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‘When someone is displaying challenging behaviour, you must have a calm approach’

Ensuring that care is personalised

SHARING PRACTICE
How older people benefit from global exchange
EDITORIAL

Every single user of care services must have their personal needs met

Personalisation has become the latest buzzword. The concept is bandied around in just about every conference or article. The challenge for social care is to turn it from being a rhetorical statement into an experience for every single user of care services.

This is a greater challenge than it might at first appear. If we are going to truly respond to people’s individual and personal needs, aspirations and wants, there will have to be a major change in the way in which we organise and deliver support.

At a time when the care system is under enormous pressure and the focus of so much of what we do is around cost, the rhetoric of quality, autonomy and personalised care is sometimes very difficult to achieve.

Several matters are needed to underpin a change in how people experience services. These are challenges to structure, to professions, to funding and to services. It will require all of us to move out of our comfort zones and to move into unchartered and, at times, difficult territory.

We need to look at how we communicate with service users. The whole tenor of the conversation has to change from one that focuses on the intervention of professionals to one that focuses on the needs and aspirations of clients.

We have to understand the level and pitch at which clients are comfortable. We have to begin conversations in ways that are meaningful to them and delivered in the way they want.

One comfort that we may find as we move into personalised care services is that some of the high-cost, complicated care that we previously delivered is not what clients want. So often, when the service user says what they require, it is not nearly as expensive as what they have had.

That said, this is not about providing low-quality services. It’s about helping clients to understand how to articulate their needs and all of us setting the system to respond to them.

This will be a challenge for us all, but it will also be a tremendous opportunity. When we start working in a new way, the benefits will be seen by clients and professionals alike.

Martin Green, chief executive, English Community Care Association (ECCA)
Credit crunch threatens care, warns homes association

Older people needing full-time care could be the next victims of the credit crunch, the Registered Nursing Home Association has warned.

If council social services departments freeze, cut or offer below-inflation increases in the funding of nursing home places, care of older people will suffer, the organisation said.

Earlier this year, local government minister John Healey announced an overall 4.2% increase in grants making overall funding £73.1bn for councils from April 2009.

However, the association said it had doubts whether the money would filter through to the long-term care sector.

Frank Ursell, chief executive officer of the RHNA, said: ‘The signs are that some councils are in cost-cutting mode and are unlikely to pass on the increase in government grants to fund care for older people.
‘Already, we are hearing from many of our member nursing homes around the country that, from what they have seen and heard so far, they do not expect their councils will be willing to cover the full and ever-rising costs of providing 24-hour care for highly dependent, vulnerable older people.’

He called on the government to ensure that local authorities do not use the credit crunch as ‘a smokescreen for cutbacks in elderly care services’ and to take action where councils seemed to be failing in their duties of care.

Campaign pack aims to secure home funds

A pack to help care home nurses make their case for funding for residential care has been launched by the English Community Care Association (ECCA).

The pack is designed to give residential care providers strategies and practical tools to make their case for improved funding.

Campaigning for Care is free to ECCA members and costs £25 for non-members.

Email: maria.patterson@eccca.org.uk or call 020 7492 4844.

Care must be personal

Person-centred care and dementia-care mapping reduces agitation in people with dementia in residential care.

Findings of the Caring for Aged Dementia Care Resident Study to be published in The Lancet Neurology, show both interventions reduced agitation compared with usual care.

Professor Lynn Chenoweth from the University of Technology, Sydney, Australia, and colleagues studied 15 care sites involving 289 residents with dementia. Patients were assessed before the intervention, after four months of the intervention and at follow-up.

The research concluded ‘consideration should be given to the introduction of person-centred approaches as standard practice… not just to reduce distress in residents, but to enable staff to identify and meet residents’ unmet psychosocial needs’.

NURSES TO HAVE CENTRAL ROLE IN THE DEMENTIA STRATEGY

Care home nurses are to play a vital role in delivering the first national dementia strategy, the government has said.

Backed by £150m over the first two years, Living with Dementia: A National Dementia Strategy sets out how the lives of people with dementia can be improved.

It has implications for all nurses.

