It is important that residents in care homes are engaged in meaningful activities; the Living Well Through Activity in Care Homes toolkit aims to help staff do this.

A toolkit for encouraging activities in care homes

In this article...

- Why activity is important for care home residents
- Simple changes nurses can make to offer activities
- Tips on motivating staff to think about suitable activities

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Abstract Bishop K (2014) A toolkit for encouraging activities in care homes. Nursing Times; 110, 29, 22-23. Activity is vital for the physical and psychological wellbeing of care home residents. It should be an integral part of their daily routine but can be viewed as an additional burden for busy staff. Activity is defined as everything we "do", and even older people who are frail can still be active. Nurses need to consider how activity can be incorporated into residents’ daily lives; the Living Well Through Activity in Care Homes toolkit, produced by the College of Occupational Therapists, aims to help staff provide meaningful activities for residents.

There is a common perception that moving into a care home involves a loss of independence and autonomy. However, while communal living may involve some compromise, it does not mean older people have to give up the things they enjoy that are central to their identity.

When people are left to sit for most of the day with little movement or stimulation a number of detrimental physical and psychological changes occur including:

- Muscle weakness;
- Decrease in gastrointestinal movement;
- Urinary tract infections;
- Increased risk of chest infections (Department of Health, 2011);
- Irritable;
- Less alert and less able to concentrate;
- Confused;
- Disorientated;
- Low in mood (DH, 2011).

Meaningful activity has huge benefits for residents and staff and should be as integral to daily care home life as providing essential care like bathing and dressing. Everyone working in health and social care has a responsibility to support this and nurses in residential care are in an ideal position to drive this change.

The toolkit

The College of Occupational Therapists has developed the Living Well Through Activity in Care Homes, a free online toolkit, which shows that meaningful activity can be achieved in care homes. It contains ideas on how staff can support activities, even when they have a limited amount of time (Box 1). It also tackles additional challenges such as:

- Choice versus risk;
- How to motivate people;
- Integrating activity into care planning.

The section for care home owners and managers contains materials to help them identify the existing activity culture and suggests measures for reviewing progress.

The DH (2014) defines wellbeing as: “feeling good and functioning well and [something that] comprises an individual’s experience of their life”. The toolkit highlights how wellbeing can be captured, including those times when people have difficulties communicating how they feel.

Nurses are also advised to read the quality standard published by the National Institute for Health and Care Excellence (2013), which references our toolkit. This calls on care homes to ensure that opportunities for activity are available and staff are trained to offer spontaneous and planned opportunities for residents to participate

5 key points

1 Older people in care homes should still be able to do the things they enjoy most
2 Engaging care home residents in meaningful activities can improve their physical and mental wellbeing
3 Residents who are frail can still undertake meaningful activities
4 Activities can be as simple as engaging a resident in conversation or watching television with them
5 Staff should see activities as a part of residents’ daily routine and not an additional burden

Staff can encourage residents to engage by asking them about their loved ones.
Experience is more positive. More demanding, but the resident’s experiences. Nurses can begin by fostering a culture of spontaneity when talking to residents, and making the most of occasions when they can interact with them on a one-to-one basis. Actions that will instantly make interactions more human and personal include taking the time to:

- Share a snippet of daily news;
- Comment on an object in their room;
- Make a joke or tell a story about what happened to them that day.

**Working with colleagues**

Promoting and incorporating activity into everyday work can seem like yet another pressure on staff, but discussing ideas as a team will give a feeling of shared ownership. Staff should be encouraged to review progress together in staff meetings, taking time to consider what works, what does not and why this is the case. This provides an opportunity for good practice to be benchmarked.

Nurses can start by reflecting on what the care home already does successfully and how activity can be built into the normal daily routine. As an example, they can encourage residents to get involved in the day-to-day running of the home; Box 1 outlines some tasks that can facilitate this.

**Tips for motivating staff** are outlined in Box 2.

**Piloting the toolkit**

The toolkit was piloted in six sites; in one of these a resident summed up this approach: “It is not what nurses do but how they do it.” He cited being given his morning medication as an example: some nurses would greet him and hand him his tablets; others would chat to him, ask him how he slept and whether everything that he needed was within reach.

The first example demonstrates a task being completed but the second indicates a one-to-one moment that could provoke further activity, such as reading the paper or listening to the radio. From the nurse’s point of view, the second interaction is no more demanding, but the resident’s experience is more positive.

