowances and expenses.

Further analyses of grades and management structures should be considered if staffing costs appear to be out of line with other providers in the same sector, or if staffing structures are to be reviewed.

Costs are not reduced for staff who spend a percentage of their time on other duties, such as day care. Such an allocation would only be relevant if removal of the additional service would result in a reduction of residential staff in post. The cost of dedicated staff employed on other services is not included.

Note 2

For private sector homes a notional salary of £25,000 was included for owners who worked full-time in the business in a managerial role.

Note 3

Includes all staff who undertake care duties, whether they are qualified or unqualified.

Note 4

Where relief costs are high, the underlying cause should be identified and documented.

Note 5

For management information purposes, repairs and maintenance costs should be averaged over five years to even out the effects of one-off major repairs. The treatment of these costs and the issues surrounding them are discussed more fully in the costing methodology section.

Note 6

Buildings insurance is likely to be the major component of other premises costs.

Note 7

Cleaning costs should be analysed into staff and materials (which includes equipment). For DSOs a breakdown of costs should be obtained.

Note 8

Charges under commercial cleaning contracts should be included here, as should the cost of window cleaning and clinical waste disposal.

Note 9

Catering costs should be accounted for in the same way as cleaning costs. Where contract caterers are used a mechanism should be in place to monitor the cost and quality of food provided.

Note 10

The cost of excursions and entertainment should be included here, net of any contribution from residents or from welfare funds.

Note 11

Other supplies and services will include: the cost of registration and inspection, public liability insurance, professional fees, advertising and publicity, bedding and linen, and crockery.

Note 12

The category 'medical supplies' is intended to capture any costs specifically associated with nursing homes.

Note 13

Total Direct Running Costs is used to calculate the unit cost of the home for the purpose of comparing with other providers on a 'like for like' basis. It does not represent 'full cost' for the purpose of calculating the standard charge, as central overheads and capital costs are excluded.

Note 14

The number of places should be stated on the basis of full capacity. Both residential and respite places should be included on the premise that the unit cost of these services is unlikely to differ significantly. Where significant under occupancy has occurred during the year the cost of vacant places should be identified.

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