The care exchange – Series 5
Episode 3: The standard you walk past, is the standard you accept

Hosts
Pia Rathje-Burton and Wendy Adams

Guest
Lindsay Rees, Head of product content, Quality Compliance Systems (QCS)

Pia Rathje-Burton 00:08
Welcome to the care exchange skills for care podcast for managers in social care. I'm Pia Rathje-Burton,

Wendy Adams 00:14
and I'm Wendy Adams,

Pia Rathje-Burton 00:16
today on the podcast, we've got Lindsay Rees. Lindsay is the head of social care contents with QCS. She has worked with QCS for just over two years.

Wendy Adams 00:25
So QCS, or quality compliance systems, is the leading digital provider of compliance management, policies and procedures. Lindsay is a registered nurse, and she's worked in social care for 17 years in various roles, which include being a registered manager, a regional support manager and head of quality. So

Pia Rathje-Burton 00:47
really looking forward to having a chat with Lindsay today and on the show. So welcome to the care exchange. Lindsay,

Lindsay Rees 01:03
thank you very much. Thank you for having me.

Pia Rathje-Burton 01:06

It's really great to have you here today. We had an introduction there that you work for QCS. So just by start off, can you tell us a little bit about that role?

Lindsay Rees 01:16
Yeah, of course. So QCS are a software provider, essentially, and at the core of our product is policies and procedures. So the digital policies and procedures. So instead of having those on your shelf on paper, they are digitally available on the desktop and on an app, we do other things as well, but that's kind of where the product really product really started, taking policies that were paper, making them digital, and making them accessible all the time,

Pia Rathje-Burton 01:49
okay? And your role in that.

Lindsay Rees 01:53
So my role is that I'm kind of like the subject matter expert in terms of social care, specifically residential side of things, because that's my background, 17 years in Adult Social Care, and my title is Head of Product Content. But what I do is I say, This is what customers want. This is what customers need from my experience and also from talking to customers. And then I say to the people that do the technical stuff, make it so,

Pia Rathje-Burton 02:20
right? So you are sort of, kind of the voice of reason, yeah,

Lindsay Rees 02:23
and they will say sometimes to me, you know, we've, we've designed this thing, and we think this will be great because, and I'll say that won't work because, or I'll say, No, that would be amazing because, okay,

Pia Rathje-Burton 02:35
and you get to visit services And, and,

Lindsay Rees 02:39
yes, based, yeah, very much so. So that's one of the big challenges for me, actually, in this role, two years ago, I left essentially frontline operational management leadership to join a software company, and my commitment when I first arrived was that you have to let me out, because I don't want to lose touch with the sector. It's fundamental to my role at QCS, but also to my own sanity, because that's what I love. So yes, a commitment to a minimum monthly site visit and then contact with customers as and when, as much as I possibly can virtually.

Wendy Adams 03:17

Yeah, that's really good that you've got that ongoing contact with all sorts of services, and I guess some of those will be services that are rated Good or Outstanding. Some of them might be services that that maybe are struggling a little bit a little bit more when you visit those services that are Good or Outstanding, what are the sort of things that you notice.

Lindsay Rees 03:43
So I think it's been one of the so in my operational years, I only would ever really speak to or visit the people that I work for. I might occasionally do a sneaky mystery shop, but generally, you know, it would be the services that I that I was supporting and leading. And so now in my position, I get, as you say, I get to actually step over the threshold of all sorts of different services, all shapes and sizes. And one of the great insights actually has been going into areas where I've never been before. So supported living, for example, the understanding how supported living works. Because being brutally honest, it was a complete mystery. To me, it's still, to a certain extent, a bit of a mystery, because they're so diverse. The services are so different every no one is the same. And so that's been a wonderful learning experience, you know, figuring out what that means.

Pia Rathje-Burton 04:34
And do you sort of notice is there sort of common feature? So if you're thinking about sort of kind of Good and Outstanding services, are they sort of things that you think that's a common feature in all those services?

04:45
I would say the most common thing in a well run service, or a service that's rated higher is two things. I would say, firstly, it's the it is the first. Impression from whoever answers the door when you first show up, that first impression, you kind of just get an idea of whether the people that are there, A care, and B are well-led. You get, just get a sense of whether there's chaos or not. You know, not necessarily, you know, not the quality of the care. It's just that sense of that very first impression whoever answers the door will give you a really good impression of the service, I think. And then secondly, the manager. So if there isn't a manager, generally speaking, the service will have difficulties. And then meeting that manager, you get a really quick feel for how in touch they are. And one of the things I always look for is, do they know their staff by name, and do they know their service users, their residents or the people they support? Do they know them by name? If they know the service well, then I genuinely get the feeling that they will be a well run service. Yeah,

Wendy Adams 05:53
that's really important. What you're saying about that first impression when you step through the door. Because obviously, in the role of locality manager for Skills for Care. Pia and I are also in and out of services quite a lot. And I think we've also had that experience of, you know,

stepping through the door and some of the care staff maybe are looking at you a little bit suspiciously and just getting about their business, and you're sort of standing there, and nobody says, Hello, I'm so and so, you know, who are you, what? Why are you here? Can we help you? And that does make such a difference to the feel of to the feel of an organization. And when I've spoken to managers before, sometimes managers will say, well, staff, sometimes don't feel very confident to do that, or, you know, they're a little bit nervous when they don't recognize you as to who you might be. So there is something about creating that right culture, I guess, within a service so that everybody feels like it's it's part of their role to do that.