A senior staff member in every care home will be made responsible for ensuring the needs of residents with dementia are met, the strategy states. This person will lead the development of a strategy for the management and care of people with dementia in the home.

There will be dementia advisers who will act as a single point of contact for a patient and their carers – a role that could be taken on by nurses.

In addition, the strategy aims to increase support for care home staff caring for dementia patients. It features proposals to strengthen specialist NHS mental health support to independent nursing homes, including assessment of patients’ needs on admission and six-monthly reviews. It also recommends specialist input into the decision-making concerning the initiation, review and cessation of antipsychotic medication for people with dementia.

Earlier diagnosis should improve care planning and ensure that individuals receive the right intervention at the right time. Guidance on best practice in dementia care should be readily available for care home staff.

Nurses will receive better education and training. The Department of Health will be working with training providers on pre- and post-registration education.

See tinyurl.com/dementiastrat for further information.
Whether it’s keeping chickens or doing the crossword, activities must be what individuals want – and staff need to acknowledge and act on this. Victoria Hoban reports

What’s the one thing you would feel lost without – your dog, your mobile, your lipstick? ‘If you were moving into a care home,’ asks Sylvie Silver, director of National Association for Providers of Activities for Older People (NAPA), ‘isn’t that the first question you would want someone to ask you?’

Asking that question and meeting those needs, argues Ms Silver, is the definition of best practice in activities provision in nursing and residential care homes. A weekly bingo session or singalong is simply inadequate – activities should be both meaningful and individualised.

Social and productive activities lower the risk of mortality as much as do conventional fitness activities (Glass et al, 1999), bringing benefits such as increased muscle strength and joint mobility, increased appetite and improved sleep.

NAPA, a charity, aims to raise the profile and understanding of activity needs of older people, providing information, resources and training to members – with an emphasis on ‘activity’ rather than ‘activities’.

‘It might be watching the birds feeding, which give someone a sense of pleasure. There may be group activities at a home – but they should only be attended by people who express an interest,’ explains Ms Silver.

‘To wheel someone along to bingo when they want to watch the golf is more than just an indignity – taking someone to an activity not of their choosing and from which they have no means to leave constitutes a deprivation of liberty,’ she stresses.

‘Taking someone to an activity from which they have no means to leave is a deprivation of liberty’

Initiatives such as Hampshire county council’s Activehearts campaign (see case study) are improving how activities are provided in many care homes,
but there is still much room for improvement.

In 2006, a report by Help the Aged – My Home Life – stated that almost half of care home residents’ time is spent asleep, socially withdrawn or inactive, with only 3% on constructive activity.

A year later, the government published Putting People First, which states that care in adult services must be made more personalised by 2011, “enabling people to live their own lives as they wish”.

Ms Silver supports the important role of activities coordinators, but stresses that nursing staff are pivotal in instilling a progressive attitude.

‘Nurses have great influence over how carers behave. A dedicated activities coordinator can set up delivery of that provision, but a nurse manager can turn the whole culture around,’ she says.

Including daily activities in residents’ core care plans guards against the sidelining of social and well-being needs.

‘If a resident has done the Daily Mirror crossword every day for the last 60 years, the care plan could include “must have Daily Mirror by 9.30am”,’ suggests Ms Silver.

Samantha Bell, home manager at Ferendune Court in Faringdon in South Oxfordshire, believes that weekly meetings with activities coordinators and regular residents’ meetings help staff to personalise activities.

‘Many of our residents are from the local farming community,’ she says. ‘One lady, a farmer’s wife, had always put the chickens to bed. So we got eggs from a farm, hatched them and now have three hens in the garden. We even asked a nearby farm to bring a donkey, sheep and goats into the home for the day – it was quite a menagerie.’

Through NAPA, Ferendune Court staff have trained in skills such as hand massage, enabling them to offer alternative activity choices at little or no ongoing cost.

‘Rather than sourcing outside, we trained with an organisation to enable us to run seated exercise classes. We structure the exercises to suit both residential and nursing clients, according to ability,’ says Ms Bell.

