

Activity Provision

Benchmarking good practice in care homes

College of Occupational Therapists



About the publisher

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Preface

This guidance is primarily concerned with the provision of activities for older people in residential care homes, as indicated by the supporting evidence base in Appendix C.

The term 'resident' is used throughout this guidance to refer to a person in receipt of care, that is, a service user who is living in a care home. However, the term 'service user' is used when a direct quote is provided or in relation to specific policy documents.

Many of the principles outlined can be applied to other care settings for older people and adults, or to other care home residents.

For the purposes of this guidance, activity is described as follows.

Activity is essential to human existence, health and wellbeing. It has the potential to restore, maintain and improve physical and mental health. Our individual personality, life history, interests, values and beliefs influence our choice of activity. What we do helps to define who we are. The urge to engage in purposeful and meaningful activity is a basic human drive. This in-built motivation does not diminish or disappear as people age, but the common effects of ageing, such as reduced vision, poor hearing and the increased incidence of arthritis and dementia, can affect an individual's ability to participate in activities.

Care givers who identify care home residents' special needs and personal preferences will provide appropriate activity choices regardless of age and/or diagnosis. In care homes where there is an activity culture, residents will be seen participating in a variety of leisure and daily interests.

It is essential that there is mutual understanding, awareness and acceptance in the care home between all staff and residents about the importance of activities and the underlying principle that activity provision is vital to each resident's health and wellbeing.

Activity needs to be integral to care and not seen as an optional extra.

Activities take many forms and the list of possible activities is endless. They might include daily routines such as mealtimes or preparing a drink, or they might be recreational activities, such as listening to music, playing a game or going for a walk. They can be done alone, as in reading the newspaper, or they can be done in groups or pairs, maybe just simply chatting with friends or other residents or visiting the shops or a local club. Activities might be linked to a resident's political interests or religious beliefs and values, such as voting or attending a local church. They might take place in communal settings, for example in the garden, or in the community, such as a trip to the local cinema. Leisure pastimes, daily activities, social experiences and 'quiet time' are all important activities for many people.

Activity provision is therefore about the ways in which residents are supported to do all of these things throughout the whole day, not just the structured groups in traditional activity programmes. It should also meet each individual's activity needs in a range of areas, for example physical, intellectual, sensory, spiritual, social, emotional etc.

Foreword

We want to ensure that older people have greater opportunities to enjoy old age.

(Department of Health 2006)

Evidence shows that providing a range of activities within care homes can improve residents' quality of life. As the number of older people increases, and growing numbers reside in care homes, the challenge becomes even more urgent.

The provision of meaningful activity at a level appropriate to the individual's abilities and needs is a complex business. I believe this publication will assist in meeting this challenge. It outlines and describes 'good' activity provision within care homes for older people. The person-centred quality indicators that constitute the audit tool provide a clear benchmark against which current service provision can be measured and from which an appropriate action plan can be devised and implemented.

I was present at the launch of the strategic partnership between the College of Occupational Therapists and the National Association for Providers of Activities for Older People. Their combined expertise and experience within the field of activity provision have produced an evidence-based and highly practical tool that will be of immense value to care home managers and staff, and commissioners, as well as being of interest to residents and their families, and inspectors. I am therefore delighted to welcome this important outcome of their collaboration.

It will contribute to enhancing residents' wellbeing and go some way towards providing all care home residents with greater opportunities to enjoy old age.



Professor Ian Philp
National Director for Older People
Department of Health

1 Introduction

This guidance outlines what constitutes 'good' activity provision within care homes for older people. A benchmark tool is provided to evaluate current practice and promote excellence.

The guidance is aimed at care home providers and commissioners and is available to residents, their families and friends, and inspectors. It offers a framework of person-centred quality indicators and outcome measures to inform, guide and encourage those who are responsible for and take part in managing, developing, providing and purchasing activity provision within care homes. It also provides a guide for inspectors on good practice in activity provision.

The College of Occupational Therapists (COT) and the National Association for Providers of Activities for Older People (NAPA) launched a strategic partnership in 2005 in order 'to work together to make access to meaningful occupation a reality for older people' (COT and NAPA 2005). This included the production of a benchmark document that relates to the 'provision and inspection of meaningful occupation for older people' (COT and NAPA 2005).

Further information about the aims, key objectives and organisational structures of the College of Occupational Therapists and NAPA can be found in Appendices D and E.

This guidance was commissioned by the College of Occupational Therapists and produced in partnership with NAPA, supported by a Reference Group of experts from the following organisations:

- BUPA
- College of Occupational Therapists Specialist Section – Older People
- Help the Aged
- National Association for Providers of Activities for Older People
- Southern Cross Healthcare.

The group offered a combined wealth of personal experience in activity provision and service development, staff training and development, inspection, operational management, and research within care homes for older people. The benchmark indicators were reviewed by members of the Reference Group in partnership with care homes within the statutory and non-statutory sectors.

2 Background

Care givers who enable residents' continued participation in activities will help to reduce difficulties as a result of depression, falls and dependency (Perrin 2005). This is especially important because older people in care homes are at greater risk of falling than those who remain in their own homes (Help the Aged 2004). Furthermore, there is a wealth of evidence to support the idea that engaging in activity has many other physical and psychological benefits and is essential to everyone's health and wellbeing. See Appendix C for more information.

There are many factors that will influence whether care home residents participate in different activities. These include, for example, the environment, opportunities to contribute to the local community and to participate in activities that are within a person's capabilities, and being able to choose which activities to do.

Current government policy focuses on wellbeing and inclusion, and for some countries in the UK giving service users choice is becoming increasingly important. People who are given a choice about the services they receive and how they receive them, including activity provision in care homes, will find their needs are being met in more fulfilling ways. The opportunity to take part in activities is essential, irrespective of age, gender, sexual orientation, disability, cultural, religious or other needs. See Appendix A for more information about key relevant policies and legislation.

The quality indicators and benchmarks in this guidance have been developed from a number of existing tools that measure aspects of wellbeing and quality in services for older people, including those designed for older people with dementia.

The benchmark tool in the following pages would be useful for care home providers to assess their current level of service provision and to identify areas for improvement in an action plan. If they wish, they could produce this as evidence during an inspection.

Section 3 of this publication has been designed to be photocopied for individual use.

3

Benchmark tool for activity provision in care homes

This benchmark tool has been designed to evaluate practice and performance in care homes. It will help with the delivery of resident-focused outcomes in activity provision by making evidence-based comparisons. An action plan can be developed and implemented and the tool can also be used to monitor changes and review ongoing performance to develop best practice.

There are many potential benefits to using this tool, for example:

- To provide evidence of best practice for activity provision within the care home.
- To improve the quality and performance of activity provision within care homes.
- To raise awareness among staff about their own and their colleagues' performance.
- To give staff and residents the opportunity to be involved in the benchmarking process, thereby improving motivation and developing consensus to make changes.
- To give a better understanding of the wider picture.
- To increase understanding and improve working practices between residents, staff and management.

Each quality indicator is outcome focused and supported by a series of graded benchmarks:

A	Excellent	A standard of excellence and best practice that has been continually sustained over time. Staff demonstrate imagination and enthusiasm for providing an individualised, person-centred approach. Within the organisation there is an activity culture where activity is recognised as vital to health and wellbeing and is integral to daily care, regardless of the staff roles.
B	Good	A good standard of activity provision has integrated most activities into daily care, is working within care plans, uses a person-centred approach and identifies weaknesses in order to address and improve the residents' living experience.
C	Adequate	The minimum acceptable standard. Most points are adequately addressed, but considerable improvement could be made to improve the quality of provision regarding activities and to enhance the residents' living experience by integrating activities into daily care.
D	Poor	There are major gaps in activity provision. Actual care is not consistent with that suggested within the activity care plan or there are no identified activity care plans. A situation where there is potential for resident dissatisfaction or ill-being. There is little or no attempt to integrate activity provision into daily care and little enhancement of the residents' living experience.

3.1

How to use this benchmark tool

For the purposes of this tool the following definitions have been used:

- **Staff** – includes everybody working in the care home, including owners and managers.
- **Care staff** – staff responsible for providing care on a daily basis, including the activity organisers.

3.1.1 Getting started

Before starting to use the benchmark tool, take five minutes to read the notes below.

The focus of this tool is the residents' experiences of activity. However, information is collected using different methods and from different sources, which includes the residents themselves, staff, managers, friends and relatives, and the care home's documentation.

Working with residents who are unable to articulate their experiences, for instance those who have dementia, requires the use of different techniques to collect evidence from them. Observing these residents to assess, for example, their emotional wellbeing, their engagement with an activity, or their attention is one possible method (Kitwood 1997). Other evidence can be gained by listening to someone who knows the resident well, for example a spouse, partner, family member or close friend.

Some residents may not be able to articulate their experiences for physical reasons. For example, they have had a stroke or have another disability. Alternative methods of communication can be used, such as pen and paper or other communication equipment and non-verbal gestures.

3.1.2 How to collect the evidence

It is necessary to collect evidence in a variety of ways, especially when residents are unable to verbalise their views. This can be done by:

- Observing what is happening in the care home.
- Listening to residents, relatives, friends, staff and managers talk about their experiences with regard to the social life of the home and activity provision.
- Reading supporting documentation.
- Observing the behaviour and interactions between residents, staff, visitors and managers.
- Observing residents' attention and engagement in activities. Do they look content, happy, frustrated, animated, withdrawn or agitated?