Lindsay Rees 07:00
Yeah, and it and if that culture is not there, it's really hard to change it, I know. And if people are not confident and frightened to answer the door, frightened to speak out, because they don't know how you know how they're going to be received, and that speaks volumes about the service and how they're when you're not there, that's how they feel as well. Otherwise they wouldn't be feeling that away with

Pia Rathje-Burton 07:21
yourself. Yeah, exactly. And it's interesting. I was talking to somebody, and they were saying about how, you know, if you're thinking about you or us, kind of visiting any kind of service, and it could be home care, supported living or residential services, and you know, you know we're not, you know, we're not there in an inspecting capacity, but obviously the regulator will come in in the same way, unannounced and how our staff, and almost this person, was sort of saying about how kind of host, you know, almost needs to see it as a hosting a party, you know, like, you know, anybody coming in feeling welcome, feel like they've and practice that. So practicing, if it's staff, isn't it about, you know, the strangers coming in. How do we all react to that? So it's really interesting.

Lindsay Rees 08:05
The mantra of the standard that you walk past is the standard that you accept. I know it might be sound like a bit of a cliche, but it is so, so important, because that's where the trouble starts. If one person walks past the call bell and doesn't answer it. If one person walks past the person calling out and doesn't go and see them and say, Are you okay? Then that's when it starts. And that's when that you get that unfortunately, you know, that snowballing of dignity at the end of the day,

Pia Rathje-Burton 08:34
yeah. And if I always kind of look at, you know, I was driving past the care home yesterday, and it's a care home that I've had some had some contact with a couple of years ago, and they were having some difficulties then, and their their sign was all dirty. And I was thinking,

obviously, haven't got much better there. Because that's that's the impression it may have that, you know, they may be absolutely perfect inside, but just the fact that the sign had all kind of mold around it and stuff like that, you know, it's really interesting, isn't it, and

Lindsay Rees 09:01
that's one of the first things you do as when you're doing a turnaround, if I'm doing a turnaround, if I'm looking at a service, one of the I stand outside, and it starts right at that point when I pull up in the car, my impression is there rubbish on the car park floor. If there's rubbish on the car park floor, the managers walk past that on their way to work, and that speaks volumes about what I'm going to see when I get inside the home. Yeah. So I was

Pia Rathje-Burton 09:21
going to ask you about that turnaround role you had in your previous role. What? What was that all about? You know? What? What did you have to do?

09:28
So it would vary, and I've worked with various different providers, but I would, I would be so I I've never had the role as a tam, as they were called, in one of the organizations I used to work for turnaround manager, as in, you can, you can be paid a daily rate to do that. My turnaround experience is more in terms of, I would be sent from the group operational level to a struggle, to a service that's struggling, and it will be, we'll know it's struggling because of the data in terms of either, you know, staff turnover or resident outcomes or complaints or medicines management. So it would usually be some sort of particular thing that I would be going in to look at, and I would then also potentially be asked to work alongside the manager, to support the manager who's struggling, or if there wasn't a manager, I would do all of that and be the manager at the same time, and I might do that in different services over over a period of time, and sort of come up with a project plan. So let's find out, because it's not a one size fits all. So if the issue is around medicines management, then that's where I would start, if you see what I mean, and in doing that, I will probably then discover some of the other leadership issues that have allowed the situation to occur when we've got an issue with medicine management, and I won't know what that is until I dig into the detail.

Pia Rathje-Burton 10:50
Okay, and are there anything from doing that role that you sort of think is useful to share with other managers?

Lindsay Rees 10:59
So I think understanding that the sort of cause and effect, every every outcome has a cause, and it might not be what you think it is. And so you have to figure out, I call them, figure out what sandbags are. Figure out where one of the things that are holding the service down,

stopping it excelling. And until you look, you don't know, and it might not be what you think it is. And so always have that bigger picture approach. I always, I have the saying that 99.9% of people who work in care, care, nobody wants to do a bad job. And so if there are problems, it's not because anybody wanted there to be problems. So there must be a reason. And so think my advice would be, think broad, think big picture. Don't assume that just because there's a problem with a particular thing, like medicines management, it's to do with medicines management, it's probably got nothing to do with the actual medicines. It'll be to do with something else, and the bigger leadership piece around why that problem has occurred. That

Wendy Adams 12:04
must have been quite a difficult role to go in when something had been highlighted that was a problem that must have been quite difficult to build that relationship with the manager and with the staff team. How did you do that? Because they could have seen you as being quite threatening, or, you know, being quite defensive.

