A new model of care for the older person

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There are two approaches to caring for older people in care homes. The first has a protective focus of “caring for” people, in which caregivers perform actions that recipients cannot undertake without help. The second approach takes a remedial focus that seeks to “caring about” people by counteracting impaired function through promoting self-help, adaptation and autonomy as much as possible.

Caring For and Caring About (CFCA) is a model of care originally devised for nurses in what were then known as long-stay geriatric hospitals (Wild, 1989). It has been revised for nurses and support carers in independent-sector care homes for older people, and offers staff (collectively referred to as caregivers) a means of exploring the nature and appropriateness of their approaches to care in relation to the disabling impairments of late life.

The CFCA shows these approaches as having a dynamic relationship (power through movement), according to the changing needs of care recipients. The term remedial is used to describe the model because this is a more appropriate aim than rehabilitation in addressing age-related debilitation. While full rehabilitation may not be possible, even a small functional improvement can have a disproportionate effect on an individual’s quality of life.

Improving care in care homes

Precise figures for the numbers of older people in care homes with and without on-site nurses in England remain elusive.

The most recent Care Quality Commission figures show that there are some 469,000 beds within approximately 19,000 care homes available mainly for older people. Of these beds, a higher number are designated as “without nursing” than those “with nursing” (CQC, 2011).

The decision to place older people in a...
particular type of care home is made according to whether their dominant needs involve healthcare (nursing home) or social care (residential home). In nursing homes, older people are referred to as “patients with illnesses needing nursing care”, whereas in residential homes they are residents who are “frail” (a more general description of the consequences of deteriorating functional performance) needing personal and social care but not on-site nursing care. However, despite the terminology, nursing needs and disabling impairments of people in residential homes are often high and overlap those of patients in nursing homes (Bowman et al, 2004).

Described by Isaacs (1992) as the “giants of geriatric medicine”, the common impairments of late life are: incontinence; impaired mobility; impaired stability and falls; sensory loss; and impaired mental performance; to which can be added pain and insecurity. These rarely occur in isolation and the resulting complexity is challenging and time-consuming for caregivers. For example, in one recent census by a major independent provider, 70% of residents had incontinence and around half experienced mobility problems (Lievesley et al, 2011).

These findings could suggest a lack of focus on remedial care practice to some extent, in particular in the area of continence. Reasons for this could lie in a recent report in which care homes were described as having insufficient access to and support from NHS medical, mental health and rehabilitation expertise (British Geriatrics Society, 2011). It also reported that the use of a social care model alone, found predominately in residential homes, was unable to meet residents’ complex health needs.

Help the Aged (2006) has recommended that, because residents’ access to nurses is limited, training residential care home staff to anticipate health problems or deliver care could improve outcomes. Nazarko (2007) recommended increased access to funded NHS healthcare education and training to improve nurses’ expertise in meeting older residents’ health and disability needs. Wild et al (2000a) reported that lack of top-up funding for training, care staff’s inadequate knowledge of residents with challenging behaviour, work-load issues and cross-sector barriers inhibited efforts to provide care to allow a “home for life” for all residents. However, an earlier study found that, when supported by a dedicated nursing team, social support carers equipped with essential nursing and monitoring skills in residential homes succeeded in reducing hospital admissions and community nursing input (Szczepera et al, 2008a).

The above evidence base suggests there is a need for staff in care homes – and in residential homes in particular – to explore the nature and appropriateness of the care that they and others offer in the context of maximising residents’ potential for improved quality of life. This has implications for the content of healthcare skills training, the professionalisation of support care workers, and improving support from the NHS, all of which are currently under wider consideration.

The nature of the caring relationship

In a protective care approach, the caregiver’s focus is set within a relationship often dominated by physical interventions to compensate for the recipient’s disabilities due to impaired function. Following a literature review Fine and Glendinning (2005) noted that when older people are the recipients of care, dependency is rarely viewed in a positive light. The use of words such as “burden” and “bed blockers”, reported as descriptors of disabled older people as consumers of community care are indicative of such ageist negativity (Wild et al, 2000b). In contrast, Baltes (1996) suggested that when disabled people seek and receive help this can be viewed as a positive adaptation to dependency because it fosters valuable social contact.

Although major impairment and episodic illness may legitimise the caregiver’s focus on protective care, this should not preclude the concurrent setting of remedial goals. These should encourage the care recipient’s decision-making autonomy – that is, negotiation of or control over the care to be given – and, by doing so, enable them to use their dependency creatively and grow as human beings (Collopy et al, 1991).

Recognising the level and appropriateness of a resident’s desire to self-help spontaneously or, conversely, their over-reliance on the caregiver (despite a potential to self-help) are important preliminary observations for the caregiver seeking to move towards a remedial and dynamic approach. Similarly, the caregiver’s understanding of their own and the recipient’s motivation and motivators within the care relationship is crucial to attaining and sustaining progress.