3.1.3 Using the tool

Please note – the benchmark tool and action plan forms contained in this publication can be photocopied

1. Collect evidence by using the different methods described above.
2. Record the evidence you see, hear or have read in the evidence box against the relevant benchmark. You may find you have evidence in several of the boxes for each quality indicator.
3. When you have completed all the quality indicators, review good practice and areas where performance can be improved.
4. It is helpful at this stage to share the information you have found with residents, colleagues, staff and managers.
5. Using the evidence, decide what needs to be done to improve activity provision and complete the actions for each quality indicator.
6. You should now have an action list that can be worked on. Using the action plan forms (pages 25–32), agree and record who will take responsibility for completing each action and a timetable for implementing these.
7. Agree a review date to repeat the process. This will give the opportunity to measure and record improvements to activity provision within the care home.

3.2 The benchmark tool

The benchmark tool is designed to highlight areas of weakness that can be improved upon by developing an action plan. It is not about achieving a score. The tool is organised around four key areas that are the foundations to providing meaningful activity to people in care homes.

The key areas are:

1. The activity culture within care homes.
2. Communication and relationships between people.
3. Activity, social and community participation.
4. Care planning to ensure a positive activity outcome for each resident.

Benchmark 1 – The activity culture within care homes

Care home owners and managers are responsible for ensuring there is a culture that promotes and includes activity in all aspects of daily life for the residents. An activity culture will be fully integrated into the values and actions of all staff, including managers, housekeepers, caterers, maintenance and care staff. Activity will also be reflected in all the care home's documentation, including the policies and procedures.

Staff with the relevant knowledge and skills to provide appropriate activities can enrich the relationships within the home to keep the activity culture vibrant and alive. In a home graded as 'excellent' this will be all staff but at a minimum should be the care staff and any dedicated activity organisers.

A relevant training programme for staff will be in place to demonstrate the organisation's commitment to activity provision for its residents.

Quality indicators

- 1.1 The care home manager demonstrates extensive knowledge about his or her residents' needs, interests and preferences, irrespective of age and/or diagnosis, and how they are being met through the provision of activities.
- 1.2 All staff receive appropriate training about the effects of ageing, conditions of ageing, person-centred care, communication skills, and the selection and provision of appropriate activities.
- 1.3 Residents are free to engage in personal and social activities of their choice in a relaxed and friendly environment within the care home.

<p>1.1 Quality indicator The care home manager demonstrates extensive knowledge about his or her residents' needs, interests and preferences, irrespective of age and/or diagnosis, and how they are being met through the provision of activities.</p>	
A	<p>Evidence</p> <ul style="list-style-type: none"> • The manager communicates and demonstrates his or her commitment to the activity culture within the home's policies, processes, training and leadership. • Activity takes place at any time of day and night, and is flexible to the residents' needs, wishes and personal routines. • The manager, all staff and residents can describe* how all activities and tasks can be seen as an opportunity to build relationships and enhance the residents' living experience.
B	<p>Evidence</p> <ul style="list-style-type: none"> • There is commitment to the activity culture but it is only partly reflected in the home's policies and processes. • Activity takes place at most times of the day and evening and is usually flexible and person centred. • The approach is person-centred for most residents. Managers and care staff can describe how activities can be seen as an opportunity to improve the residents' living experience.
C	<p>Evidence</p> <ul style="list-style-type: none"> • There is commitment to the activity culture but it is not reflected in the home's policies and processes. • Responsibility for activity provision is delegated to key members of staff and/or activity organisers, who can describe the importance of activities for residents. • The approach is person-centred for some residents, but not all.
D	<p>Evidence</p> <ul style="list-style-type: none"> • There is little or no importance attached to activity in the care home and it is not seen as part of daily life or routines by managers and staff. • There might be a general activity timetable that is not person-centred or consistently followed. • Staff are seen as too busy to provide meaningful activity. They believe the residents are not interested, nor do they view personal or domestic care as an opportunity for activity.

*For alternative methods of collecting evidence see pages 4 and 5

1.2 Quality indicator

All staff receive appropriate training about the effects of ageing, conditions of ageing, person-centred care, communication skills, and the selection and provision of appropriate activities.

A	<ul style="list-style-type: none"> • All staff have received appropriate training. They can describe how they have helped residents select activities and enabled them to take part using a person-centred approach while taking into account any age-related needs, disabilities and personal choices. • All staff can demonstrate or describe how activity provision is everyone's responsibility. • All staff communicate effectively with residents to ensure they are included in activity planning on a regular and ongoing basis. 	Evidence
B	<ul style="list-style-type: none"> • Most staff have received training and can describe how they have helped some residents select activities, taking into account any age-related needs, disabilities and personal choices. • Care staff can demonstrate or describe how activity provision is their responsibility. • Most staff communicate effectively with residents, consulting with them to ensure they are included in activity planning. 	Evidence
C	<ul style="list-style-type: none"> • Most staff are dedicated to using activity meaningfully, but they may not have had training. • Care staff help residents select activities and enable them to take part. • Residents are consulted as and when it is felt necessary by staff, for example on admission to the home. This procedure is not fully integrated into the activity planning process. 	Evidence
D	<ul style="list-style-type: none"> • There is no evidence of training in meaningful activity at any level. • Staff cannot describe the importance of everyone's role in providing activities, nor explain how an activity culture has implications for residents' health and wellbeing. • Residents are not consulted regularly about a choice of domestic, leisure or personal activity and some activities do not take account of their age-related needs. 	Evidence

For alternative methods of collecting evidence see pages 4 and 5

1.3 Quality indicator Residents are free to engage in personal and social activities of their choice in a relaxed and friendly environment within the care home.	
A	<p>Evidence</p> <ul style="list-style-type: none"> • Residents can be observed interacting with each other most of the time without necessarily being engaged in a functional task. • Residents report* friendly and social communication with all staff at all times and feel included in the community of the home. • Residents report* that they are free to pursue a range of personal or social activities of their choice at all times. • Residents report* that all staff respect their 'quiet' time i.e. time for a person to be private and enjoy quiet reflection.
B	<p>Evidence</p> <ul style="list-style-type: none"> • Residents can be observed interacting with each other some of the time. • Residents report* that all staff communicate with them in an appropriate and friendly manner most of the time. • Residents report* that they are able to pursue a range of personal or social activities of their choice most of the time. • Residents report* that most staff respect their 'quiet' time.
C	<p>Evidence</p> <ul style="list-style-type: none"> • Residents can be seen interacting with each other. • Residents report* that staff communicate with them when necessary. • Residents report* that they are occasionally able to pursue activities of their own choice. • Residents report* that care staff usually respect 'quiet' time.
D	<p>Evidence</p> <ul style="list-style-type: none"> • Residents can be seen sitting alone and rarely communicating with each other. • Residents report* that there is minimal communication with staff. • Residents report* that they are rarely, if at all, able to pursue activities of their own choice. • Residents report* that they rarely have the opportunity for 'quiet' time.

* For alternative methods of collecting evidence see pages 4 and 5

Benchmark 2 – Communication and relationships between people

Communication is much more than an exchange of information. It is the means by which we express our thoughts, feelings, hopes, fears and aspirations. It may be a glance, a touch of the hand, a song or a smile that makes a connection with another human being. When an individual can no longer use words to communicate, we must use non-verbal signals to demonstrate that we are listening and that the other person matters to us.

Admission to a care home can result in residents feeling alone among strangers, bereaved of family, friends and familiar roles, routines and objects. It is essential that care home staff create a sense of belonging within which residents feel physically and psychologically safe, where relationships are positive and rewarding, and where they can freely express their feelings and opinions, take part in activities and contribute to the community within the care home.

People living in a care home should be able to expect:

- Appreciation, sensitivity and acknowledgement of their feelings and psychological needs.
- Positive, rewarding social relationships.
- Acknowledgement as a unique individual with their own identity.

Quality indicators

- 2.1 Staff understand the value and importance of effective communication and the relationships they build with residents and how these directly affect residents' opportunities to take part in activities.
- 2.2 Communication between staff and residents is effective and sensitive to enable residents to make informed choices about the activities they do.

2.1 Quality indicator Staff understand the value and importance of effective communication and the relationships they build with residents and how these directly affect residents' opportunities to take part in activities.	
A	<p>Evidence</p> <ul style="list-style-type: none"> • All staff can describe each resident's communication needs and the barriers to successful communication as a result of a resident's disabilities, age-related problems and language difficulties. • All staff have received training and know how to use residents' communication equipment and different communication methods. They describe how they use different approaches to meet residents' needs. • All staff can describe how they develop good relationships with residents and their relatives to gain an understanding of each individual's activity needs and wellbeing.
B	<p>Evidence</p> <ul style="list-style-type: none"> • Most staff can describe each resident's communication needs and the barriers to successful communication as a result of a resident's disabilities and age-related problems. • Staff know how to use residents' communication equipment and different communication methods and most have had training. • Care staff can describe how they develop good relationships with residents to gain an understanding of each individual's activity needs.
C	<p>Evidence</p> <ul style="list-style-type: none"> • Care staff can describe most residents' communication needs that are as a result of their disabilities and age-related problems. • Common communication equipment and basic communication methods are used. Staff can demonstrate they use these. • Good relationships between staff and residents can be seen. Staff can describe these and how they affect residents' participation in different activities.
D	<p>Evidence</p> <ul style="list-style-type: none"> • Staff are unable to describe residents' communication needs. • Basic communication equipment is available but rarely used. Staff report they have not been trained to use this equipment or alternative methods of communication. • Staff may carry out functional tasks well but are unable to describe how their relationship with the residents might affect their participation in any activities.