‘We used to use a separate room but now hold sessions in the lounge so residents can watch and join in as they wish. By the end of the session, everyone has done something.’

Val Baggott, general manager at Kernow House Care Home in Launceston, Cornwall, believes that thorough assessment on admission can give an invaluable insight into making activities appropriate.

‘We take a life history looking at interests, hobbies, past occupation. I prefer to assess residents in their own homes as you can see their life story all around them.’

She adds that her staff strive to promote activities that take residents beyond the four walls of the home.

‘We have two minibuses and a company car. An activity might involve us taking a resident home for a few hours to potter in their own garden. ‘We even took four younger gentlemen with Huntington’s disease to a lap-dancing club last year, because that is what they requested. We never say no, always how. For those men, it was a normal guy’s thing to do.’

‘We all have things we like to do,’ she adds. ‘The important thing is not to presume with residents that you know what they might be.’

Reference

PAINTERS, POETS AND PUPPETS

Professional artists and musicians have been performing and running participatory activities in residential care and nursing homes in Hampshire, under the Activehearts project.

Activehearts – a project across the council’s 32 homes set up in 2003 – is run in partnership with the council’s arts service and adult social care.

Staff access a menu of performers and activities via the council’s intranet and book using a ringfenced budget. Staff have reported many benefits, including a reduction in medication as levels of apathy are lower.

Previously, frailer residents were in danger of being excluded from activities. But Activehearts performers tailor material to the individual, interacting at the bedside if necessary.

Performers at Marfield Care Home with Nursing have included puppeteers, old-time music hall performers, painters and poets.

‘The poetry lady makes up poems for the residents – sometimes she starts one and a resident finishes it off,’ says activities coordinator Sue King.

‘All performers have been well received. My colleague, activities coordinator Sarah Westbrook, knows the residents well and thinks hard about which activities they will like.’

Ruramisai Gandiwa (pictured above) is operations manager, head of care and acting manager at Marfield at Hampshire county council.

‘It has made a big change to our residents, particularly those in the nursing unit. Rather than waiting for staff to initiate an activity, they just get on with it,’ says Ms Gandiwa.

‘One lady was very tearful when she arrived. She had recently lost her husband and felt isolated. Activehearts helped her come out with renewed confidence. She’s now at the forefront of organising activities like dominoes and supporting others to take part.’

The scheme has helped staff to gain a better understanding of the types of activities that residents enjoy, she believes.

‘Sometimes you are not aware of how much a resident is able to do or what they are passionate about until they have the chance to get involved in different activities.’
Rother Heights does not look like the average care home, says Tanya Smith, nurse and home manager. Most people would find the unit for people with autism a bit Spartan. ‘We have underfloor heating, no radiators and the walls are blank. With people with autism, you try to desensitise the environment,’ she says.

Rother Heights is one of five residential units run by part of Autism Care UK. Based in South Yorkshire, it comprises four bungalows that can house six adults each.

Ms Smith, a learning disabilities nurse with an interest in autism, says the home is tailored to its residents. ‘Historically, autism was grouped with learning disability. You don’t have to have a learning disability to have autism, although they are often associated,’ she says.

‘The trouble with a learning disability service is that they focus on the learning disability. We spend a lot of time dealing with sensory issues – hypersensitivity to hearing or touch. If someone has hypersensitivity to hearing, we don’t have any television or radio on. ‘Staff talk very quietly. Because residents are not having to concentrate so hard on their hearing, we can then start to introduce new stimuli to them,’ she explains.

A 2007 survey by the National Autistic Society of adults with autism found that two-thirds of respondents did not have enough support and 40% lived at home, dependent on their families. This is why places such as Rother Heights are important. Ms Smith describes this approach as a ‘home for life’, where service users can feel comfortable and make progress. The staff to client ratio is at least one to one and, in some cases, two to one.

The home uses non-abusive psychological and physical intervention to deal with challenging behaviour. Staff are able to recognise behaviour from agitated to potentially lethal and use methods that have worked with individuals in the past. Ms Smith says it works well because it is tailored to each resident.