It has been observed that a care relationship is one of interdependency because it is built on a reciprocal relationship (Fine and Glendinning, 2005). This is irrespective of the recipient’s dependency. In this sense, the caregiver cannot fulfil the care role without the recipient, and the recipient cannot overcome disablement without care from the caregiver. As the caregiver is responsible for the recipient’s wellbeing, this could create an imbalance of power in the relationship. However, only when power is misused by taking advantage of the recipient’s incapacity and expectation of trust can a situation of abuse arise (O’Keeffe et al, 2007).

Seeing the potential of focusing on a remedial rather than a protective approach in caregiving requires critical appraisal of current practices. For caregivers, asking

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BOX 1. QUESTIONS TO ASK ABOUT CURRENT PRACTICE

- Do I encourage my care recipients to self-help?
- How many of them are over-reliant on me, when I think there is the potential to self-help?
- Is it easier or quicker to do something to or for them than to offer support and time for re-learning to accomplish an action or skill?
- How often do I discuss alternative ways of giving care with a recipient?
- How well do I use (re)assessment to inform my care planning and do I have an appropriate range of assessment tools to help my decision-making?
- Has my care become a series of routine tasks?
- Have recipients become more objects for care than people I care about?
- What motivates me in the care I give?
- Are my care relationships interdependent or dependent?
- Do I provide the kind of care that I would like to have myself?

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**Fig 1. CAREGIVER QUALITIES**

Knowledge Competence Confidence

Empathy Commitment Compassion Conscience

Reasoning Negotiation Set goal

Talking Listening
Discussion

Nursing Practice

The models

The dyNAmIC proCess uNderpINNINg THE MODELS

The caregiver’s qualities

The personal qualities of the caregiver need to be considered, as these can either enhance or inhibit the drive towards a more remedial approach. Roach (1987) conceived these as five Cs and suggested that all need to be present in a caregiver:
- Commitment;
- Compassion;
- Confidence;
- Competence;
- Conscience.

In Fig 1, these qualities are either included or implied but, while some can be learnt, others seem to be part of the caregiver’s nature. The qualities that can be learnt are: knowledge of disablement, including assessment; the ability to talk with and listen to the recipient; and confidence and competence in practice. These underpin the carer’s reasoning in the negotiation of goals with the recipient and how these could be met. However, without commitment, compassion, conscience and empathy (the power of mentally identifying with and understanding another), all of which arguably can be neither taught nor bought, the move towards remedial care will not progress easily and is unlikely to be sustained.

Concepts of “caring for” and “caring about”

Before changing the focus of care, particularly towards one that is remedial, the caregiver needs to make sound personal and recipient preparation.

The use of the word “care” is commonplace. There is a debatable assumption that it means the same to all using it, including the recipient and the caregiver.

When trying to find a clear definition for the word, Oscar Wilde’s (1895) comment holds true: “Truth is rarely pure and never simple.” Based on the dictionary definition and tracking primary and secondary definitions, the results for “care” were illuminating in their diversity. As a noun, it has the meanings of interest, concern, control, whole, relate, protect, safety, serious attention, charge and protection. In contrast, when used as a verb, the meaning of “to care” is radically altered into two distinct groups by the addition of the suffixes “for” and “about”. These groups are shown in Table 1, under headings of “caring for” and “caring about”, each with a range of meanings from caregiver and recipient perspectives.

From the caregiver’s perspective of “caring for”, the meanings are indicative of giving supportive actions for, on behalf of or to the recipient, for example, “to ensure the safety of” or “to take charge of”. Thus, the recipient could respond by giving up part or all of their self-determination to the caregiver permanently or temporarily, voluntarily or involuntarily. If this supportive caregiving remains unchanged, there could be a danger of the caregiver becoming a custodian of the recipient, who in turn will be locked into a dependent rather than an interdependent relationship.

In contrast, when the caregiver adopts a “caring about” approach with meanings of “feeling of concern” or “interest in relation to” or “empowers in an all-round way”, this suggests they are giving positive holistic support and motivation. In response, the recipient could develop greater self-worth and, if able, want to self-help. These more interdependent recipient responses, coupled with high motivation, are the ingredients needed for remedial care.

The activation of remedial care requires the caregiver to adopt a proactive thinking; that is, planning the focus of caregiving before activating change. Sharing this preparation phase with the recipient enables realistic expectations of change to a more remedial approach to be explored.

As Fig 2 shows, the appropriateness of the caregiving approach relies on continuous reasoning as the basis for changing the focus from one approach to the other, presented as cogs A and B. Each cog relies on the other but they turn only at the direction and pace dictated by cog C, that is, the recipient’s assessed progress towards an agreed goal. This goal should be foreseen as being attainable. Adhering to the adage that “small is beautiful” is advisable because success is likely to be achieved more quickly and will act as a mutual motivator for subsequent goals. Furthermore, from the recipient’s perspective, the amount of benefit may be greater than the size of any change.