For alternative methods of collecting evidence see pages 4 and 5

2.2 Quality indicator Communication between staff and residents is effective and sensitive to enable residents to make informed choices about the activities they do.	
A	<p>Evidence</p> <ul style="list-style-type: none"> Residents describe* how staff appear to take a genuine interest in lives. They say they trust the staff, they are friendly and can be approached at any time. Good rapport and effective, sensitive communication between staff and residents can be seen and heard. Staff demonstrate understanding and patience with residents who need more help and support to choose activities.
B	<p>Evidence</p> <ul style="list-style-type: none"> Residents report* they are settled in the home and have good, trusting relationships with the staff. Good rapport and effective communication between staff and residents can be seen and heard. Staff demonstrate patience when helping residents select activities.
C	<p>Evidence</p> <ul style="list-style-type: none"> Residents report* they are settled in the home and have good relationships with the staff. Staff engage in routine greetings, accept and give compliments and positive gestures of acknowledgement. Staff are warm and caring but are not always able to help residents select activities.
D	<p>Evidence</p> <ul style="list-style-type: none"> Residents report* they sometimes find the staff unpleasant and uncaring and therefore do not ask about activities. Staff are not often seen greeting or talking with residents. Staff are mostly caring but give little time to talk with residents and show little understanding of residents' activity choices.

* For alternative methods of collecting evidence see pages 4 and 5

Benchmark 3 – Activity, social and community participation

Recognising the importance of activity and the need for residents to be included, regardless of their impairments, is essential when encouraging residents' participation and social interaction.

Care home staff can ensure a choice is available for residents by being responsive to new ideas, by responding to requests for different activities and by developing different ways to help residents take part.

When helping residents select and participate in activities it is necessary to consider such things as:

- Residents' wishes and interests.
- Maintaining residents' dignity while undertaking different activities.
- Residents' ability and the help they might need to take part in an activity, irrespective of their age and/or disability.
- Time of day, month and year.
- Residents' preferred daily routine.
- The place where the activity will take part and whether this is inside, outside or elsewhere in the local community.
- The number of people taking part in the activity, for example, a group of people, two people or whether the resident will work alone.
- The person or people the resident chooses to accompany them in these activities. These might be, for example, friends or family, a member of staff, other residents or someone from the local community.
- Residents pursuing continued interests either within the home or by visiting their usual groups, clubs, places of worship, etc.
- The opportunity to take up new activities, interests or hobbies.
- Enabling community-based activities to come into the care home.

The physical environment of the home, both inside the building and in the garden, offers opportunities for social contact and sensory stimulation.

Daily living tasks are day-to-day activities many residents wish to continue to do when they move into a care home. These are personal tasks such as getting up and choosing what and how to dress, taking a bath or washing, and eating a meal.

‘Excellent’ care homes will have appropriate staffing levels that will give consideration to the residents’ needs, ranging from activity provision to emergency care. Consideration will be given to employing staff with relevant skills, for example occupational therapists and activity providers.

Care homes graded as ‘excellent’ will have sufficient budgetary resources to meet the activity needs of all their residents.

Quality indicators

- 3.1 Inclusive activity provision enables all care home residents to take part in activities of their choice, with appropriate and sensitive consideration to culture, age, gender, health, sexual orientation, disabilities and age-related needs.
- 3.2 The range of activities for each resident reflects their choice, their social, cultural and religious preferences, and is available at frequent and regular intervals throughout the week. The need for ‘quiet time’ is recognised and respected.
- 3.3 The opportunities for residents to engage in personal daily living tasks are integrated into daily care.
- 3.4 Mealtimes and the social aspects these everyday events can offer are recognised as an important activity.
- 3.5 There are sufficient financial and other resources, such as equipment, materials, training and facilities, and effective use of the available environment and local community, to provide a range of activities.

<p>3.1 Quality indicator Inclusive activity provision enables all care home residents to take part in activities of their choice, with appropriate and sensitive consideration to culture, age, gender, health, sexual orientation, disabilities and age-related needs.</p>	
A	<p>Evidence</p> <ul style="list-style-type: none"> • All staff can demonstrate, by observation or description, that they understand the specific activity needs of all residents and ensure inclusive activity provision. • All staff have appropriate training and can describe how they comply with relevant discrimination legislation and policy on social inclusion. • All residents can describe* how they participate in activities of their choice, taking into account but not excluding them on the basis of their culture, age, gender, health, sexual orientation, disabilities and age-related needs. • All care home policies are inclusive and staff can be seen to be implementing them.
B	<p>Evidence</p> <ul style="list-style-type: none"> • Most staff can demonstrate, by observation or description, that they understand the specific needs of most residents and ensure inclusive activity provision. • Most staff have appropriate training and can describe how they comply with relevant discrimination legislation and policy on social inclusion. • Most residents can describe* how they participate in most activities of their choice taking into account but not excluding their culture, age, gender, health, disabilities and age-related needs. • All care home policies are inclusive and most staff can be seen to be implementing them.
C	<p>Evidence</p> <ul style="list-style-type: none"> • Care staff can demonstrate that they understand the needs of some residents. • Care staff have basic training about discrimination legislation and/or policy on social inclusion. • Some residents can describe* how they are included in some activities of their choice. • Some care home policies are inclusive.
D	<p>Evidence</p> <ul style="list-style-type: none"> • Few care staff can demonstrate that they understand the specific needs of residents. • Few staff, if any, have had basic training about discrimination legislation. • Few, if any, residents can describe* how they are included in activities of their choice. • Few, if any, care home policies are inclusive.

* For alternative methods of collecting evidence see pages 4 and 5

3.2 Quality indicator The range of activities for each resident reflects their choice, their social, cultural and religious preferences, and is available at frequent and regular intervals throughout the week. The need for 'quiet time' is recognised and respected.	
A	<p>Evidence</p> <ul style="list-style-type: none"> • Residents and visitors describe* a variety of activities that have taken place in the last month that the residents have chosen and enjoyed. • Residents and visitors report* there is daily access to community-based activities and assistance is available if needed. • Residents and visitors report* that staff encourage appropriate types and quantities of activity and take into account every individual's abilities, changing wishes and requests for 'quiet time'. • Residents who wish to are regularly involved in making group decisions and planning weekly activities.
B	<p>Evidence</p> <ul style="list-style-type: none"> • Residents and visitors describe* different activities that have taken place in the last month that the residents have chosen and enjoyed. • Residents and visitors report* there is frequent access to activities in the local community with assistance if needed. • Residents and visitors report* that staff encourage participation in activities and this usually takes into account individuals' abilities and requests for 'quiet time'. • Residents contribute to group activity planning if they wish.
C	<p>Evidence</p> <ul style="list-style-type: none"> • Residents and visitors can list* a few activities they have enjoyed in the past month. • Access to activities within the local community is limited and there are few links with people outside the home. • Residents and visitors report* that staff encourage them to take part in activities but some of these do not meet their capabilities or wishes.
D	<p>Evidence</p> <ul style="list-style-type: none"> • There are occasional social opportunities depending on which staff are available. • There are few social opportunities or trips to/visits from the local community. • Residents are encouraged to try activities for which they do not always have the necessary skills and abilities.
<p>* For alternative methods of collecting evidence see pages 4 and 5</p>	

3.3 Quality indicator The opportunities for residents to engage in personal daily living tasks are integrated into daily care.	
A	<p>Evidence</p> <ul style="list-style-type: none"> • Residents and staff work in partnership when undertaking personal daily living tasks and adapt them where necessary. • Staff can describe how completing daily living tasks are activities that are rewarding and fulfilling for individual residents. • Residents report* that they choose their daily routine and the help they receive and are encouraged to make changes that suit their strengths and preferences.
B	<p>Evidence</p> <ul style="list-style-type: none"> • Staff involve residents when undertaking personal daily living tasks. • Most staff can describe how daily living tasks are activities that can be rewarding for individual residents. • Residents report* they choose their daily routine and the amount of help they receive.
C	<p>Evidence</p> <ul style="list-style-type: none"> • Staff are caring, but residents are not actively encouraged to take part in their personal daily living tasks. • Some care staff can describe how completing daily living tasks are activities that can be rewarding and fulfilling for residents. • Residents report* they can determine their daily living routines and tasks, but this is not always consistent and can depend on which staff are on duty.
D	<p>Evidence</p> <ul style="list-style-type: none"> • Staff demonstrate a 'doing to' rather than 'working with' approach to personal daily living tasks. • Staff are not able to describe how daily living tasks have meaning for some residents. • Residents report* they would like to have more say in their daily living routine and tasks or show signs of frustration or anger when receiving practical help.

* For alternative methods of collecting evidence see pages 4 and 5

3.4 Quality indicator Mealtimes and the social aspects these everyday events can offer are recognised as an important activity.	
	Evidence
A	<ul style="list-style-type: none"> • The dining room is clean and pleasant and the tables and seating are arranged in a way to encourage social contact. However, residents can eat in their own rooms if they wish. • Residents describe* mealtimes as a pleasant social activity. They are given a choice of seating, food and drink, taking into account dietary and other needs. • Relatives are actively encouraged to accompany or assist residents as appropriate. • Staff can be seen talking with residents at the meal tables. Meals are served in an unhurried but efficient manner and assistance is skilfully given to those who need help.
B	<ul style="list-style-type: none"> • The dining room is clean and pleasant, and attention is paid to where people are seated to encourage social contact. • Residents describe* mealtimes as pleasurable. They usually have a choice of seating, food and drink, taking into account their needs. • Relatives are able to accompany or assist residents at mealtimes as requested by the residents. • Staff can be seen talking with residents at the meal tables. Meals are served efficiently and assistance is given to those who need help.
C	<ul style="list-style-type: none"> • The dining room and tables are clean. • Residents say* they look forward to mealtimes, but think they could be more enjoyable. • Relatives are aware they can accompany and assist the residents but few are encouraged to do so. • Staff assist those who need help.
D	<ul style="list-style-type: none"> • The dining room is uninviting and the tables are not laid. • Residents describe* mealtimes as routine and staff often tell them where to sit. • Visiting relatives rarely attend at mealtimes. • Staff show little skill and awareness of residents' needs for help and for enjoying mealtimes.