What nurses can do

The skill of the nurse lies in understanding the importance of activity and finding ways to encourage choice and engagement. Nurses can ensure they are familiar with the key points of each resident’s biography, interests and preferences. This will help them to understand whether it is appropriate to encourage individual residents to participate in particular activities. Discussing ideas with friends and relatives may be a good place to start.

It is important not to shoehorn residents into an activity or event, but to see them as individuals with their own preferences. Nurses can begin by fostering a culture of spontaneity when talking to residents, and making the most of occasions when they can interact with them on a one-to-one basis. Actions that will instantly make interactions more human and personal include taking the time to:

- Ask residents questions - What do you want to do? Who is in that photo with you?
- Ask yourself questions - Is there anything I can do to help this resident be more active, for example, tune a radio station, help to phone a relative?
- Ask residents to help - Get them involved with sorting the post, watering the plants, drawing the curtains in the living room. Rather than thinking “What do I need to do next?” try “How can I do this activity with a resident?”
- Get prepared and plan ahead - Have a selection of portable activities that can help people to make the most of the opportunities when they come along.

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in meaningful activity. Drawing on existing guidance, it contains measurable statements and comprehensive recommendations for care homes to follow.

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**Environment**

As well as behavioural changes, staff can make simple but effective adjustments to the immediate environment that can facilitate activity and contribute to a general feeling of wellbeing. These include:

- Talking to residents and observing how they spend time in their rooms. What activities do they routinely do and is the room set up to enable these? For example, do they sit in their easy chair to read – is there adequate lighting for this and a table where they can rest their book? Is it better to turn the chair to look out of the window so they can watch activity outside? Could you put up a bird table outside to encourage wildlife? From the bed, can they reach the radio, television remote control or their telephone?
- Making sure rooms are suitably lit;
- Ensuring the communal rooms have a range of chairs at different heights and widths, and people are sitting in the right chair for their height and body shape;
- Thinking about the purpose of the room – is it set out for the benefit of staff completing tasks or is it set up for the residents? What changes can be made to enhance the experience of residents? How would you like to room to be if it was your home?

Identifying any spaces that are not really used and working out what to do with these – could you leave objects out or create an area of interest for people to explore, for example, a writing table with paper and pens or picture books on side tables?

**Conclusion**

Care homes need not be places where residents are inactive or cease to engage in the activities they enjoy or that reflect key aspects of their personality. Small actions can make a big difference to each resident’s experience in the home. Nurses should get to know residents and actively look for ways to encourage them to engage with staff, each other and their surroundings to improve both their physical and mental wellbeing. NT

- The toolkit is available free of charge from tinyurl.com/COT-Living-Well, where nurses can also sign up to the Living Well in Care Homes network.

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A new model of care for the older person

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.

Wells (1980) juxtaposed these approaches:

- “Modern nursing care of the elderly should be about mobilisation not bedcare; it should be about regaining and maintaining skills and abilities, not acceptance of less than the older individual’s maximum functional level. Underlying such dynamic nursing care of the old is comfort and support.”

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 care home often focuses on compensating for their disabilities. A remedial model of care can be used to promote their autonomy and quality of life.
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 balance; 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 predominantly 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 to identify and refer the need for specialized 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 (2010a) 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 (Szczepura et al, 2008b).

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, 2008b). 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...
Discussion

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 way of 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. Applying 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

Nursing Practice
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 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 (C).

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.

Caring 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.

**References**


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

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

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Abstract

This second in a three-part series shows how to use the Caring For and Caring About model in practice. Part 1, published last week, described the model; part 3, to be published online on 10 April, shows how to manage care using existing resources.

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.

Keywords: Older people/Caregivers/Care recipients/CFCA model
- This article has been double-blind peer reviewed
As Miss Reader is seen as being at risk of a fall and caregivers are concerned because her nephew has a punitive attitude, she is usually taken to the toilet after meals in a wheelchair. This routine has no positive impact on her incontinence; on most occasions, despite protective pads, her underwear is already wet. Caregivers do not consider the logic that it takes 10 minutes to take her to the toilet and wash her hands but 20 minutes to wash her and change most of her clothes when she is incontinent. Similarly, they do not notice that their toileting regimen is not in the same timeframe as her bladder’s voiding function.