Lindsay Rees 12:25
I think, well, I say it's easy. It's not easy. It's really hard. But for me, it's easy in that it's simple. You have to get alongside staff, feel it and breathe it with them, rather than say you're wrong. This is wrong. This is bad. Obviously, it's not great, that's why I'm here. So let me help you understand what the problems are. Because, like I said, Everyone cares. Nobody wants to do a bad job, so you have to physically get alongside people. And again, sounds a little bit cliche, perhaps, but roll your sleeves up. You know, really get involved. You know, get in the pair of Scrubs, get in uniform, get alongside people. If you invest that time and make that first impression, it will absolutely then, you know, work wonders for further down the line, when you're going to ask people to do things that they might not want to do and change their practice, in order to give you the right to do that, you have to get alongside them.

Wendy Adams 13:19
Yeah, because people, people need to want to change. You know, if you're going to make those changes to a service, people need to want to make that change, not be changing because you've told them to change, actually. So again, it comes back to that culture, doesn't it? Of that organization and people feeling like it's okay to be honest about what's going well, what's not going well in that service. And

Lindsay Rees 13:46
to give you an example around, sort of a practical example, sort of the service that I was supporting that had a big problem with medicines management, for example. And one of the root causes of the issue was that they weren't discussing and looking at the data in terms of missed medicines and stock control that was available them to them on an app was available, and it was there, and they just thought that it went somewhere else. And, you know, somebody

dealt with it. No, they weren't reviewing it daily. And so when we got all the team leaders together and we reviewed it daily, and we made that habit, and we made that at 10 o'clock every day. We all looked at that, and we all solved the problems together and looked at the gaps, and we got into the habit of doing it that solved the problem, because we you know, it was just a habit that we formed. But I did it with them. I didn't say you must do that and report back at the end of the week. I would gather them all around every morning at 10 o'clock, come on. Let's get the apps together. Let's look at our stock, and you do it together, and you learn together, and then suddenly you get to five o'clock on a Friday and you've run out of a particular medicine. But that doesn't happen anymore, because you've solved the problem yourself, and you're being kind to your future self by putting in a new process. But you have to live it and feel it to see the benefit.

Pia Rathje-Burton 14:56
Yeah, and I suppose by doing it that way, you. You're because I think that's, you know, like you in my previous roles. I've been involved with stock turnaround management, dealing with complaints, whistle blowing, all that kind of thing. So whenever you're doing that, it's really, can be really difficult to get everybody on board, because there's a natural reaction when somebody comes in and, you know, comes into to deal with it, with a problem as such, so that people become really defensive, and they they feel, yeah, you've come to tell me off, or tell me I'm not doing what I'm meant to be doing, you know, and that may be part of it, but unless you want to lose them, and that occasionally is the case, but most of the time, you don't want to lose any of those staff, they are, as you say, they are there, you know, trying to do their very best. So trying to, you know, working alongside them, I can really see how that will make a huge difference to the to the staff team and and the manager, I suppose, as well. And

15:56
came to me while you were talking there, Pia so important as well, is not to do this nine to five. So operationally, as you, as you become more senior, you tend to work more nine to five. And everyone wants to work nine to five. Of course they do. It's much more sociable. But care is not nine to five. So that turn around piece one of the other. You know, when I mentioned about turning up in the car park and making my first impression, I'm going to be doing that at 7am yeah, I'm also going to be doing that at three o'clock on a Sunday. I'm also going to be doing that on a night visit at 2am in the morning, because you and that is practical, because obviously you're trying to look to see where the issues are, where you can support but it also shows the staff that you care and that you will go to their place when it comes to that 24 hour provision of care you understand, and touching base with the night staff and the day staff is absolutely critical. Yeah,

Pia Rathje-Burton 16:46

absolutely, absolutely. And I think in particularly in, I suppose it's the same in home care and supported living. But that feeling that staff are supported out of hours, I think, is, you know, it's a it can be difficult to solve that, but it's really essential, isn't it? Because, you know, you know it's all very well. Kind of everybody feeling supported at three o'clock on a Monday afternoon? You want absolutely feel supported on Sunday at 11 o'clock, or whatever time it is, because that's, that's the timing can be really, really difficult, isn't it? The stuff always happens on a Sunday afternoon.

Lindsay Rees 17:20
Yeah, absolutely. And well, it stuff always happens, actually, at five o'clock on a Friday as well. You take that phone call at five o'clock on a Friday. I'm so not going home anytime soon.

Pia Rathje-Burton 17:33
Kind of just have to realize that that's part of the job, isn't it? Really, yes, your workforce is working that 24 o'clock, if that's the sort of service that you provide, therefore you you have to, as a manager, provide some of that support, or or at least provide a structure to have support, so you know, if you're able to share it with someone, so it's not you on on I'm not suggesting that somebody needs to be on call 24 hours a day, but having a structure so people feel supported, isn't it really,

18:01
yeah, and I think, you know, having someone on call is important. And also, from a manager's perspective, you can't get into this position where you're always firefighting and you're always coming in, you know, because you'll burnout, you can't always cover the shift. Yeah, that's not a sustainable situation. But sometimes you need to come in, and that's a good thing, because it shows the staff that you won't leave them in the lurch. In a really dire situation. They know that you'll come that's really important, too.