While most homes for people with autism do not employ nurses, Ms Smith believes her training is an advantage. ‘When someone displays certain behaviour, you think about what happened last time. Not that the unqualified staff here don’t reflect on their practice but I think it’s bred into a nurse,’ she says.

Her nursing background is a help concerning general health and it gives her a status when talking to other professionals. A key attribute of nurses is that they are unflappable. Ms Smith says: ‘When someone is displaying challenging behaviour, you need to have a calm approach.’

‘With people with autism, you try to desensitise the environment’
OFFERING CHOICE IS VITAL FOR RESIDENTS

Providing person-centred care involves not assuming that you know best, even concerning what may appear to be simple matters such as the type of clothing residents should wear.

Linda Nazarko, MSc, PgDip, Bsc, RN, OBE, FRCN, is nurse consultant, Ealing PCT, Ealing.

Linda Nazarko describes how choice of clothing is integral to person-centred care.

CASE STUDY
Alexander Walker has lived at home with his wife since he had a stroke a year ago. She normally cares for him but is due to have a hip replacement so Mr Walker has been booked into a care home for six weeks.

‘Mr Walker would never have dreamed of wearing a tracksuit’

The home is lovely. It has wonderful gardens, the rooms are beautiful and the food is superb. Mr and Mrs Walker are very happy until staff suggest that Mrs Walker brings in some tracksuits for her husband. The nurse adds: ‘They’d be more comfortable and easier for him.’ Mrs Walker looks unsure and says that her husband does not have any tracksuits.

‘Perhaps you could buy him a few and some trainers,’ the nurse replies. Mrs Walker says that she will think about this.

The next day, Mr Walker’s daughter tells the manager that she says she would like to move her father to another home. The manager looks astonished and asks if there is a problem. She replies: ‘It’s the tracksuits and trainers. My mother is so distressed that she’s thinking of postponing her operation. It’s clear that you have no idea who my father is or how to care for him.’

DISCUSSION
Is the family being unreasonable? To answer this question, we have to ask who Alexander Walker is.

Alexander Walker is a unique human being. He comes from a certain culture and has beliefs, values and preferences that are unique to him. His family want him to receive care that is appropriate to him.

Mr Walker is a retired army officer. He worked in the city of London for many years.

Mr Walker always liked to look smart. His brogue shoes gleamed and he had knife-edge pleats in his trousers. Few people have seen him without a shirt and tie. Since his stroke, Mr Walker has had difficulty communicating but his family are convinced that he would never choose to receive visitors in a tracksuit and trainers.

Staff at the Grange consider that tracksuits are more comfortable for men but they are viewing comfort through the prism of their experience and views. Tracksuits are not easy clothes for a person who has had a stroke to wear. It is easier for Mr Walker, who has limited movement in one shoulder, to put on a shirt than a sweatshirt. Jogging bottoms do not have zips and this can make it more difficult for men who have had a stroke to urinate. So, from the perspective of a man who has had a stroke, a jogging suit is not ‘easy’.

Nursing theorist Virginia Henderson defined the function of the nurse as ‘to do what he or she would do for him or herself if he or she had the will, strength and knowledge’.

Mr Walker would never have dreamed of wearing a tracksuit. If staff aim to provide truly patient-centred care, they must provide care that meets the needs, hopes and aspirations of the person.

In Mr Walker’s case, his family could support him by clearly stating who he was and what his wishes were. In other cases, it can be difficult for staff to ascertain a person’s wishes and preferences.

Further reading
Sharon Blackburn, RGN, RMN, is managing director Heart of England Housing and Care.

Sharon Blackburn outlines why personalised care is important and the role of the nurses in implementing it.

Personalisation is a term that features repeatedly in Department of Health publications and policies (DH, 2008a; 2006; Social Care Institute for Excellence, 2008).

This shared ambition to put people first is to be achieved through a radical and major reform of public services, which must involve the independent sector. The aim is to empower people to shape and control their own lives and the services they receive.