Caregivers find Miss Reader quiet and withdrawn. They have tried encouraging her to join in bingo and exercise classes because they think being in the company of other residents is better than being alone in her room. They do not consider her request to stay in her room as feasible or practicable as it is more time-consuming to keep checking she is safe. Socially, Miss Reader is quiet by nature and, beyond daily pleasantness, caregivers tend to talk to each other rather than include her in conversation. Misguidedly they believe they are keeping her safe and clean. As she never complains, no one has noticed she has become passive and dependent because she is not allowed to exercise any choice or risk.

No one has thought about the effectiveness of her analgesia or potential side-effects from her hypertension medications.

Miss Reader’s perceptions of her care
Miss Reader suffers her arthritic joint pain stoically; she rarely asks for painkillers because they do not resolve it. As she does not ask, caregivers tend to assume she does not need painkillers, or forget to ask.

Miss Reader thinks she is forgetful because every day is the same and it is difficult to remember which day of the week it is. She passively accepts her life as being “just the way it is”, and says she does not like to bother caregivers “because they are always saying how busy they are”. She was never one for company apart from her cat, and finds communal living stressful, particularly now she is incontinent. She has tried not to drink fluids, believing this would stop her incontinence.

Her aspirations, expectations, sense of self-worth and desire to self-help have diminished over time. She no longer reads as it is too difficult to find enough light and, as caregivers will not allow her the peace and quiet of her room, there is no point in trying to concentrate with the communal television on all day.

The caring relationship
It appears caregiving has settled into an overprotective and custodial approach, mainly because Miss Reader has a compliant nature. The caring-for approach is dominant and, although well intended, is inappropriate; Miss Reader has been encouraged to be dependent and so has lost confidence in her former abilities. The caring-about approach is less evident as there is no evidence of negotiated remedial activity.

Assessment and care planning are completed but, as care is static for Miss Reader, the outcomes reflect this – that is, a good day is a day when nothing has changed. The care relationship is governed by recipient dependency and caregiver control, with little inclusion of Miss Reader as a person. Communication is noticeably without a remedial purpose and the relationship is not interdependent but skewed towards benefitting caregivers’ ways of working.

Beginning the remedial journey
Relationship building, exploration and assessment

Only when the interdependent relationship is sufficiently mature can remedial...
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, underweight, unkempt in appearance, housebound and reliant on neighbours for shopping. She was diagnosed with arthritis mainly 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 fitted flat character.

**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

**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?

**BOX 3. PREPARATORY ACTIVITIES FOR THE CORE GOAL**

- Monitor and measure pain intensity in relation to time, body site, activity and timing of analgesia and so on
- Arrange a GP medication review
- Continue monitoring efficacy of new medication regimens on pain, mobility, stability, headaches, bowel instability and mental health
- Explore alternative therapies: aromatherapy and massage, such as using lavender oil for pain and anxiety

- Monitor blood pressure for postural hypotension. Do this while patient is sitting and standing
- Monitor and measure pain intensity in relation to time, body site, activity and timing of analgesia and so on
- Arrange a GP medication review
- Continue monitoring efficacy of new medication regimens on pain, mobility, stability, headaches, bowel instability and mental health
- Explore alternative therapies: aromatherapy and massage, such as using lavender oil for pain and anxiety

**ACTIVITY FOR THE CHALLENGE**

- Monitor and measure pain intensity in relation to time, body site, activity and timing of analgesia and so on
- Arrange a GP medication review
- Continue monitoring efficacy of new medication regimens on pain, mobility, stability, headaches, bowel instability and mental health
- Explore alternative therapies: aromatherapy and massage, such as using lavender oil for pain and anxiety
Responding 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 disabilities 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 disability. 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 and more effective caregiver hands-on support, which was gradually withdrawn as her ability and confidence grew.

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 CFCA to change levels of disabilities 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.

**References**


Using an adapted model of care to manage change

In this article...

- The Caring For and Caring About model as an organisational change model
- How to prepare for organisational change management
- Developing the home as a remedial learning culture

This is the final article in a three-part series on the Caring For and Caring About (CFCA) model designed to promote remedial care practice in care homes for older people. Part 1 described the model, the rationale for its development and care relationship requirements to make it work (Wild et al, 2012a). Part 2 focused on using the model in practice to encourage appropriate remedial care for the major disablaments of late life, such as continence promotion, remobilisation, confidence-building and motivation (Wild et al, 2012b).

