Dementia care is a silent crisis. Around 750,000 people have the condition in the UK and this figure is projected to double in the next 30 years (Department of Health, 2012). The lack of skilled staff with training in dementia care in general nursing care homes, hospitals and domiciliary care is resulting in poor treatment (Brooker, 2003), which has been criticised in the media.

Dementia care must therefore be powered by a specific model (Dewing, 2004). There is an urgent need to educate carers (Ford and McCormack, 2000), and provide them with a toolkit that enables them to develop the key skills to support people living with dementia.

At Palm Court Nursing Home, we see the Kitwood model, first published in 1997 and updated in 2007, as forming the basis of dementia care in the UK (Kitwood, 2007). Kitwood has six strands: love; identity; inclusion; comfort; occupation; and attachment (Fig 1). It enhances personhood, which is conferred through actions and interactions between two people.

We became its pioneers when we started a full implementation in 2007. We now share our experiences; the successes we see and the improvements we aspire to in its new form are what we call Kitwood Plus. We believe this will help shape the future landscape of dementia care.

Dementia care redefined
Reflecting on her own condition as a person living with dementia, Bryden (2005) said she found it difficult to make sense of yesterday and to project her thoughts on tomorrow because dementia affected her faculties.

At Palm Court we use this to define dementia care as “no yesterday, no tomorrow, but today”. This shapes our care practice, making it alive, relevant, real and not routine. Our vibrant approach ensures that our residents are stimulated to enjoy the moment of care and interaction.

The nature of dementia can be likened to driving on a foggy road, suddenly coming into a clear patch round the corner then re-entering the fog. The challenge for care practice is to make those clear moments brilliant and be helpful and be understanding during the mist.

Kitwood Plus: the carers’ toolkit
Dementia care needs to be focused on experiences and relationships instead of activities of daily living (ADL). Kitwood Plus illuminates the two dominant themes...
in dementia care planning, namely relationships and daily experiences, supported by Kitwood's six strands.

Our experience of Kitwood's original model confirms that it does not focus on the critical themes above, but promotes love and affection through the strands. This is not enough; it should be built on relationships and daily experiences of our residents to be of any use. Kitwood Plus emphasises what is done and how it is done to enhance personhood. This has powerful implications for care practice.

The pillar of Kitwood Plus (Fig 1) is the quality of interaction between carer and the person living with dementia. Drugs have limited value and are mainly for symptom control. Enhanced personhood plus high-quality interaction result in positive daily experiences, and can be achieved by using the STEP tools. Positive talk includes conversational life review, which is more beneficial than reminiscence (Bohlmeijer et al, 2007).

These are basic, inexpensive tools that carers can use to maximise relationships and enjoyable experiences. When practitioners apply these tools consistently, they visibly strengthen care practice.

Carers connect with the person first then care. It is not just about seeing the person first; connecting with them is more critical to initiate the relationship to maximise daily experience. No connection means no communication and poor care. STEP first to connect, then offer care.

The anchors
Palm Court established four anchors in implementing our model.

First anchor: people living with dementia need consistency and stability in their care.

Employing temporary staff is likely to interfere with the quality of interactions. A stable workforce is essential.

Second anchor: the learning culture is a strategy for excellence. There is a strong relationship between an organisation's learning culture and the quality of its care (Shipman et al, 2011).

We have a structured in-house training programme to help carers develop insights into their practices.

Third anchor: care theory is functional when reinforced regularly to strengthen practice.

This process embeds our model in practice.

Fourth anchor: caring skills are mostly hidden and tacit, elicited through reflection.

Reflection is used to search for solutions to develop stronger relationships.

The four anchors drive our centre to ensure residents have a rewarding and fulfilling day. They are instrumental in building a pattern of care behaviours that staff emulate in practice.

Identifying difficulties
We identified two significant challenges in implementing Kitwood Plus.

The first involved the conceptual leap that staff must make from a model focusing on ADL to one based on quality of interactions. Kitwood Plus makes personhood, relationships and daily experiences the priority, so ADL become supporting activities. Personhood in dementia care is the single factor that carers must maintain and promote if we are to see the person first and then the condition.

We facilitated this through several reflective sessions on personhood, connecting with people, quality of living experiences and relationships. Carers observed the amount of interaction residents were involved in and whether they were withdrawn or uncommunicative. We developed strategies to increase interactions, as a prolonged state of reduced activity or increased sadness or anxiety can develop into illness such as depression and anxiety.

The difficult issue was that the care plan emphasises personhood, while staff and social services were accustomed to focusing on ADL. We felt that a total removal of ADL would create uncertainty and possible confusion, so we decided to frame the care plan with actions (what carers have to do based on risk assessment and residents' profile) and interactions (how to be positive).

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We held several meetings with all staff and shared our thoughts and framework. There was a consensus that our approach had many merits and staff supported the change of format. Through the reflective sessions, we established a unity of purpose and a clear understanding of what helps people to live well with dementia. In practice, staff recalled: “It was like learning to care again – STEP into the world of dementia.”
The model in practice
A care plan is a complete portfolio of life history (Buron, 2010). It is compiled with the resident, relatives and significant professionals. It is a positive document indicating how to use enhancers and eliminate detractors to move away from “no cure, no help, and no hope” (Kitwood, 2007).

The care plan includes words or procedures suggesting how talk can be framed in a positive way. It is not a rigid schema of stages to be delivered in a fixed order – we use it as a flexible trigger to encourage interaction while attending to residents’ physical needs, framing nursing care through interactions. The emphasis is on recognising and promoting personhood.

The care plan’s language is descriptive and it clearly shows how actions are to be framed to preserve personhood and connect with the person. In practice, the instruction to carers is: “You are about to give a wash to resident A; please bear in mind our definition of dementia care and make this moment a memorable one.”

We have a 10-minute discussion on our model every morning, followed by a fortnightly one-hour reflective session, which all staff (including ancillary staff) attend. The aim is to reinforce the care plan in practice and make it a practical document. This reflective openness and analysis raises the level of awareness in the quality of interactions between carers and residents, and develops insight into practices and formulates actions for future practice.

Effects of introducing the model
The first anchor builds a cohesive team. Consistency empowers staff to take a deeper personal interest in residents’ welfare and build relationships with relatives. Staff understand better how to use enhancers. Residents feel more at ease as staff around them have developed a reassuring and motivating bond.

There is a dynamic interplay between what we espouse as our ideology and the level of understanding necessary to translate this ideology into practice. Therefore, when we appoint staff, we discuss learning and attendance at reflective sessions at length and make them aware of our learning culture right from the start.

Our central constructs for new staff are: unity of purpose; linking theory and practice; and knowledge for reality. The dynamic interplay between these constructs enables carers to collaborate with residents and relatives. The result is a vibrant atmosphere in which residents are engaged in thinking and talking, grounded in social interaction and occupation.

Staff value their own practices in terms of experiential knowledge and their ability to generate knowledge appropriate to our culture and practices. This has changed staff perceptions and their ability to be critical thinkers. They have found this empowering, and their increased confidence and skills have made them better able to care for people with challenging behaviour.

Our residents experience a supportive mode of care in all spheres of human interactions. We improve interaction, eradicating patterns of dominance and submission in carer-resident relationships. Our model has helped staff to think about what a care home is; it is the residents’ home and staff are privileged to enter it and provide a service. Their behaviour and attitude are guided by this concept. This interpretation of the home appears to shift the power base from staff to residents.

References