Wendy Adams 18:31
And I suppose you know a really good way of getting to know all of your staff. Because I suppose one of the challenges for me to ask yourself as a manager is, do I know all of my staff equally, or do I actually have great relationships with the staff who work days, who work similar times as me? But actually I don't know half as much about what makes the staff tick who work nights or work evenings or who work weekends. So I suppose one of the real temperature checks for managers listening to the podcast is, can I hand on heart say today that I know all of my staff equally, regardless of what shift patterns they do?

19:12
Yeah, yeah. 100% agree. And if I've heard anything at once, I've heard it many times when I have gone into services where there's been a series of managers turnover, and it's a troubled

service. One of the chief complaints is exactly that, manager doesn't know who I am, manager doesn't care about me. And I hear that specifically from night staff, who never get to see the day management team, because they're never there, and so they, you know, they don't feel connected. And that's a common, common thing that people say, yeah, in services that are struggling.

Pia Rathje-Burton 19:42
When I was a register manager, I used to work every Tuesday. I used to, I was still doing office based. I was in the office, but I would, I would come in at two o'clock, and then I was stay to 10-11, o'clock, you know, basically, do a late shift. I covered into the night, because I got to see the evening staff, and I got to see my night staff. And they knew that I did that every Tuesday, so if they needed to talk to me, they could come and I was I was there. So I think initially I probably did it. I did it just to see the night staff. But actually it was a really helpful because I got to know the routine in the evening. I could hear stuff. Because I think even if you're not hands on, because you've got stuff to do in terms of admin and pressure. There's a lot of admin that needs to be done in terms of being a manager, but you still have ears, and you can hear how, you know, making sure that people are doing. And I go and have my dinner with everybody, and you know, just work really, really well.

Lindsay Rees 20:37
Wendy, you were saying about knowing the staff. I also wanted to add in there about knowing the residents, knowing the service users, people that you support, is also so important two reasons. Obviously helps you make sure they're having quality care, but also it shows the staff that you care and you do care. So you know that knowing the residents, every single you know, I would always say to myself when I was in a position of being a registered manager, or if I'm doing that turnaround piece, when I'm doing that day to day leadership piece, I might not see every single resident in an 80 bed care home in the course of a day, but in the course of a week, absolutely, I will have eyeballed every single member, every single resident in that home. At some point during the week, I've kind of have a mental check of it, because that's my duty of care, to see and observe myself that I'm happy with the quality of their care. Yeah,

Pia Rathje-Burton 21:32
good, good kind of standard to have, isn't it? Yeah, I wanted to ask you. So I know you've done a number of kind of webinars and blogs for Skills for Care on audits. What are your sort of kind of top tips around audits? You know, effective auditing, that kind of thing. Well,

Lindsay Rees 21:53
I think probably one of the most important things having had, I'm sure you know, everyone's had experiences of being inspected and having interesting and challenging times with the regulator, or even internally. So if you have done an audit and you've not completed the

actions, it's worse than not doing the audit at all. Yeah, so you found a problem, you've done nothing about it. That's like the worst crime, yeah, guilty knowledge. So be so I think probably the most important thing is to be to really be mindful in your auditing, why you're auditing, what you're auditing, and there has to be an outcome ifyou're auditing for auditing sake, you might as well not bother. It's not a tick box exercise, and there isn't a one size fits all. So your your auditing, and the types of audit that you do have to make sense for your service and your service users. So for example, if everyone's independently mobile and spends very little amount of time ever in a bed or a chair, and they're all relatively young, then a pressure area prevention ulcer type audit isn't going to be important, not a detailed one. There needs to be something which says all my service users are independent mobile, so I have a very low risk of pressure ulcers, therefore, I'm only going to look at their care plan once a month to check that they're still mobile. That's an audit, but it's just one standard. And whereas, if I'm in a nursing home, there's multiple complex comorbidities, lots of people in beds and chairs, high level of potential risk, then my pressure area prevention, or it's going to be really detailed, and I'm going to do it often, yes, particularly

Wendy Adams 23:35
if you're a manager of a service within a bigger organization, you end up on that hamster wheel, don't you of I've got this audit to do, that audit to do, and you're running around that hamster wheel, ticking them all off, but not really thinking through, why am I doing this audit beyond somebody told me to, or somebody told me I needed, I needed to do it.