Up to this point, changing a static care philosophy towards one that is dynamic has been related mainly to a one-to-one relationship but inevitably it will also need to involve other caregivers across the shift system. Therefore, all staff will need to have a shared philosophy of care to underpin not only changes in the nature of practice activities but also in the way staff are organised to meet a remedial goal. A literature review suggested that changing the culture of a care home requires management and leadership. Adopting new work practices without investment in training or a commitment to establish participatory decision-making could mean they struggle to succeed (Szczepura et al, 2008b). Improving a resident’s function...
Progress towards the agreed goal (H) is more remedial than “caring about” (D). However, this does not make “caring for” (C) in “caring for” actions, and low in “caring about” (B) in “caring for” actions. Analysis in “caring for” models (G). The move away from protective towards remedial care could also entail modifying or enhancing the home’s physical environment.

The “caring for” and “caring about” model

Fig 3 presents the “caring for” and “caring about” approaches as a dynamic process model. It presupposes an inter-relation-ship between the caregiver and recipient, and that reducing the focus in one care approach will increase that of the other.

Underpinning and influencing this whole process are the caregiver’s learnt and innate qualities (Fig 1) and ability to use ongoing assessment outcomes to determine the appropriateness of any care focus in progressing towards a goal (Fig 2).

The CFCA model’s elements are labelled A to H, with each representing a part of the journey towards a remedial goal rather than a representation of linear progress towards it. The “caring for” and “caring about” approaches, each with “high” to “low” levels, are shown within two interdependent circles. The point where the circles overlap is the crucial “reasoning and negotiation” zone (F) in which decision-making and the appropriateness of any change of focus from one approach to the other (transition) is appraised. Making a transition towards the goal established with the recipient at the outset (A) is informed by initial and regular reassessment (G).

Caring For and Caring About places no restrictions on adding new tools or knowledge to support the outputs from zone F. Initially the focus of care may well be high (B) in “caring for” actions, and low in “caring about” (D). However, this does not mean both forms of care are not in evidence, only that the imbalance indicates that the focus of care is more protective than remedial.

As “caring about” increases (E) and progress towards the agreed goal (H) is assessed, the need for “caring for” should diminish (C) as the recipient begins to become more self-sufficient. Alternatively, the recipient’s advanced age and susceptibility to episodic illness could destabilise progress temporarily or permanently. Thus, as CFCA’s two-way horizontal arrows indicate, the dynamic between the two approaches may need to be revised and even reversed towards strengthening the focus on “caring for” actions, if there is a legitimate dependency need to be met.

Of course, if overall “caring for” and “caring about” were both low (C and D) in a setting other than a long-term care home, we could deduce that it would be possible for care recipients to manage at home with domiciliary community professional support.

Conclusion

It can be hypothesised that, with high levels of disabling impairments in older residents, care homes are unlikely to be offering a remedial care approach. This article, therefore, questions whether caregivers give sufficient consideration to the appropriateness of care in this context.

Caregiving is a complex human process, bringing together several elements from and for both caregivers and recipients. As a major long-term care resource for the NHS, care homes offer an opportunity to explore the combination of healthcare and social care within a “home” environment.

The move away from protective towards remedial care would improve residents’ quality of life and provide a stimulating learning environment for staff.

This will depend on several factors: the quality of the caring inter-relationship; the qualities of caregivers, in particular their possession of those that are innate as opposed to those that can be learnt; and the use of assessment outcomes to gauge recipients’ progress.

Table 1: Meanings attributed to “caring for” and “caring about”

<table>
<thead>
<tr>
<th>Approaches to care</th>
<th>Remedial – caring about</th>
<th>Protective – caring for</th>
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</thead>
<tbody>
<tr>
<td>Carer</td>
<td>Recipient</td>
<td>Carer</td>
</tr>
<tr>
<td>Takes charge of</td>
<td>Passive towards</td>
<td>Interest in</td>
</tr>
<tr>
<td>Looks after</td>
<td>Depends on</td>
<td>Concern for</td>
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<tr>
<td>Provides for</td>
<td>Relies on</td>
<td>Defers to</td>
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<tr>
<td>Protection of</td>
<td>Relinquishes to</td>
<td>Sets a goal</td>
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<tr>
<td>Responsible for</td>
<td>Seeks security</td>
<td>Encourages</td>
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<tr>
<td>Ensures safety</td>
<td>Avoids risk</td>
<td>Facilitates</td>
</tr>
<tr>
<td>Provides support</td>
<td>Leans on</td>
<td>Empowers</td>
</tr>
<tr>
<td>Makes comfortable</td>
<td>Finds relief</td>
<td>Motivates</td>
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<td></td>
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<td>Gives comfort</td>
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References


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