* For alternative methods of collecting evidence see pages 4 and 5

3.5 Quality indicator There are sufficient financial and other resources, such as equipment, materials, training and facilities, and effective use of the available environment and local community, to provide a range of activities.	
A	<p>Evidence</p> <ul style="list-style-type: none"> • The activity policy, developed in consultation with residents and staff, is regularly reviewed and up to date. It includes access to a variety of resources that are sufficient for the residents' activity needs. • There is a mix of private, quiet and shared areas where different activities and social events can be undertaken. • There is a wide selection of materials readily available to residents, taking into account a range of abilities. • Staff can describe how they use opportunities within available resources in imaginative and practical ways. They seek out new materials, ideas and links with the local community.
B	<p>Evidence</p> <ul style="list-style-type: none"> • An activity policy has been developed in consultation with residents and staff and includes access to a variety of resources. • Areas have been set aside for individual and group activities. • There is a selection of materials readily available to residents. • Staff use the resources effectively and seek out new ideas and links with the local community.
C	<p>Evidence</p> <ul style="list-style-type: none"> • An activity policy is in place, but needs updating. There has been limited consultation with residents and staff. • Areas for quiet and group activities are available but limited. • Some activity materials are readily available for use, but these are not all easily available to residents. • Staff use the resources available to them but are not innovative in seeking out new materials and ideas.
D	<p>Evidence</p> <ul style="list-style-type: none"> • There is no activity policy in place and little or no resources for activities. • There is little space identified as suitable for the various activities or social events that could take place. • Activity materials are not readily available for use. • Staff do not use/have access to resources and do not initiate activity.

For alternative methods of collecting evidence see pages 4 and 5

Benchmark 4 – Care planning to ensure a positive activity outcome for each resident

Recording and using information about a resident's life history is essential when including activity in the care planning process. To ensure a positive activity outcome, biographical knowledge combined with information about the resident's current strengths, expectations, wishes and needs is required. Strengths will include what the resident can do, what they like to do, and the people who are willing to help them.

A good care plan is a living document i.e. it will be effective only if people record it, follow it, review it and then redo it, so it grows and develops with the resident. Reviewing and meeting the activity and social needs of residents is within the national minimum standards (Department of Health 2003 – see Appendix B). As well as reviewing individual activity needs it is important to collect information about residents' satisfaction with regard to activity provision. This can be collected using a range of methods, such as questionnaires, suggestion boxes, residents' meetings, talking to individuals and monitoring their wellbeing. It is important that the activity plan is an integral part of the resident's individualised care plan.

While participation in activity is vital for residents' health and wellbeing, any potential risk of injury must be acknowledged, particularly if there are any physical, cognitive or sensory impairments. Care planning needs to include risk assessments for relevant activities and circumstances. However, to enable residents to take part in their chosen or preferred activities, a balance needs to be struck between managing risks and helping residents to participate. This may also mean acknowledging those activities which have associated health and financial risks, such as smoking, drinking alcohol, gambling etc. The starting point should always be, 'How can this person be supported to do the things they would like to do?'

The successful activity co-ordinator (Hurtley and Wenborn 2005) states that it is important to collect relevant information about a resident. This information will inform the activity part of the care plan and should include:

- Relevant medical history, including mental health and current wellbeing.
- Physical ability and mobility, such as range of movement and strength of upper and lower limbs, dexterity, hand–eye co-ordination, balance and any equipment needs.
- Communication, comprehension and speech.
- Sensory abilities, including eyesight and hearing.
- Cognitive abilities, for example short-term and long-term memory, concentration, problem solving, logical thinking and sequencing.

- Past and present work and family roles, activity and leisure pursuits.
- Past and present friends and relatives.
- Cultural preferences.
- Potential risks to residents, relatives, staff or others when participating in activities.

Quality indicators

- 4.1 Biographical information is recorded with consent from the resident and kept up to date to inform the care plan and activity provision.
- 4.2 Residents' current activity preferences, interests and abilities are regularly reviewed, and outcomes and user satisfaction are recorded in the care plan and are evident in practice.
- 4.3 The activity planning process and documentation includes relevant risk assessments.

4.1 Quality indicator Biographical information is recorded with consent from the resident and kept up to date to inform the care plan and activity provision.	
A	<p>Evidence</p> <ul style="list-style-type: none"> • The care home's policies include reference to individualised activity provision and gaining consent within the care planning documentation. • To comply with care home policies about choice and consent, residents and relatives give a biography/life story where appropriate. • There is recorded evidence in the care plan that this information is used to develop appropriate activities with residents. • Residents' activity preferences are known, understood and met by staff who regularly update the care plans.
B	<p>Evidence</p> <ul style="list-style-type: none"> • The care home's policies include activity provision and gaining consent within the care planning documentation. • A biography/life story is obtained from residents and relatives. • There is recorded evidence that this information is used to develop activities with residents. • Residents' activity preferences are known, understood and met by staff.
C	<p>Evidence</p> <ul style="list-style-type: none"> • Outlines of the major events in the residents' lives have been recorded and are used when planning and providing activities. • A brief life story is obtained from residents and relatives. • Staff are enthusiastic, but there is inconsistent evidence that information is regularly used to develop activities with residents. • Residents' activity preferences are known by staff, but they use this information inconsistently when agreeing suitable activities.
D	<p>Evidence</p> <ul style="list-style-type: none"> • Little or no biographical information has been obtained from residents and recorded. • Staff report they do not collect life stories and are not aware of relevant care home policies. • There is insufficient information to offer residents appropriate activities. • Residents' activity preferences are not known by staff.

For alternative methods of collecting evidence see pages 4 and 5

4.2 Quality indicator Residents' current activity preferences, interests and abilities are regularly reviewed, and outcomes and user satisfaction are recorded in the care plan and are evident in practice.	
A	<p>Evidence</p> <ul style="list-style-type: none"> • The care plan is drawn up with involvement from the resident, recorded in a style accessible to the resident, and agreed and signed by the resident and/or relative. • Residents' satisfaction is collected* and recorded using different methods that reflect their abilities and needs. • Each resident's activity needs and wellbeing are recorded 6–12 weeks after admission when the resident has settled in. These are reviewed with residents and care plans are updated as changes occur or at a minimum annually. • Care staff can describe the activity aims, objectives and outcomes for all the residents and these are evident in practice.
B	<p>Evidence</p> <ul style="list-style-type: none"> • The care plan is drawn up with the resident, recorded and agreed and signed by the resident and/or relative. • Residents' satisfaction is collected* in different ways to reflect their abilities and needs. • Each resident's activity needs and wellbeing are recorded and reviewed annually. Care plans are updated. • Care staff can describe the activity aims, objectives and outcomes for all the residents and put these into practice.
C	<p>Evidence</p> <ul style="list-style-type: none"> • The care plan is drawn up with the residents and recorded. • Residents' satisfaction is collected* in an ad hoc way. • Residents' activity needs are recorded. • Care staff can describe their involvement in developing activity aims, objectives and outcomes but are inconsistent about recording, updating and using this information.
D	<p>Evidence</p> <ul style="list-style-type: none"> • Little importance is attached to care plans. • Residents' satisfaction is rarely collected*, if at all. • Activity needs and choices are poorly recorded. • Activity aims, objectives and outcomes are not available for over half of the residents and staff are unable to link activity plans with daily operations.

* For alternative methods of collecting evidence see pages 4 and 5

4.3 Quality indicator The activity planning process and documentation includes relevant risk assessments.	
A	<p>Evidence</p> <ul style="list-style-type: none"> • Person-centred risk assessments have been carried out, recorded and are regularly reviewed regarding residents' abilities to participate in activities of their choice. • Risk assessments promote residents' freedom, welfare and their right to choose, regardless of their disabilities and other needs. There is evidence that alternative activities and support measures have been fully explored. • Where appropriate, residents and relatives report* they are involved and joint decisions are reached about any actions.
B	<p>Evidence</p> <ul style="list-style-type: none"> • Risk assessments have been carried out and recorded regarding residents' abilities to participate in activities of their choice. • Risk assessments promote residents' freedom, welfare and their right to choose. There is evidence that alternative activities and support measures have been fully explored. • Residents and relatives report* joint decisions are usually reached about any actions.
C	<p>Evidence</p> <ul style="list-style-type: none"> • Risk assessments are completed and recorded. • Risk assessments promote the welfare of the residents but routine safety prevails over residents' choice. Assessments show some evidence that alternative activities and support measures have been considered. • Relatives and residents report* they would like more involvement in the risk assessment process.
D	<p>Evidence</p> <ul style="list-style-type: none"> • Individual risk assessments are rarely, if at all, carried out to enable residents to participate in activities of their choice. • Risk assessments do not take into account the residents' abilities and right to choose activities. • Risk assessments are carried out and decisions made on behalf of residents and relatives rather than jointly.

* For alternative methods of collecting evidence see pages 4 and 5

Quality indicators and action plan

The following pages can be photocopied to record who will take responsibility for completing each action, when they should be implemented by and an agreed date to review the process.