Lindsay Rees 23:59
Yeah, and I think not to be frightened to ask exactly that question. Wendy, you know, so why? Why am I auditing this? What's the point? So, what, where is the outcome that is going to be beneficial to the people I'm

Pia Rathje-Burton 24:10
supporting? And I suppose the thing is, as well, it's it audits can. I don't think anybody says that the manager has to do, although, whatever audits is that you've assessed that you need to do. It's really good to get lots of levels of of staff involved with doing audits, but you're a bit about if they find something for them, then either having a process for you to be for it to be highlighted to you as the manager, or for you to be checking you know what, what they're finding, and then making sure this action is, is so important, isn't it? It's, I know that it can be really tricky to keep on top of it, but let's just say it's, it's almost worse to do and all that,

Wendy Adams 24:56
and to be able to evidence, I guess what you've done. Because I think what I see that happens quite a lot is that managers identify the problem, they solve the problem, but couldn't then evidence that we ordered through that up as an issue, and this is what they did in response.

So yes, they've solved the problem, but if I went back and said, Well, show me where's the evidence that you've solved it or tackled that issue or put a different measure in place. That's the bit that I think sometimes that loop doesn't get closed, yeah,

Lindsay Rees 25:31
and that sharing of that information so important, you know? And it's that proactive pre empting of problems, so you can spot a potential risk, so that you know you've done an audit on your care plans, and 80% of your care plans haven't been updated for the month of January. So what do you do? You get them all updated quick, you know, get that review in there, allocate that but how you know it's not going to happen in February Yeah, and March. You have to look at the why is this problem occurring? Auditing isn't about just filling the gaps. It's solving the problem that caused the gaps to happen in the first

Pia Rathje-Burton 26:10
place. Yeah, absolutely, and making sure that what you are auditing. Because I think sometimes audits, obviously not if they come from from QCS. But sometimes audits are kind of inherited, and they may not keeping up to sort of things like, nice, you know, I was talking, was saying that I'd realized that what they were auditing was actually at, you know, it just been what, this is, what we've always done, and, you know, haven't actually read the this is particularly about medicines, having read the, the nice standards that were then, Oh, didn't actually realize we did that had changed. You know, we need to make some make sure that they've kind of covers what you're what you're expected to do. Um, I wanted to ask you about something completely different. So you you've been in your previous role, you were involved with a falls project. So tell us a bit about this.

Lindsay Rees 27:03
Sure, one of my absolute passion, passion pieces. And the reason for that is that I've seen some some great outcomes, simple things. And I will remind me if I don't mention it, and there's a really good example of that involving slippers. So the work that I did on Falls was part of a project. So I did an older person's fellowship at King's College in London. And it was a year's course that I had the opportunity to go on. And I went up to London once a month and had a day out. And I was working very hard at operationally in a quality assurance team at the time, and that once a month, when it came up, I would, in a way, dread it, because I'm going to have to go and I've got so much work to do. But when I came out of that session, I could change the world, because it was inspiring. And it was my one day off, month off the hamster wheel, to really get into a headspace of doing something positive. And so from that, I had to do a project, a quality assurance project. So I did a project on falls and what we did was I looked at all the research that was available at the time, which is still very much relevant now. And Nottingham University, actually, there's a big lots and lots of research still going on there. And there's an action falls program, which there's training that is available from them, which is the

first training of its kind, which is really exciting, all came from their research. So I didn't actually do any research. I found the best practice, best research that I could and I use that in a collaborative way to redesign the falls risk assessment tool we were using at the provider I worked for at the time. And so we use that research to look at our risk assessment, and we changed our risk assessment from being based on a score to not having a score, because the research said the score is pointless. Everyone's at risk of falls. You're at risk of falls. I'm at risk of falls. The question is assessing your falls risk factors, and people get fixated on a score, and so they're low risk, so let's not worry about them. No, if you're in social care and you're over the age of 65 you are at risk more significantly a falls than thy or I. so you need to take some action on those risks factors. So an example of a falls risk factor is whether you're on medication that is associated with fall, so diuretics and opiates, are you your footwear is a risk factor. Are you able to select appropriate footwear? Are you frightened of falling, or do you have no fear of falling? Is also a risk factor. So you look at each of those risk factors, and then you take an action to support that person, to help reduce their risk of falls. Yeah, and we reduce falls. I won't. I can't quote the figure exactly, so I won't quote it, but it was around, it was around, sort of a 23% mark. We did reduce falls in the services that I was I was working in. And that falls program, and the falls risk assessment that I put in place is still being used in that organization today. And one of the things we deployed, which wasn't my idea it was out there, widely available, was the Falls huddle. And the Falls huddle is an opportunity that you do post event, post fall when you get everybody together that's relevant, and that can be all members of the team. Doesn't have to be the manager. And you talk about the particular fall, you look at that person's falls risk factors, which one's contributed to the fall, and then look at what you can do to reduce the risk of that particular type of fall happening again. And really important then that is the data in terms of location and time of day. So pulling that kind of whole picture in place so that you can really start to ask why this person is falling and what can we do to modify the risk?

