Staff in care homes can use the Caring For and Caring About model to promote residents’ autonomy. This article shows how to use the model in practice.

Implementing a care model for the older person

In this article...
- Setting this approach to care in an ethical framework
- A scenario showing use of the model in practice
- How to prioritise goals to move towards remedial care

Keywords: Older people/Caregivers/ Care recipients/CFCA model

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The first article in this series discussed the caring relationship, the caregiver’s qualities and the remedial Caring For and Caring About (CFCA) model (Wild et al, 2012). Remedial care in this context seeks to maximise recipients’ independence, abilities and quality of life through actions mutually agreed within an interdependent caring relationship. Developed by Wild (1989), CFCA has been revised for nurses and support staff (collectively referred to here as caregivers) who work in care homes for older people. This second article outlines the use of CFCA’s two approaches to caregiving to guide a remedial journey in practice.

Summary of CFCA
The two approaches and their dynamic relationship are shown in Fig 1 as two interdependent circles: caring for (looking after, or doing to, or doing for someone) and caring about (enabling, deference to, interest in, encouraging). Part 1 of this series gave full descriptions of the model and the meanings attributed to each approach (Wild et al, 2012).

The CFCA model is weighted towards a caring about approach that is remedial rather than protective. In practice, remedial care most likely will require caregivers to withdraw hands-on actions to allow them to be taken over partly or wholly by recipients. This does not mean the overall care is one approach at the expense of the other; the reality of meeting complex needs will usually require both to coexist. However, once the remedial goal is set, attaining it can only be achieved through the transition of increasingly strengthening “caring about” by reducing “caring for”.

Setting CFCA within an ethical framework
As ethical thinking is at the heart of caring (Pera, 2005), it is natural to closely align it with using CFCA in practice. This is the essential framework into which CFCA’s decision making about the appropriate care approach is set.

The ethical principles derived from nursing are:
- Beneficence (to do good);
- Non-maleficence (to do no harm);
- Respect for autonomy (an individual’s right to choose); and
- Justice.

These have particular emphases on relationships, human dignity, empathy and fair treatment (Edwards, 2009) – the very aspects of care that, rightly or wrongly, the right care can empower individuals.

The CFCA model
The CFCA model is part of a new learning package for care homes staff and managers that is currently under evaluation. The model is copyrighted to the lead authors and cannot be copied or reproduced without their permission.

For more information contact: deidre.wild@btinternet.com

The right care can empower individuals

5 key points
1 Remedial care aims to maximise recipients’ independence, autonomy, abilities and quality of life
2 The Caring For and Caring About model is weighted towards a remedial rather than protective approach
3 The quality of interaction between caregiver and recipient will determine how, what and in which timescale remedial care can succeed
4 Success depends on what the recipient and caregiver agree to commit to as an attainable improvement
5 The decision about the appropriateness of the approach involves taking an informed direction that is consistently thought through
media relentlessly accuses nursing and support social care staff in some care homes of lacking.

Boykin and Schoenhofer’s (2001) Nursing as Caring model suggested caregivers should develop knowledge and reflect on its application within the context of their personal experiences of caring. This encourages aspiration not only towards becoming “knowledgeable practitioners” but also towards professionals knowing themselves as “caring practitioners”. This is clearly what older people want their caregivers to be (Kydd, 2009).

Unfortunately, impaired physical and mental function tends to diminish older people’s ability and right to choose the type of care they want just when they need it most. It also makes it easier for caregivers to exercise increased choice and control over what, how and when their caregiving is delivered.

In terms of using CFCA, appropriate care is about more than reacting to the evidence-based outcomes of assessment. It has the added human value the caregiver brings to a relationship with the recipient. The quality of this interaction between caregiver and recipient will determine how, what and in which timescale remedial care can succeed. Although defining such human added value may be elusive, it is recognisable in the individual caregiver who makes the effort to transform an inappropriate reliance on task-led over-protective caring towards a remedial caring about approach.