1. The activity culture within care homes

<p>1.1 The care home manager demonstrates extensive knowledge about his or her residents' needs, irrespective of age and/or diagnosis, and how they are being met through the provision of activities.</p>	<p>Actions</p>	<p>To be actioned by:</p>	<p>Date:</p>	<p>Review date:</p>
<p>1.2 All staff receive training about the effects of ageing, conditions of ageing, person-centred care, communication skills, and the selection and provision of appropriate activities.</p>	<p>Actions</p>	<p>To be actioned by:</p>	<p>Date:</p>	<p>Review date:</p>

<p>1.3 Residents are free to engage in personal and social activities of their choice in a relaxed and friendly environment within the care home.</p>	<p>Actions</p>	<p>Review date:</p>
<p>To be actioned by:</p>	<p>Date:</p>	

2. Communication and relationships between people

<p>2.1 Staff understand the value and importance of effective communication and the relationships they build with residents and how these directly affect residents' opportunities to take part in activities.</p>	<p>Actions</p>	<p>Date:</p>	<p>Review date:</p>
<p>2.2 Communication between staff and residents is effective and sensitive to enable residents to make informed choices about the activities they do.</p>	<p>Actions</p>	<p>Date:</p>	<p>Review date:</p>

3. Activity, social and community participation

<p>3.1 Inclusive activity provision enables all care home residents to take part in activities of their choice, with appropriate and sensitive consideration to culture, age, gender, health, sexual orientation, disabilities and age-related needs.</p>	<p>Actions</p>	<p>To be actioned by:</p>	<p>Date:</p>	<p>Review date:</p>
<p>3.2 The range of activities for each resident reflects their choice, their social, cultural and religious preferences, and is available at frequent and regular intervals throughout the week. The need for 'quiet time' is recognised and respected.</p>	<p>Actions</p>	<p>To be actioned by:</p>	<p>Date:</p>	<p>Review date:</p>

<p>3.3 The opportunities for residents to engage in personal daily living tasks are integrated into daily care.</p>	<p>Actions</p>	
<p>To be actioned by:</p>	<p>Date:</p>	<p>Review date:</p>
<p>3.4 Mealtimes and the social aspects these everyday events can offer are recognised as an important activity.</p>	<p>Actions</p>	
<p>To be actioned by:</p>	<p>Date:</p>	<p>Review date:</p>

<p>3.5 There are sufficient financial and other resources, such as equipment, materials, training and facilities, and effective use of the available environment and local community, to provide a range of activities.</p>	<p>Actions</p>	<p>Review date:</p>
<p>To be actioned by:</p>	<p>Date:</p>	

4. Care planning to ensure a positive activity outcome for each resident

<p>4.1 Biographical information is recorded with consent from the resident and kept up to date to inform the care plan and activity provision.</p>	<p>Actions</p>	<p>To be actioned by:</p>	<p>Date:</p>	<p>Review date:</p>
<p>4.2 Residents' current activity preferences, interests and abilities are regularly reviewed, and outcomes and user satisfaction are recorded in the care plan and are evident in practice.</p>	<p>Actions</p>	<p>To be actioned by:</p>	<p>Date:</p>	<p>Review date:</p>

<p>4.3 The activity planning process and documentation includes relevant risk assessments.</p>	<p>Actions</p>		<p>Review date:</p>
	<p>To be actioned by:</p>	<p>Date:</p>	

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Appendix A: Policy drivers

Though there are many similarities, the policies, legislation and regulatory frameworks governing the provision of services such as care homes for older people differ in each of the four countries within the UK.

This section summarises some of the policy drivers most relevant to activity provision within care homes. Readers are advised to refer to the relevant regulations, standards and policies for the most up-to-date information.

England

National Service Framework for older people

(Department of Health 2001)

The National Service Framework (NSF) for older people aims to promote the health and wellbeing of older people through better co-ordinated services of the NHS and local authorities.

Standard 8 focuses on the promotion of health and active life in older age and makes specific reference to increasing physical activity (p. 110) and promoting certain strategies for preventing falls and their consequences in care home settings (p. 80).

A new ambition for old age: next steps in implementing the national service framework for older people

(Department of Health 2006)

Ten programmes of activity will be delivered covering the following three major themes:

1. *Dignity in care*, which aims to improve and upgrade the environment of in-patient wards and care homes and assure quality by working closely with inspectorates and regulators. It will ensure dignity is central to the provision of care for older people, including those with mental health problems and those at the end of life.
2. *Joined-up care*, which outlines a system reform for stroke, falls, mental health, complex needs and urgent care services and the development of the Common Assessment Framework, to 'ensure that comprehensive assessment is undertaken prior to long-term or residential nursing home care' (p. 14).
3. *Healthy ageing*, whose aims include improving physical fitness and overcoming barriers to active life by improving access to equipment, foot-care, oral health, continence care, low-vision and hearing services, healthcare and health promotion services.

Everybody's business: integrated mental health services for older adults: a service development guide

(Department of Health, Care Services Improvement Partnership 2005)

Many older people with mental health problems live in non-specialist care homes. It is estimated that 60–70% of care home residents have dementia and 40% have depression (p. 36). This guide highlights that 'staff should seek to know more about their [residents'] biographies and previous lifestyles so that they can provide personalised care and encourage the maintenance of interests and skills. Activity programmes will help reduce depression' (p. 37).

Our health, our care, our say: a new direction for community services

(Department of Health 2006)

The key themes in *Our health, our care, our say* are to promote independence, wellbeing and choice through services that are provided around individuals and their personal needs and preferences.

The aims are to:

- Provide person-centred, tailored, seamless services that give positive outcomes for clients.
- Provide good customer care.
- Provide dignity in care.
- Promote health, wellbeing and prevention of ill-health.

Dignity in care

Practice guide 09

(Social Care Institute for Excellence 2006)

This guide has been developed to improve standards of dignity in care. It provides information for service users on what they can expect from health and social care services. It gives practical guidance to service providers and practitioners to help develop their practice, with the aim of ensuring that all people receiving health and social care services are treated with dignity and respect.

The guide covers:

- The meanings and aspects of *Dignity in care*.
- Information and guidance on how to tackle poor standards of service, for practitioners, service users and carers.
- Key pointers to improving the dignity of older people.
- Examples of ways in which dignity can be incorporated into care.
- The policy context and key research and policy findings, with references.
- Relevant guidance and standards.

The guide includes the *Dignity challenge*, which is a clear statement of what people can expect from a service that respects dignity. It is supported by ten tests that can be used by providers, commissioners and people who use services to see how their local services are performing. Dignity challenge number ten is to 'act to alleviate people's loneliness and isolation'. This is defined as follows: 'People receiving services

are offered enjoyable, stimulating and challenging activities that are compatible with individual interests, needs and abilities' (SCIE 2006).

Inspecting for better lives: delivering change

(Commission for Social Care Inspection 2005)

Inspecting for better lives is a programme of change and modernisation that focuses on the experiences of people who use services, such as care homes, and how the providers, such as care home owners and managers, are improving the quality of care they provide.

Regulations for care homes have changed following the introduction of a self-assessment scheme, called Annual Quality Assurance Assessments (AQAA). The *key lines of regulatory assessment* (KLORA) will guide people over what aspects of their service will be reviewed in relation to assessing the quality of the service they are providing (CSCI 2006).

England and Wales

Dementia: supporting people with dementia and their carers in health and social care

National Clinical Practice Guideline Number CG 042.

(National Institute for Health and Clinical Excellence, Social Care Institute for Excellence 2006)

This is the first joint guideline produced by the Social Care Institute for Excellence (SCIE) and the National Institute for Health and Clinical Excellence (NICE). It covers the identification, treatment and care of people with dementia, and support for carers within health and social care in England and Wales.

Key priorities for implementation include: non-discrimination; consent; carer assessment and support; co-ordination and integration of health and social care; memory assessment services; structural imaging for diagnosis; assessment of behaviour that challenges (to establish an individual care plan); provision of dementia-care training to all staff working with older people in health, social care and voluntary sectors; and meeting mental health needs within acute hospital services.

Implementation advice for social care and health professionals is available from NICE and SCIE.

Northern Ireland

Department of Health, Social Services and Public Safety business plan 2007–2008

(Department of Health, Social Services and Public Safety 2007)

The Department of Health, Social Services and Public Safety (DHSSPS) was created in 1999 and its mission is 'to improve the health and social well-being of the people of Northern Ireland. It endeavours to do so by ensuring the provision of appropriate health and social care services, both in clinical settings and in the community'.

The DHSSPS supports a range of programmes including health promotion and encouraging people to adopt activities and attitudes that will lead to better health and wellbeing.

A healthier future: a twenty year vision for health and wellbeing in Northern Ireland 2005–2025

(Department of Health, Social Services and Public Safety 2004)

The regional strategy for health and wellbeing, *A healthier future* is a vision for health and wellbeing in Northern Ireland for the 20 years up to 2025. It is intended to give the direction of travel for health and social services and focuses on:

- Promoting public health.
- Engagement with people and communities to improve health and wellbeing.
- The development of responsive and integrated services which will aim to treat people in communities rather than in hospital.
- New, more effective and efficient ways of working through multi-disciplinary teams.
- Measures to improve the quality of services.
- Flexible plans, appropriate organisational structures and effective, efficient processes to support implementation of the strategy.

The Elderly and Community Care Unit at DHSSPS has developed objectives which aim to support an increasing number of people to live independent lives, preferably in their own homes, and to develop effective alternatives to hospital care, which are designed to reduce inappropriate admissions and unnecessary lengths of stay. Its objectives include developing a range of housing and care options and expanding the respite and support services for carers. In co-operation with the independent sector, it also plans to expand the use of such things as supported living and day care.