Wendy Adams 30:52
Sounds really interesting, and that makes perfect sense, doesn't it? Because, you know, I could be I could have a score of four, Pia could have a score of four, but actually, the reason why I've got a score of four and Pia's got a score of four could be totally different. So you can see why that numerical scoring can be a challenge. But what I really like about that is that evidence based practice, because I think we could do so much more in social care around looking at the evidence base and the research base for some of the decisions that we make, and that, why do we do

Lindsay Rees 31:26
it? Yeah, absolutely. And getting people involved. That's one of the really powerful things with that project, which, you know, I absolutely would implore everybody to do, is to get everybody involved. And so you have this awful situation, unfortunately in social care, where, okay, an

older person, particularly an older person who's living with dementia, they're just going to fall. Can't do anything about it. And people have this negative attitude that people will fall, and they will fall a lot, and there's nothing I can do about it. They're high risk. They're always going to be high risk. And that was what I was set out to challenge and say, Absolutely, yes, these individuals are more likely to fall, but you can make an impact in terms of reducing that risk and reducing the risk of harm when they do fall, by making sure that there's more support available, but thinking about it more holistically. So I'll give you the slipper example.

Wendy Adams 32:15
Tell us about the slippers.

Lindsay Rees 32:18
So in the context of that individual, so a person, a gentleman, who has Parkinson's disease and dementia associated with the Parkinson's disease, and was having numerous falls, you know, sometimes five or 10 a week were really struggling with the Parkinson's and we'd had falls Team, we'd had site, you know, the experts in terms of his cognitive ability, we had a GP. We had the pharmacist who optimized everything that we possibly could, in all the usual ways. But this guy was still falling, and one of the things that we optimized was his footwear. So he had Sketchers really firm, fitting, well fitted footwear, makes perfect sense, but does it, so falls huddle. One day, one of the carers said, No, can I say something? And one of the carers said she thought it was really interesting that he seemed to be sort of stumbling, staggering on the carpet, and she wondered if it was his shoes. And so, contrary to the rule of thought on this, we bought him some really slippy slippers that were hard, no grip on them at all. And because he had a Parkinsons shuffle, he was shuffling along the floor. And once we got him some slippy slippers on the high quality carpets in the high quality care home that were ridiculously thick, once we got him some slippy slippers, he could glide with his Parkinsonian shuffle and guess what, his fall started to reduce because he wasn't getting stuck on the carpet with his really secure shoes.

Pia Rathje-Burton 33:58
Wow. And that just shows it. Just need that one person to make that

Lindsay Rees 34:04
one person, yeah, just to say, Hang on a minute. But unless you have that talking about that first impression, open, engaging culture, freedom to speak up, that was a carer that made that and that outcome for that gentleman was less bruises, less pain, less suffering. And he didn't. He didn't live much longer than that, because he was very elderly and very frail, but the remaining months of his life were less unpleasant, really

Pia Rathje-Burton 34:26

great. And how that, obviously, that falls project you you were involved with, or you created, was, you know, with the risk assessments, was in a residential older person's care home. How do you think some of those things can be translated into learning disability services, supported living home care.

Lindsay Rees 34:43
I think the exact same principles are so relevant in terms of knowing that individual person doing that individual risk assessment, looking at their risk factors and looking at that mapping. So we would map falls very visually, and we would just use the. Uh, the Fire Map, photocopy the Fire Map, stick it on the wall, and literally, like bingo marker, where the Falls were over the period of a month, and suddenly you've got this little pattern in the lounge. And it's obvious when you when you see it, but it's not obvious when you've got a pile of forms in front of you. So applying those principles, again to any setting, if you're looking at a profile and looking at some trends, just taking a step back and seeing where the incidents occurring in itself sometimes is really open, really sort of mind blowing.

Pia Rathje-Burton 35:35
Yeah, it's amazing, isn't it? When you, when you step, take a step back from anything like that. They just suddenly, you think, how did we not see this before?

Lindsay Rees 35:44
Yeah, but it takes time to just visualize it sometimes. The other

Pia Rathje-Burton 35:48
thing I wanted to ask you about was, again, another one thing you know you're passionate about is good end of life care. So tell us a little bit about why, the why you have that passion.

Lindsay Rees 35:59
Um, I think one of the so taking, tacking back to my acute years. So I used to work in coronary care and cardiothoracic surgery. Before I left the NHS, my role was in CCU. So I was dealing with emergencies all the time, cardiac arrest, level emergencies and great drama. And when I left the NHS to join social care, people said to me, you're going to be so bored. You're throwing away all these clinical skills, you know, you're going to have nothing to do. And part of me thought that might be right, but it was so wrong, because in social care, particularly in residential settings, as the registered nurse, when somebody's end of life care, it is an emergency. And it's not an emergency because you need to get them to hospital. It's an emergency because you do not want them to go to hospital. You want them to be pain free and comfortable. You need to get their family around them, and as the as the person in charge, there's no pharmacy, there's no doctor, it's you, and you've got to make some really difficult decisions quickly and act. And so it becomes sort of, sort of acute care, but it's not

acute care, but in when someone is dying, when someone's end of life, you only have one chance to get it right. So if you don't do the right thing and go off shift, then for me, once I started getting involved in that and that journey, it was some of the most rewarding years of my life,

Wendy Adams 37:28
and the passion for that comes through definitely. You know, for some managers, supporting people at the end of life with end of life care will be quite a regular part of what we do, but for some of the managers, it might be much less of a regular thing. What do you think managers can do to prepare themselves and their staff?