All health and social care providers, as well as housing, benefits, leisure and transport services, will need to engage with the concept of personalisation if social care is to be reformed. A common assessment framework is being proposed for adults and is supported by Darzi’s review of the NHS (DH, 2008b). Funds have been committed by the DH to local councils to assist in making changes at a local level so that personalised care can be provided. In total, a £520m ringfenced grant has been made available over three years. The DH has contributed to this grant as it recognises that social care and health care are related.
Investing in social care, especially early intervention and prevention, can improve well-being and health. The aim is that by 2010–2011, councils will have transformed their local adult social care services and have a personalised system of care in place.

A NEW IDEA?
Personalisation is here to stay and new ways of working will be established. Is this a new concept – or a new word that describes what health and social care professionals have been committed to delivering for many years? It certainly needs to be consistent across all services, irrespective of where they are delivered.

DEFINING PERSONALISED NURSING CARE
The media frequently focuses on personalised care in terms of individuals having budgets to choose and purchase services. Discussion often revolves around where services are available and how these are funded.

While both of these areas are important, they do not define personalisation. At its simplest, it is about putting the person first and ensuring that they have choice and control over what happens to them, the way in which it happens and when and where it happens.

MAKING PERSONALISED CARE A REALITY
For personalised care to become a reality, people will need to access timely and appropriate information so they can make informed decisions. They also need to have the capacity to make decisions or the support of an appropriate advocate if they lack this.

Personalisation is not a one-off action. From the professionals’ perspective, it is a way of behaving that moves the balance of power from the professional to the individual. We are accustomed to the relationship between customer and supplier; somehow this has been lost in health and social care.

Care homes are well placed to provide personalised care through understanding that residents and their families are customers, irrespective of who funds the care. However, there has been a tendency over the years for staff to have a paternalistic approach.

With person-centred care, these attitudes can be challenged and care should focus on the relationship with the resident and their choices.

In recent years, regulation and inspection of care homes has moved towards measuring outcomes. The aim is to capture the residents’ experience of services and their relationships with staff. This focuses on the choice and control residents have over their daily lives, how involved they are in decisions that affect them and the care they receive.

THE NURSE’S ROLE
In care homes with nursing staff, the nurse has a key role in creating a culture where personalisation is the norm.

Assessment and care planning
Assessment is the starting point where conversations that look beyond diagnosis, disability or need take place, although these areas should be acknowledged. An individual needs to know what options are available. They need to know how their choices can become a reality and, if this is not possible, then what can be done so that their choice and control is maximised.

Care planning will need to demonstrate and capture not just the care and services that are to be delivered but also the residents’ response to those services and the choices and decisions they have made.

A biographical approach to assessment and care planning is helpful. Moving into a home is a major transition. An identified need will have resulted in a to do this. The care home environment can offer a new beginning. Building a picture that details not just who the person is but also how they like to live their life is an important part of personalisation.

Care documentation serves as a communication tool. It should show who the person is, not just what they need. It is not a static document, as likes and dislikes change. Nurses can and need to demonstrate leadership in the area of assessment and planning.

Information
This needs to in an accessible form, not just how staff think it should be. The key to achieving personalisation is to extend choice in the first place and ensure that options that are offered are realistic.

Creating a learning environment
All staff need to understand the culture and philosophy of how personalisation works in care homes. This understanding is vital to it happening.

Nurses can act a role models; demonstrating what personalisation looks like in practice and how it can be implemented. This will involve describing the behaviours and attitudes that staff will need to have to ensure an effective partnership with the resident and their relatives and friends.

CONCLUSION
Personalisation is jargon. It needs to be lived. Nurses and staff in care homes have an opportunity to lead the way in implementing it.

References


Bupa aims to become the world leader in the care of older people. It plans to achieve this by expanding its care home business to new countries and providing the best possible care.

Collaborative working is underpinning Bupa’s aims to develop and share best practice. This is both between homes within individual countries and between professionals working in different countries. An exchange programme for nursing staff is being set up to cement this sharing.

Eleven years ago, Bupa began providing nursing and residential care on a large scale for older people in the UK, where it now has 304 care homes. Eight years ago, it started to provide residential care in Spain under the brand name Sanitas.

It expanded further in 2007, when it acquired Amity in Australia and Guardian Health Care in New Zealand, which are being rebranded Bupa. Bupa plans to expand further into and beyond Europe.