The Bamford review of mental health and learning disability (N. Ireland)

The Bamford review of mental health and learning disability comprises several reviews that encompass policy, services and legislation. One of these, *Living fuller lives*, is a service report relevant to older people with dementia and other mental health problems.

Living fuller lives

(Dementia and Mental Health Issues of Older People Expert Working Committee 2006)

The draft report for consultation *Living fuller lives* (2006) makes a range of recommendations about services for older people with dementia and other mental health problems. For example, a range of models of respite care should be delivered and these models should be responsive and beneficial to older people with mental health problems and their carers. Care homes should promote 'a positive and enjoyable quality of life, including appropriate activities, enjoyable and appropriate food and promotion of independence' (p. 106).

Older people's strategy: ageing in an inclusive society

(Office of the First Minister and Deputy First Minister Northern Ireland 2006)

The vision for this strategy is 'to ensure that age related policies and practices create an enabling environment, which offers everyone the opportunity to make informed choices so that they may pursue healthy, active and positive aging' (p. 9).

The strategy has six objectives, as follows:

1. To ensure that older people have access to financial and economic resources to lift them out of exclusion and isolation.
2. To deliver integrated services that improve health and quality of life for older people.
3. To ensure older people have a decent and secure life in their home and community.
4. To ensure that older people have access to services and facilities to meet their needs and priorities.
5. To promote equality of opportunity and full participation in civic life and to challenge ageism wherever it is found.
6. To ensure government works in a co-ordinated way interdepartmentally and with social partners to deliver effective services for older people.

The 2005–2006 report on progress against departmental actions to achieve the strategic objectives was published in January 2007.

Investing for health 2002

(Department of Health, Social Services and Public Safety 2002)

The *Investing for health* strategy is built around two goals and seven objectives, with a number of measurable, illustrative targets linked to these objectives. These include information on promoting independent living for older people through a community development approach (pp. 24–25).

Priorities for action: planning framework for the HPSS 2006–2008

(Department of Health, Social Services and Public Safety 2006)

This framework outlines the key priorities for health and social services for Northern Ireland for 2006–2008. It sets out the actions to be taken forward to deliver high-quality, safe and accessible services that meet the needs of the people of Northern Ireland.

Scotland

Co-ordinated, integrated and fit for purpose: a delivery framework for adult rehabilitation in Scotland

(Scottish Executive 2007)

Launched in February 2007 this new model of service delivery gives strategic direction and support to all health and social care services and practitioners who deliver rehabilitation services to individuals and communities.

The document focuses on core principles of rehabilitation specifically as they relate to older people, adults with long-term conditions and people returning from work absence and/or aiming to stay in employment.

The new vision calls for a fundamental shift in the way the NHS works, from an acute, hospital-driven service to one that is embedded within the community, is patient focused on a philosophy that moves from 'care' to 'enablement' and rehabilitation. The focus is on meeting the twin challenges of an ageing population and the rising incidence of long-term conditions.

The ethos is about enabling physical, psychological, emotional, social and occupational potential of the individual and improving quality of life. It recognises that social engagement and purposeful occupation are key to self-worth and wellbeing.

Better outcomes for older people: framework for joint services

Executive summary

Part 1: Implementing and evaluating joint services

Part 2: Joint services and the journey of care

(Scottish Executive 2005)

This framework has three functions:

1. To promote the implementation and mainstreaming of joint and integrated services by local partnerships.
2. To set out the requirements and timescales which the local partnerships of NHS boards and councils should meet in developing joint and integrated services.
3. To act as a tool to assist in the implementation of joint and integrated services.

Changing lives: report of the 21st century social work review

(21st Century Social Review Group, Scottish Executive 2006)

Changing lives reports on the recommendations made by the 21st Century Social Work Review Group for the future of social services in Scotland.

It promotes the idea that services should meet people's needs rather than people fitting the available services. It recognises that social work services make an essential contribution to the promotion and development of a society that is healthy, prosperous, safe, fair and inclusive.

The recommendations include designing and delivering services around the needs of the people who use the services and their carers and providing effective, integrated services to support vulnerable people and promote social wellbeing.

Draft standards: healthcare services used by older people in NHSScotland

(NHS Quality Improvement Scotland 2004)

This document introduces the NHS Quality Improvement Scotland (NHS QIS) draft standards for healthcare services used by older people in NHSScotland. The standards follow four key parts of the patient journey and are identified as:

1. Avoiding admission – to ensure there are services in place that can respond quickly to provide health promotion, assessment, care and rehabilitation for older people regardless of their current residential setting.
2. Admission and rehabilitation – to focus on assessment, acute care, care planning and rehabilitation.
3. Transfer and discharge – to facilitate safe discharge home and support people after discharge.
4. Supporting services – to focus on multi-agency planning of services used by older people.

These standards are used by NHS QIS to assess performance in areas throughout NHSScotland where services are used by older people. These will include care homes for older people.

Wales

Fundamentals of care: guidance for health and social care staff

(Welsh Assembly Government 2003)

This initiative is included in the *Plan for Wales* (National Assembly for Wales 2001) as part of 'Improving Health and Care Services' and aims to improve the quality of aspects of health and social care for adults. The document provides guidance and promotes good practice by describing and presenting practice indicators for use as benchmarks. The areas of practice include communication, relationships, respecting people, promoting independence, ensuring comfort and safety, eating and drinking.

National minimum standards for domiciliary care agencies in Wales

(Welsh Assembly Government 2004)

This document sets out the national minimum standards for domiciliary care agencies in Wales. The purpose of these standards is to ensure a reasonable level of personal care and support which people receive while living in their own home in the community. The standards will be applied to agencies providing personal care to a wide range of people, such as older people, who need care and support while living in their own home.

The strategy for older people in Wales

(Welsh Assembly Government 2003)

The five key aims of this strategy can be summarised as:

1. Tackling discrimination against older people.
2. Promoting and developing older people's capacity to continue to work, learn and make an active contribution for as long as they wish.
3. Promoting and improving the health and wellbeing of older people.
4. Providing high-quality services and support to enable older people to live as independently as possible in a suitable and safe environment and to ensure services are organised around their needs.
5. To implement *The strategy for older people in Wales* to ensure that it is a catalyst for change and innovation across all sectors, improving services for older people.

Healthy ageing action plan for Wales

(Welsh Assembly Government 2005)

This plan provides guidance for use at local level on evidence-based health promotion interventions for older people. It is structured around the priorities within the various National Service Frameworks and health gain targets, and highlights the role of national and local statutory, voluntary and independent agencies.

The health promotion action plan for older people in Wales

(Welsh Assembly Government 2004)

Consultation document

The plan is structured around the main target areas, including physical activity and emotional health and wellbeing, for action to promote the health of older people. It highlights the role of national and local statutory, voluntary and independent agencies.

National Service Framework for older people in Wales

(Welsh Assembly Government 2006)

The National Service Framework (NSF) sets national, evidence-based standards for the health and social care of older people, thereby helping to ensure that a good level of service is available everywhere in Wales. The NSF sets out a three-stage programme to bring all services up to a minimum good standard in the shorter term, and to share and spread good practice to continually improve services and strive towards excellence.

The NSF consists of ten key standards, which set out the rationale and evidence base, followed by the key actions required. There are six cross-cutting themes which underpin all of the standards:

1. Equity.
2. Person-centred care.
3. Engaging older people and carers.
4. Whole systems working.
5. Promoting wellbeing and independence.
6. Management capacity.

The Welsh Assembly Government regards the *National Service Framework for older people in Wales* as providing the main policy drive for dignity in care in Wales. Any initiatives with respect to older people's care will be driven through implementation of the NSF.

Making the connections plan

(Welsh Assembly Government 2004)

Making the connections outlines four main principles:

1. **Citizens at the centre** – services are to be more responsive to users, with people and communities involved in designing the way services are delivered.
2. **Equality and social justice** – every person is to have the opportunity to contribute and services must work to connect with the hardest-to-reach members of the population.

3. **Working together as the Welsh Public Service** – more co-ordination between providers to deliver sustainable, quality and responsive services.
4. **Value for money** – making the most of our resources.

This relates to the way services are commissioned and delivered and impacts on all areas of health and social care, indeed all public services. This is the agenda that promotes collaborative rather than competitive working in Wales.

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Appendix B: Care standards

Like the policy drivers, each of the four countries in the UK has produced its own care standards and inspection processes, which are constantly reviewed. Most of these focus on service users and achieving high-quality outcomes.

Readers are advised to refer to the relevant standards and inspection processes for the most up-to-date information. This section summarises some of the key information about care standards for each country.

England

Legislation: Care Standards Act 2000

Regulatory body and inspectorate: Commission for Social Care Inspection

Regulations: Care Home Regulations

Standards: National minimum standards for care homes for older people (Department of Health 2003)

Inspection:
Three types:

1. *Key inspection* – a thorough look at how well the service is doing, taking into account detailed information provided by the owner or manager.
2. *Random inspection* – short, targeted inspection either focused on the specific issue, or to check on improvements that should have been made, or to investigate a complaint, or for no reason at all.
3. *Thematic inspection* – focused on a specific issue, or a specific region, in order to look at trends.

The main cross-cutting themes are:

- focus on service users
- fitness for purpose
- comprehensiveness
- meeting assessed needs
- quality services
- quality workforce.

Standards relevant to activity provision:

Standard 7 – Service user plan

Outcome: the service user's health, personal and social care needs are set out in an individual plan of care.