Lindsay Rees 37:49
I think to not, not be shy about it. So one of the projects that I implemented, or was very much involved in, the leadership of implementing in one of the services that I was at was advanced care planning. So the advanced care plan, there is no good time to ask the question, so ask it right at the start. So when someone is fit and well, I would encourage every single manager to include in their pre admission process an initial conversation about advanced care planning, what are the wishes of that person, and if that and if and if you do it at the moment of commencement of care, it's just one of a long list of things that you ask about. But if you wait until that person is becoming poorly, then it's a big issue, and everyone's worried about it. But if you've had the initial conversation, who are the important people in your life, what's important to your end of life, have you considered burial, cremation or other things? If you ask those questions really routinely and matter of factly, when someone's well, it's not an issue or it doesn't need to be an issue, but they're really difficult conversations to have, so I would encourage people to be always thinking of it. So I don't know if you've heard of the gold standards framework on your travels. It's very much still, still out there. And I implemented gold standards framework in several settings, or been a part of that, part of that implementation in several settings, and was a coordinator, or way back when, a long time ago now, in one particular nursing home, and they ask the surprise question of every single resident, and the surprise question is, would you be surprised if they died within the next week, within the next month, or within the next year? And they operate a coding system, and so it's about advanced planning. And so as a manager, you need to know how many people you've got who are a week or month, and it's not that they're going to die. It's not that you're expecting them necessarily. They might go on for years, yeah, but there's someone who's nearer you wouldn't be surprised if they die within a week, then some things have need to happen. Have they got a DNA or CPR in place? Whereas somebody who the surprise question is, oh, no, at least a year or more, you don't need to worry about that so much. Yeah, so planning. You have to plan, as a manager, everyone's going to die eventually, so you need to really proactively think about that. Yeah, it sounds a little bit morbid, maybe, but I think it's proactive and it's actually positive, because it creates better opportunities for better outcomes.

Pia Rathje-Burton 40:20
Yeah, I was talking to a manager from an LD service who, unfortunately, had had somebody who had a terminal diagnosis, you know, out of the blue and, and they were a little bit kind of what's going to happen now, you know, and which is understandable, because it's not something that they would expect, but because I think it can be difficult, if you're working with with younger people, to have that conversation, isn't it? You know, you're, you know, you know somebody who's 30, and really, you know, active, you know, it seems weird to ask those questions when they first come to you, didn't it? But at the same time, you could, as you say, you could just what that is, what we ask when people start, start living here, or we start providing support, support to because you don't have that information, you can then work on it, when, when, if, and if something does change, then you're already starting everyone with that information, gathering and start and provide that support really quickly. Because, as you say, you only get one chance. Yeah,

Lindsay Rees 41:19
and, and and sometimes, you know, and often, you only get one chance. And when things do go, go, go, go, not go wrong. When, when somebody does start to deteriorate, I guarantee you it will be at three o'clock in the morning on a Sunday. It's not going to be at two o'clock on a Tuesday. No. And so you won't have those resources immediately available, necessarily. So if you've captured information in advance, it stands you a better stead, better chance of getting it right. Yeah, and I think as well that not shying away from it, from a from a staff perspective, from a teams perspective, people, people really care about the people that they support, and it's okay that you know to be sad and to cry and to be upset, you have to be respectful, because you know it's not your mother, it's not your father, and you know you need to be respectful of relatives. But can't, you know, under or over estimate, I can't, I can't say how much that is, as a manager to understand that that staff really do feel it, and when people die, some more than others, and knowing your team will know how to support each other, because sometimes it's some point that they get attached, and they don't realize until until they've gone, and then they suddenly feel bereft. And it's important to acknowledge those feelings. Really very much. So

Pia Rathje-Burton 42:37
absolutely their well being, isn't it definitely

Wendy Adams 42:41
that that's been a really interesting conversation. We always have two questions that we ask our podcast guests, so I want to just move on to those two questions. We have our time for care slot in every episode where we ask our guests, what are what Is your most time saving tip?