The model in practice
To illustrate CFCA in practice, a scenario has been developed with a fictitious character, Miss Elizabeth Reader (Box 1). This clearly shows that, to be effective on a remedial journey, caregivers need knowledge of the impairments of late life and their interactive disabling effects. These impairments were described by Isaacs (1992) as the five giants of geriatric medicine: impaired continence; impaired mobility; instability and falls; impaired mental performance; and sensory loss. We have added two more – sensory loss. We have added two more – falls; impaired mental performance; and sensory loss. We have added two more – sensory loss. We have added two more – sensory loss. We have added two more – sensory loss. We have added two more – sensory loss. We have added two more – sensory loss. We have added two more – sensory loss. We have added two more – sensory loss. We have added two more – sensory loss. We have added two more – sensory loss. We have added two more – sensory loss. 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Nursing Practice

Discussion

BOX 1. MISS READER

Elizabeth Reader, aged 74 and a former librarian, has been in a residential home for six months after a fall in her own home, where she lived alone with her cat.

On admission to hospital Miss Reader was described as mobile but with unstable balance, continent, overweight, unkempt in appearance, housebound and reliant on neighbours for shopping. She was diagnosed with arthritis primarily in her knees and hands, hypertension and a urinary tract infection and seemed liable to confusion.

Unable to self-care, Miss Reader was admitted to a residential home where some deterioration has taken place. She can get up out of a chair without help but with a struggle, but tends to be unstable when standing. Caregivers tell her not to get up unless they are there. She has become incontinent of urine mainly during the day and wears pads. She feeds herself although she tends to leave food, and has to be reminded to take fluids. Although Miss Reader can walk unaided she is afraid of falling so she tends to wait for a carer to take her by wheelchair to the toilet, dining room or lounge where she sits for most of the day. She occasionally says she would prefer to stay in her room. She is quiet when in company and does not enjoy activities.

She has daily diuretic and antihypertensive medication and can have paracetamol as needed for pain. She has a poor appetite, and occasional diarrhoea. She thinks her caregivers filled in some sort of documentation about her but she is unsure. With failing eyesight, she no longer wants to read. She has a nephew who visits her about once a month.

This is a fictitious character.

BOX 2. EXAMPLES OF EXPLORATORY QUESTIONS

- What would Miss Reader want to improve in terms of her function and what benefit does she envisage?
- Why does she want to stay in her room?
- Does she enjoy her own company more than that of others or is she embarrassed by her incontinence?
- Would access to a toilet be increased by staying in her room?
- What elements of risk are increased/decreased by her desire for solitude?
- Was the loss of her cat a bereavement and, if so, could this be remedied?
- What motivates Miss Reader?
- What did she and would she like to read, and would access to a library be beneficial?
- Has her eyesight and/or hearing deteriorated?
- What are her fears, likes and dislikes in the home?
- How and what does she like to eat, and when? For example, little and often?

What is an “appropriate” approach in caregiving?

The premise that older people are “treatable and teachable” (Pfeiffer, 1986) underpins CFCA. Similarly, for remedial caregivers, the first thought in translating the model into practice should be: “What can I do about these disabling effects?” The considered answer may be only one small change – but small can be beautiful if something that was once lost can be reclaimed. Irrespective of the size of change, it is all about what the recipient and caregiver agree to commit to as an attainable improvement.

The commitment is to a journey on which both caregiver and recipient must be willing to embark, but it is the thoroughness of preparations that determines the potential for success.

The first step in using CFCA is, before doing, to activate the caregiver’s thinking through evidence gathered about and from the recipient. This evidence should inform decisions about the most appropriate of two dynamic care approaches to achieve an agreed goal.

Decision making is informed by the caregiver’s knowledge, assessment and negotiation with the full inclusion of the recipient. Deliberations for the appropriateness of a caring-for approach, when dominant, could include recognition that it has made the recipient passive, too dependent or disempowered. Conversely, it could be that if the recipient was unable to act independently due to episodic illness or trauma, the same caring-for approach was legitimately providing respite and comfort.

Similarly, if the caring-about approach is dominant, the caregiver could question whether it has sufficiently invigorated the recipient’s self-help, relearning, self-worth and confidence and whether the gains were sustainable. Alternatively, questions could be asked about whether the caregiver’s expectations were too high compared with the recipient’s abilities, leading to insecurity or anxiety.

Within the context of an interdependent care relationship, on each progressive step of the remedial journey consideration must be given to the implications of the gradual withdrawal of caring-for actions and the impact this could have on the recipient’s confidence.