- 7.2
The service user's plan sets out in detail the action to be taken by care staff to ensure that all aspects of the health, personal and social care needs of the service user are met.

Standard 12 – Social contact and activities

Outcome: service users find the lifestyle experienced in the home matches their expectations and preferences, and satisfies their social, cultural, religious and recreational interests and needs.

- 12.1
The routines of daily living and activities made available are flexible and varied to suit service users' expectations, preferences and capacities.
- 12.2
Service users have the opportunity to exercise their choice in relation to:
 - Leisure and social activities and cultural interests.
 - Food, meals and mealtimes.
 - Routines of daily living.
 - Personal and social relationships.
 - Religious observance.
- 12.3
Service users' interests are recorded and they are given opportunities for stimulation through leisure and recreational activities in and outside the home that suit their needs, preferences and capacities. Particular consideration is given to people with dementia and other cognitive impairments, those with visual, hearing or dual sensory impairments, and those with physical disabilities or learning disabilities.
- 12.4
Up-to-date information about activities is circulated to all service users in formats suited to their capacities.

Standard 13 – Community contact

Outcome: service users maintain contact with family, friends, representatives and the local community as they wish.

- 13.1
Service users are able to have visitors at any reasonable time and links with the local community are developed and/or maintained in accordance with service users' preferences.

Northern Ireland

Legislation: The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

Regulatory body and inspectorate: The Regulation and Quality Improvement Authority

Regulations: The nursing homes regulations (Northern Ireland) 2005
The residential care homes regulations (Northern Ireland) 2005

Standards: Care standards for residential and nursing homes (in draft form at the time of going to press)

Inspection:

Announced inspections – these inspection visits are planned and the service provider knows when the inspection staff will arrive to conduct them. These inspections can be performed by care, pharmacy, estates and financial inspectors.

Unannounced inspections – these inspection visits are planned without the service provider receiving advance notice. These inspections can be performed by care, pharmacy, estates and financial inspectors.

Unannounced inspections can be performed during working hours, early mornings, late evenings and weekends. The distribution of these inspections is important to provide assurance as to the care provided at different stages of the day and night. It is also a method for identifying poor practices.

A new methodology for the inspection process is being piloted and it is hoped this will be implemented during 2007–2008.

Scotland

Legislation: Regulation of Care (Scotland) Act 2001

Regulatory body: The Scottish Commission for the Regulation of Care (established April 2002)/The Care Commission

Standards: National care standards (Scottish Executive 2005)
National care standards: care homes for older people (Scottish Executive 2005)

Inspectorate: Care Commission
The Care Standards and Sponsorship Branch

Inspection:

All care services are required to self-evaluate their service against the *National care standards*. Services are inspected at least once a year, on either an announced or an unannounced basis, based on five core standards and a number of themes. Information about the current core standards and themes is available on the Care Commission website.

Main principles:

- Dignity – your right to:
 - Be treated with dignity and respect at all times.
 - Enjoy a full range of social relationships.
- Privacy – your right to:
 - Have your privacy properly respected.
 - be free from unnecessary intrusion.

- Choice – your right to:
 - Make informed choices, while recognising the rights of other people to do the same.
 - Know about the range of choices.
- Safety – your right to:
 - Feel safe and secure in all aspects of life, including health and wellbeing.
 - Enjoy safety but not be over-protected.
 - Be free from exploitation and abuse.
- Realising potential – your right to have the opportunity to:
 - Achieve all you can.
 - Make full use of the resources that are available to you.
 - Make the most of your life.
- Equality and diversity – your right to:
 - Live an independent life, rich in purpose, meaning and personal fulfilment.
 - Be valued for your ethnic background, language, culture and faith.
 - Be treated equally and be cared for in an environment which is free from bullying, harassment and discrimination.
 - Be able to complain effectively without fear of victimisation.

Standards relevant to activity provision:

Standard 6 – Support arrangements

You can be confident before moving in that the home will meet your support and care needs and personal preferences. Staff will develop with you a personal plan that details your needs and preferences and sets out how they will be met, in a way that you find acceptable.

- 6.1
Your personal plan will include:
 - Social, cultural and spiritual preferences.
 - Leisure interests.
 - Any special furniture, equipment and adaptations you may need.
 - Any special communication needs you may have.

Standard 12 – Lifestyle: social, cultural and religious belief or faith

Your social, cultural and religious belief or faith are known and respected. You are able to live your life in keeping with these beliefs.

- 12.4
The social events, entertainment and activities provided by the care home will be organised so that you can join in if you want to.

Standard 14 – Keeping well: healthcare

You are confident that the staff know your healthcare needs and arrange to meet them in a way that suits you best.

- 14.7
You will have opportunities to take part in physical activities in, or outside, the home. If you cannot go out of the home, you will be able to take part in physical

activities arranged by the staff that aim to help you maintain your physical independence and activity.

Standard 17 – Daily life

You make choices and decisions about day-to-day aspects of your life and about how you spend your time.

- 17.1
The social events, entertainment and activities provided by the care home will be organised so that you can join in if you want to.
- 17.2
You know that the staff will explain, justify and record any limits on your independence in your personal plan and know that these will be reviewed regularly.
- 17.3
You know that the staff are trained to listen to people living in the care home.
- 17.4
You can keep up relationships with friends, relatives and carers and links with your own community. If you want, the staff will support you to do this.
- 17.5
You are free to come and go as you please, unless there are specific legal requirements which prevent this.
- 17.6
You have no restrictions placed on the time you get up or go to bed.
- 17.7
You are supported and encouraged to use local services such as hairdressers, shops and banks.
- 17.8
You have access to information about local events, facilities and activities.
- 17.9
Staff can help you to arrange meetings with visitors and help any disabled friends and relatives into and around the building.

Wales

Legislation: Care Standards Act 2000

Regulatory body and inspectorate: Care Standards Inspectorate for Wales

Regulations: Care homes (Wales) regulations 2002
The care homes (Wales) (amendment) 2003
The care homes (Wales) (amendment no. 2) regulations 2003

Standards: National minimum standards for care homes for older people (Welsh Assembly Government 2004)
Supplementary guidance for older people with dementia (Care Standards Inspectorate for Wales 2003)

Inspection:
The inspection process was reformed as of April 2006. Providers complete a self-assessment form, including details of policies and procedures. The inspection plan is

linked to key needs of the service and sent to the provider outlining the inspection methodology to be used. Normally this includes case tracking to enable all aspects of care to be inspected through the service user's experience. An annual inspection report is compiled.

Standards relevant to activity provision:

Standard 6 – Service user plan

Outcome: each service user's health, personal and social care needs are set out in an individual plan of care.

- 6.2
The service user's plan sets out in detail the action which needs to be taken by care staff to ensure that all aspects of health, personal and social care needs of the service user are met.

Standard 9 – Social contact and opportunities

Outcome: service users find that their lifestyle in the home matches their expectations and preferences, and satisfies their social, cultural, religious and recreational interests and needs.

- 9.1
The opportunities made available and the routines of daily living are flexible and varied to suit service users' expectations, preferences and capacities.
- 9.3
Service users have the opportunity to exercise choice in relation to:
 - Leisure and social activities and cultural interests.
 - Food, meals and mealtimes.
 - Routines of daily living.
 - Personal and social relationships.
 - Religious observance.
- 9.4
Service users' interests are recorded and they are given opportunities for stimulation through leisure and recreational activities in and outside the home that suit their needs, preferences and capacities. Particular consideration is given to people with dementia and other cognitive impairments, those with visual, hearing or dual sensory impairments, and those with physical disabilities or learning disabilities.
- 9.5
Up-to-date information about activities is circulated to all service users in formats suited to their capacities.

Standard 10 – Community contact

Outcome: service users maintain contact with family, friends, representatives and the local community as they wish.

Standard 15 – Health care

Outcome: service users' healthcare needs are fully met.

- 15.8
Opportunities are given for appropriate exercise and physical activity: appropriate interventions are carried out for service users identified as at risk of falling.

Supplementary guidance for older people with dementia

- 8.7
A setting which aims to promote fulfilment will:
 - Know about the things that individuals have done in earlier life and identify and encourage the skills and interests they retain.
 - Build on the individual's positive attributes and what they are still able to do, rather than just manage negative features such as their confusion.
 - Help individuals to use their physical and mental faculties within the limit of their abilities and wishes, but recognise and care for those who have no wish to be active or sociable.
 - Recognise and care for the emotional and spiritual needs of service users.
 - Create a stimulating environment.
 - Ensure that staff understand the importance of activity for people with dementia and of the specific activities which are available.
 - Ensure that care staff offer support to the service users in making choices and about activities.

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Appendix C: Supporting evidence

C.1 The importance of activity for older people

A number of physical and psychological changes occur when someone stops engaging in activity, for example reduced muscle strength and postural stability which will increase the risk of falling, decreased respiratory, cardiac and intestinal function, disorientation, sense of loss, anxiety and ill-being.

- Perrin T ed (2005) *The good practice guide to therapeutic activities with older people in care settings*. Bicester: Speechmark.

Engaging in activity results in physical and psychological benefits.

- British Heart Foundation (2003) *Active for later life*. London: BHF.
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C.2 The importance of activity for older people in care homes

Participating in activity can reduce the levels of: depression; behaviour that challenges; falls; and dependency in care homes, thus improving wellbeing.

- Ames D (1990) Depression among elderly residents of local-authority residential homes: its nature and the efficacy of intervention. *British Journal of Psychiatry*, 156(5), 667–675.
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Purposeful activity for care home residents is acknowledged as an essential component of health, wellbeing and quality of life.