Bupa has 438 care homes across the UK, Spain, Australia and New Zealand, caring for around 30,000 residents. More than 36,000 staff work at the homes, including approximately 7,000 nurses.

Collaboration between the different countries is about developing better ways of delivering and improving care together, rather than taking initiatives developed in one country and sharing them with others.

If a country has skills in a particular area, they take the role of project lead in that area.

Three years ago, a census was conducted across all Bupa care homes in the UK to get a detailed understanding of the health needs of current and future clients so the service could be tailored to these, particularly through staff recruitment and training. An updated census is being carried out in all four countries.

Bupa Care Services’ divisional human resources director Julia March says: ‘We know – without the census – that the biggest need coming up is in dementia.’

International collaboration on this has already begun. The project lead is Dr Dwayne Crombie, managing director of Guardian Health Care, who is passionate about care for people with dementia. Earlier this year, the Department of Health in England published the National dementia strategy. This has been shared with the other three countries.

The strategy takes a person-centred perspective on care and support for people with dementia and their families and friends, focusing primarily on the individual’s needs and history. The strategy covers a wide range of areas, including the design and decor of care homes, food and nutrition, and activities.

Dr Crombie says: ‘The nurse leaders running our dementia units have been delighted with the chance to see how others are dealing with the challenging issues of people with dementia. Often nurses in these kinds of leadership positions in the care of the aged can feel relatively isolated.’

Dr Crombie is working with Dr Graham Stokes, Bupa’s head of mental health, who
will be travelling to Australasia this summer to visit homes and attend workshops with staff who run dementia care. Dr Stokes will be reviewing local practices and sharing Bupa’s UK good practice as well as bringing practices home.

The non-UK countries hope to learn how to develop training and career pathways for nurses in the care of older people.

Ms March says: ‘All the countries invest in training and CPD, and we are reviewing all approaches to build on the most effective ones and to fill gaps and weaknesses.’

In Australia, the care home nursing workforce tends to be casual, with nurses often staying for a couple of years. This has made targeted training a high priority for Amity, which employs nurse academics and teachers to ensure training is responsive, practical and nurse led.

Of the four countries where Bupa has care homes, the UK is the one where the industry is most regulated, which means it leads the way in terms of quality assurance. ‘The other countries are already benefiting from our UK systems,’ says Ms March. ‘We are moving towards alignment of all countries to best practice because we know that good governance will differentiate our standards and prepare us internationally for regulatory change across all those countries.’

UK regulation stipulates that care home managers have to be nurses. When this was introduced, Bupa UK had to develop 200 matrons into care home managers very quickly then back them up with training. However, in Spain, general managers can run homes. The Sanitas homes have a very low turnover of managers and staff. Spain will therefore be sharing its management experience and practices with the other countries.

Domènec Crosas, managing director of Sanitas Residencial Spain, says the collaboration has proved very valuable.

‘Since the four countries in the aged care division started working together in 2008, we have discovered the immense richness that comes from sharing the experience of different professionals in different environments,’ he says.

‘Among the projects that have been started in the international cooperation is the sharing and exchanging of experiences and achievements that each of us has had.

‘It is really fascinating seeing how our residents and our professionals are going to benefit from the simple fact of sharing the best of each of us and applying it in a simple way to our daily tasks.’

All four countries have vacancies for nursing and managerial staff. Bupa is keen to offer its staff the opportunity of working in a different country so is developing an exchange programme.

UK staff can work in Australia and New Zealand without having to undergo conversion training, and in Spain if they can speak Spanish.

Ms March believes exchange programmes are a good way of sharing best practice. ‘It meets people’s career aspirations and paths, and also brings to life the good practice that is happening in the countries that they work in,’ she says.

Shay Gurney, quality assurance coordinator for Guardian Healthcare, says that working in another country has benefits in terms of personal and professional growth. ‘It is really fascinating seeing how our residents and our professionals are going to benefit from the simple fact of sharing the best of each of us and applying it in a simple way to our daily tasks.’

For further information visit www.bupacarehomes.co.uk