The decision about the appropriateness of the care approach involves taking an informed direction that is consistently being thought through. If necessary, the approach can be revised and backtracking can be undertaken before moving forwards again, according to changed circumstances. As such, the approach is always
responsive to the recipients’ trajectory in terms of progress towards a goal, rather than responsive to the caregivers’ needs.

**Prioritising remedial goals**

Now Miss Reader has become a “real” person in the care relationship, the complexity of her present functional impairments can be fully assessed (A, Fig 1). This is done before identifying the most feasible goal and ways to strengthen the caring-about approach (B, Fig 1) to achieve it.

In Fig 2, Miss Reader’s disablements are presented as a series of concentric circles. All areas are important but the first task is to identify the initial goal (A, Fig 1) as one that has a negative influence on other aspects of disablement. As pain and medication side-effects were identified as key inhibitors to improving other aspects of Miss Reader’s physical function, they are placed at the core of Fig 2; controlling them is the first goal. Box 3 outlines the sort of preparatory remedial activities that could be undertaken to achieve this.

By responding to their outcomes, a GP medication review was deemed vital and resulted in a change of Miss Reader’s analgesia to include an anti-inflammatory. Its administration was no longer led by asking her whether she was in pain, but by using a simple pain measurement. Antihypertensive and diuretic medications were also reduced on the basis that their potential for collective side-effects could be the cause of several symptoms including: postural hypotension with instability after rising from a chair; potential for falls, joint pain and headaches; and her unstable bowel.

Improved pain control and reduced medication side-effects enabled the barrier to lift to activate a new goal – to improve mobility (Fig 2). This included caregivers and Miss Reader learning new skills from a physiotherapist. These needed minimal preparatory remedial activities that could be undertaken to achieve this.

The third goal was to retrain Miss Reader’s bladder to promote continence. This was facilitated by freeing her from being trapped in a chair, improving mobility and balance, and allowing her to spend time in her room, with increased ease of access to her en-suite toilet. Success in the previous goals produced spontaneous improvement in mental health due to the quality of the interdependent caring relationship and Miss Reader’s growing sense of autonomy. She perceived the use of lavender oil massage to have beneficial effects on her pain and sense of wellbeing (Kim et al., 2005).

These improvements in turn had a beneficial effect on appetite, giving opportunities to improve nutrition. As she regained some urinary continence, Miss Reader no longer felt she had to restrict fluid, so improving hydration was made easier.

Throughout the transformation of Miss Reader’s life, the addition of specific assessment tools, which can be accessed online, provided reliability in gauging her progress. Through transition (F) they purposefully minimised the caring-for approach to maximise the caring-about approach. In addition, throughout the journey, a simple repeated self-report of Miss Reader’s confidence over time testified to her re-entry into a more meaningful life with the maximum retrieval of autonomy.

**Conclusion**

Using CPFA to change levels of disablements among older residents in care homes requires meaningful interdependent care relationships grounded in ethical principles, trust and caregivers’ knowledge. Residents are also entitled to be party to the essential preparatory evidence base, as the precursor to decision making for the first and subsequent goals and the appropriate care approach to achieve these.

Justifying each step towards a goal, in negotiation with recipients, should be the norm. Remedial caregiving is about informed effort to improve damaged lives by increasing the caring-about approach while reducing the caring-for one to enable recipients’ self-help and sense of autonomy to emerge.

The outcomes of the remedial journey with Miss Reader could be regarded as a utopian vision but we would argue the contrary. Only through a remedial approach can the many “Miss Readers” regain control over life-enhancing skills and undo the insecurity that grows with age-related and institutionally created impairment. Remedial care requires a one-to-one relationship to be built with consistency across individual carers involved in shifts throughout the 24-hour day.

Changing ways of thinking about the appropriateness of the caregiving approach will inevitably change working methods and the use of skill mix. Some may think this could require more resources, but Part 3 will show it is more a case of changing ways of managing care by using existing resources in a different way. NT

**References**


**FIG 2. GIANTS OF DISABLEMENT: HIERARCHY OF RELATIONSHIPS**

- Pain, medication side-effects
- Impaired mobility, instability
- Urinary incontinence
- Insecurity, anxiety, depression
- Poor nutrition and hydration