Lindsay Rees 43:08
I get lost in my activities. I get lost in my moments, and I when I'm out there, operationally driven to get things done, and I tend to lose track of time. So one thing that I started doing actually during, during the first and second waves of COVID, actually and thereafter. But one thing I started doing was, sounds a bit weird, but setting an alarm, which is my, not my, I have to leave now alarm, but my prepare to leave alarm. And the reason I set the just to sit with my phone at around sort of three or four o'clock of the day, or whenever it was a good couple of hours before I was planning to leave, because otherwise I engage in the next task, and I and I have to finish the next task, if that makes sense. So I would actually, I actually had to sort of protect my own sanity. From a time management point of view, I would set a prepare to leave alarm, which would just give me a nudge, don't start a new thing, finish the thing you're on, and then think about exiting in a way that makes sure that you just don't disappear in a puff of smoke, because you have to go and pick your child up. Yeah,

Wendy Adams 44:15
that's a really good time. You know, time management tip, isn't it definitely, definitely. And our final question, I'd like you to imagine that we're in a lift on the 10th floor going down the group of registered managers. And before everyone gets out, you want to tell them what you think is the most important. So your key message to to leave them with, what would that be

Lindsay Rees 44:41
interesting. It kind of leads on, from what I said a minute ago, actually, about the time saving in that the last thing I would always do, and I would ask suggest that everyone does, is to not in a management position, not leave without doing a final walk around. So it's a discipline. So I always had a discipline, and it's the same in any service. If I'm visiting, I go, I walk around and I say hello, and I walk around and I say goodbye. You don't have to take very long, but it tells everybody who you're leading. I've arrived in the first instance, and then I've left in the last instance, and it's a goodbye. And somebody once actually said to me, I feel safe when you're here, Lindsay, because I know you'll never leave without saying goodbye and checking we're okay. Yeah, that might be at three o'clock in the afternoon if I'm whizzing out to do a pre admission assessment, or it might be at 8pm because I've stayed late and I've had to, you know, for the safeguarding referral, but I'll always just whiz around and just check in all the nurse stations. Everyone. All right, yep, Good, fine. I'm off now, and they know I've gone and they know that it's now on the on call service, and that's I developed that as a discipline, and I've stuck by it.

Pia Rathje-Burton 45:57
Yeah, it's a good, good tip, I think, really good. Thank you so much that that was a brilliant conversation. And thanks so much for your for your time today. And thanks very much. Bye,

Lindsay Rees 46:06
thank you. Bye, thank you, goodbye.

Pia Rathje-Burton 46:19
That was a really interesting conversation with Lindsay there Wendy, oh,

Wendy Adams 46:24
it was, wasn't it? She, she got some really great stuff to say about the work around policies, procedures and auditing and but also the end of life, work and falls. Really interesting stuff.

Pia Rathje-Burton 46:39
Yeah, absolutely with the falls, I was really interested in that, you know, they've, they falls, huddles, interesting, you know, you know, just kind of getting everybody together and just sort of chatting about, you know, why there was, and that example with the slippers, was really interesting, wasn't it? You, know, you when, sometimes, when you're getting people together, you somebody will say something, and it will be the kind of moment where everybody kind of goes, Ah hadn't thought about that, yeah,

Wendy Adams 47:09
definitely. It made me think about the Skills for Care learning from accidents and events module, you know, the 35 minute digital learning module that we have, which really equips managers with the skills and the framework to be able to conduct a learning review where there's been a an event or a near miss. And I thought what, what Lindsay was talking about, fits really well with that the the module is available for 40 pounds, and it can also be claimed back through the new Learning and Development Support Scheme. So a really good opportunity, I think, for managers to have a look at how they can embed some of that learning from, you know, from events and from things that happen into their day to day practice, which is very much what she was describing. Really,

Pia Rathje-Burton 48:04
yeah, exactly. And, and I thought it was really interesting using that for for something like a fall which you perhaps wouldn't have thought about so using that framework would be, I think, would be really, really helpful. So, that 35 minutes, it's really interesting. I thought the other interesting conversation that we had was about how she, when she was in that role of going in, you know, sort of turning around services, or to, or, you know, different call to different different names of different services. You know, how, you know, how, how she approached that work, the kind of changes that you know, she had in her head about that, a about that first impression, you know, literally, as soon as she parked the car, she had an impression of that service, and what that, you know, those issues were, but also how, when tackling in individual

issues in that service, how, what she was sort of kind of planning on doing with that, and she had a really interesting way of approaching that, with being really working, really alongside the people doing the work. I thought was really good. So again, we do have a resource that might help you if you are looking to make improvements. Are they? If you are in that role of going in as a troubleshooter or quality lead, or if you have recently had a CQC assessment and been rated Requires improvement or Inadequate the guide is called the Guide to improvement. It is a guide that we have created in partnership with the Outstanding Society, lots of ideas around making improvements. The process of making improvements, how you involve others to make improvement, how, why that's so important. And Lindsay talked about that, didn't she, you know. So I just think it's a really great guide. Lots of templates as well, which might be really, really useful if you are sort of thinking, How do I how do I start this? And. Yeah, I suppose just a really good starting point if you are looking to make improvements. So, really interesting, but great to hear from Lindsay about how, how she made that successful, isn't it really, you know how she had, you know, she had a really, this is what all the things that I do, and this is, I know that this works. So, really, really good to hear from her. So that's all for this episode. Thank you very much for joining us. Remembering all the resources that we talked about are in the show notes and on the skills for care website. Bye, for now. Bye,