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C.3 The level of activity in care homes

Historically the level of inactivity within care homes for older people has been high.

- British Heart Foundation (2005) *Moving more often: a programme to promote physical activity with frailer, older people*. London: BHF. Available at: http://changeagentteam.org.uk/library/docs/BetterCommissioning/moving_more_often.pdf Accessed on 13.06.07.
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- Godlove C, Richard L, Rodwell G (1982) *Time for action: an observation study of elderly people in four different care environments*. (Social services monographs: research in practice. Community Care). Sheffield: Joint Unit for Social Services Research.
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More recently a multi-centre randomised controlled trial examined the unmet needs of residents with dementia living in care homes. Daytime activity was an unmet need for 76% of the sample of 238. This level of unmet need rose to 84% for those residents who were also depressed and to 90% for those who were also anxious.

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The report states that the quality of residential services is generally improving. However, it also highlights that there is 'a need to focus more directly on those things that matter to individuals and enhance their quality of life' (p. 111). It also found that activities offered in homes for younger adults were more stimulating than those in homes for older people and these were usually group rather than individual activities.

- Commission for Social Care Inspection (2005) *The state of social care in England 2004–05*. London: CSCI.

C.4 Organisational culture

The manager is key to encouraging a culture of activity and to enable and empower care staff to make the necessary organisational changes.

- Beck C (2001) Identification and assessment of effective services and interventions: the nursing home perspective. *Aging and Mental Health*, 5(Supplement 1), S99–111.
- Green S, Acheson Cooper B (2000) Occupation as a quality of life constituent: a nursing home perspective. *British Journal of Occupational Therapy*, 63(1), 17–24.

C.5 Physical environment

As care home premises need to be 'fit for purpose', the facilities and equipment to encourage residents to be as independent as possible must be readily available. Poor access and lack of appropriate walking aids can impede or prevent mobilisation throughout the home, thus lowering levels of physical activity and the potential for

stimulation and social interaction. A lack of colour contrast between different levels and surfaces and poor lighting can make it difficult for residents with visual or perceptual impairments to find their way around. Certain design principles are accepted as beneficial within care homes for people with dementia.

- Brawley EC (2001) Environmental design for Alzheimer's disease: a quality of life issue. *Aging and Mental Health*, 5(1), S79–83.
- Powell Lawton M (2001) The physical environment of the person with Alzheimer's disease. *Aging & Mental Health*, 5(Supplement 1), S56–64.

Further information is available from:

- Rees L, Lewis C (2004) *Adapting homes: a guide to adapting existing homes for people with sight loss*. Cardiff: JMU Access Partnership.
- RNID www.rnid.org.uk
- Royal National Institute of the Blind (RNIB) www.rnib.org.uk
- The Alzheimer's Society (2006) *The Alzheimer's Society guide to the dementia care environment*. London: The Alzheimer's Society.
- The Dementia Services Development Centre, University of Stirling www.dementia.stir.ac.uk

C.6 Activities

It is beyond the remit of this document to advise on 'how' to provide effective activities. The potential scope is endless. However, the essential elements are getting to know the person in terms of their individual life history, experiences, interests and values, and understanding their current level of physical, sensory, cognitive and psychological ability. This knowledge then informs the selection of personally meaningful activities and their provision at an appropriate level of challenge or 'fit'. We all know how frustrating it can be to be confronted by something that is beyond our capabilities, or indeed that is too simple. So it is vital to get the right degree of 'fit'. The importance of gathering life history information cannot be overestimated, not just in relation to activity provision but to assist care givers in understanding behavioural patterns and habits.

- Gibson F (2005) Fit for life: the contribution of life story work. In: M Marshall, ed. *Perspectives on rehabilitation in dementia*. London: Jessica Kingsley. 75–179.
- Hurlley R, Wenborn J (2005) *The successful activity co-ordinator: for activity and care staff engaged in developing an active care home*. 2nd ed. London: Age Concern England.
- Knocker S (2002) *The Alzheimer's Society book of activities*. London: The Alzheimer's Society.
- Knocker S, Gaspar S (2007) *Starting out and keeping it up: a guide for activity providers*. London: National Association for Providers of Activities for Older People.
- Murphy C (2004) The critical importance of biographical knowledge. In: T Perrin, ed. *The new culture of therapeutic activity with older people*. Bicester: Speechmark. 88–103.

- Osborn C (1993) *The reminiscence handbook: ideas for creative activities with older people*. London: Age Exchange.
- Owen T ed, National Care Homes Research & Development Forum (2006) *My home life: quality of life in care homes*. London: Help the Aged.
- Pool J (2002) *The Pool Activity Level (PAL) instrument for occupational profiling: a practical resource for carers of people with cognitive impairment*. 2nd ed. London: Jessica Kingsley.
- SHAP Working Party on World Religions in Education publishes an annual calendar of festivals for 12 major religions. Available at: www.shap.org
- Wenborn J, Challis D, Pool J, Burgess J, Elliott N, Orrell M (in press) Assessing the validity and reliability of the Pool Activity Level (PAL): checklist for use with older people with dementia. *Aging and Mental Health*.

C.7 Falls prevention

Alongside strategies to keep residents mobile comes the increased risk of falling. Care home residents are three times more likely to fall than community-living older people. Forty per cent of care home admissions follow a previous fall and 40% of hospital admissions from care homes follow a fall (Help the Aged 2004). Comprehensive risk assessments need to be completed and a range of strategies implemented to prevent falls (NICE 2004). However, this should not be at the expense of limiting the individual's potential level of independence or participation in activities.

- Help the Aged (2004) *Preventing falls: managing the risk and effect of falls among older people in care homes*. London: Help the Aged.
- National Institute for Clinical Excellence (2004) *Falls: the assessment and prevention of falls in older people*. (Clinical Guideline 21). London: NICE.

C.8 Useful reading/resources

- Feil N (2002) *The validation breakthrough: simple techniques for communicating with people with Alzheimer's-type dementia*. 2nd ed. Baltimore, MD: Health Professions Press.
- Perrin T ed (2004) *The new culture of therapeutic activity with older people*. Bicester: Speechmark.
- Perrin T, May H (2000) *Wellbeing in dementia: an occupational approach for therapists and carers*. Edinburgh: Churchill Livingstone.

Appendix D: College of Occupational Therapists

The College of Occupational Therapists sets the professional and educational standards for occupational therapy. It provides leadership, guidance and information relating to research and development, education, practice and lifelong learning. In addition, 11 accredited specialist sections support expert practice in key areas.

The College of Occupational Therapists Specialist Section – Older People aims to improve older people's quality of life by promoting the development and provision of high-quality, evidence-based occupational therapy services. Members work in both physical and mental health and in social care services for older people in a variety of settings, including care homes.

Key objectives

- To be a thriving organisation that is indispensable to the profession.
- To promote the importance of occupation for the health and wellbeing of the population.
- To lead innovation in occupational therapy theory, practice, research and education.
- To have a positive influence in the development and support of a workforce that meets changing needs.
- To continue to have an input to wider debate and work to have an influence on national policies.

Structure

The British Association of Occupational Therapists (BAOT) is the professional body and trade union for occupational therapy staff in the UK. Eight English regions, four Scottish regions and the four countries are represented within its membership.

The College of Occupational Therapists is a wholly owned subsidiary of BAOT and operates as a registered charity. It represents the profession nationally and internationally, and contributes widely to policy consultations throughout the UK.

Contact

British Association/College of Occupational Therapists
106–114 Borough High Street
London SE1 1LB
Tel: 020 7357 6480
www.cot.org.uk

Appendix E: National Association for Providers of Activities for Older People (NAPA)

NAPA is a registered charity and membership organisation for all those interested in increasing activity opportunities for older people in care settings. NAPA offers direct services to its members, including an information line, publications and training courses. It also has a strategic and campaigning role in order to put activity at the heart of care.

Values

- The uniqueness of each older person.
- Raising awareness of activities.
- Understanding the care world.
- Better practice.

Key aims

Developing expertise in activity provision for older people and sharing this through:

- Delivering best practice, training and support.
- Disseminating useful information.
- Promoting, encouraging and researching best practice.
- Raising the status of activity providers.

Structure

NAPA is a registered charity and a limited company with a small permanent staff team. It is administered by a board of trustees made up of volunteers with a keen and active interest in promoting high-quality activity provision for older people.

NAPA has established working partnerships with most of the leading organisations involved with the wellbeing of older people, both voluntary and privately funded, in order to promote its aims.

Contact

NAPA
5th Floor – Unit 5.12
71 Bondway
London SW8 1SQ
Tel: 020 7078 9375
www.napa-activities.co.uk

Activity Provision

Benchmarking good practice in care homes

It is important to develop a culture in care homes where activity is integral to care and not seen as an optional extra. *Activity provision: benchmarking good practice in care homes* promotes and encourages appropriate activity for older people that is delivered in a kind and pleasant environment, regardless of residents' age and/or diagnosis, whilst still respecting their dignity and personal choice.

This publication:

- Offers a framework of person-centred quality indicators and outcome measures for activity provision.
- Incorporates a benchmark tool to evaluate current practice and promote excellence.
- Summarises relevant policy drivers and care standards for each country in the UK.
- Includes supporting evidence for good quality activities in care homes.

This document is intended to inform, guide and encourage care home providers, managers and commissioners, and will also be helpful to residents, their families and friends, and care home inspectors.

Activity provision: benchmarking good practice in care homes was jointly developed by the College of Occupational Therapists and the National Association for Providers of Activities for Older People.

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