The need for remedial care

The need for changes in practice in all types of UK care home is illustrated by the findings of a large health census of residents in one provider’s homes; a considerable overlap was found in dependency between those in nursing homes and those in residential homes (Bowman et al, 2004). Assessment and regulation were described as poorly matched to the overall care needs of residents, of whom 71% were incontinent, 76% had impaired mobility and 78% had at least one form of mental impairment. Such findings could suggest that the embedded care approach places emphasis on “caring for” residents (doing something for, to, or on behalf of, or looking after) rather than a remedial approach of “caring about” (enabling, encouraging, deferring to) that seeks to improve residents’ function. It could be argued that, as a higher number of beds are in residential homes with no onsite registered nursing requirement (Care Quality Commission, 2011), and staffed by social support carers with different roles, there is a need for a change in culture.
limited healthcare knowledge, that remedial care deficits would be an expected outcome in these settings. Other limiting factors could lie in the ad hoc nature of community nursing input (Goodman et al, 2005), and insufficient access to other NHS expertise (Livesley et al, 2011).

A literature review on caregiving by staff in care homes highlighted: the limited subscription to evidence-based practice; the need for further role development of home managers as change agents; and the importance of investing in care staff development as a precursor to changing a task-oriented care culture (Szczepura et al, 2008).

**CFCA as an organisational change model**

The adapted CFCA model for organisational change management (Fig 1) shares a similar visual format to that of the CFCA model of remedial care presented in the two previous articles (Wild et al, 2012a; 2012b). It also retains the emphasis on “thinking” before “doing” in terms of decision-making for managing change. The model’s elements are labelled A to H with each representing a part of the management journey towards achieving remedial quality-improvement (QI) goals (H) agreed at the outset with staff (A). As with the original model, the thoroughness of the preparatory phase (A) will dictate the potential for success and if incomplete or rushed, it could jeopardise managers’ credibility and staff commitment.

As shown, each of the “managing caring for” and “managing caring about” approaches has a “high” and “low” level within its inter-dependent circle. Where both circles overlap is the crucial decision-making hub (F), in which the appropriate-ness of the management changes from one caregiving approach to the other (transition) are considered using findings from audit and other tools for monitoring progress (G) and including external professionals’ feedback on performance (G2). There is no restriction on adding new tools or other knowledge at G to support the decision-making of zone F, which includes staff.

If at the outset “managing caring for” is high (B), then it is likely that staff’s ethos is to work to routines shaped over time and aimed at containing rather than diminishing disability. The greater the emphasis on “caring for”, the less management leadership is given to promoting “caring about” (D). However, this does not mean that both forms of care management do not co-exist, just that unwittingly or unwittingly, one is more likely to be dominant than the other.

For example, a dominant “caring for” approach is legitimate and essential to meet needs arising from illness. However, when caregiving becomes overprotective and inappropriate by denying opportunities for individual residents to self-help, managers need to challenge the logic of this approach with staff and promote “caring about” ways of working using remedial skills.

As “managing caring about” increases (E) and progress towards the agreed strategic goal (H) is regularly reviewed (G), any focus on “managing caring for” should diminish (C), with staff becoming more active in negotiating the appropriate input of remedial care with individual residents.

If change falters, as the model’s two-way horizontal arrows indicate, the dynamic between the two management approaches may need to be revised and even temporarily reversed in order to identify new strategies to re-strengthen and encourage “caring about”. Importantly, underpinning the use of this model are two resources for sustaining change: the need for time (particularly during the preparatory phase) and patience (particularly after implementation) to enable it to become embedded practice within ways of working (Nelson et al, 2009a).

**Preparing for organisational change**

**Managers as change-agents**

Described by Nelson et al (2009b) as “the bridge or barrier” to successful innovation in care homes, home managers’ role is further complicated by a situation whereby they may choose to lead, but staff will decide whether or not to follow according to their perceptions of their manager’s credibility as a leader (Kouzes and Posner, 2011). Thus preparing for change should begin with home managers gaining insight into their credibility as perceived by staff. In seeking this, managers should be open to inviting peer review for self-improvement and ongoing mentorship as a support. This could have the added benefit of setting a precedent to make the appraisal of staff performance across the change process a similarly constructive rather than threatening activity.

The following list are qualities and attributes for home managers seeking to be a change agent (in bold) and some positive responses (in italics) that staff could make towards them: Credible leadership Follows Knowledgeable educator Learns from Visionary strategist Confident in, Motivated by Shares and listens Feels included, Has ownership Innovative Sees change as progress Hands-on style Has trust in, Sees as a role model Relationship builder More support, More expertise

Most of all, being visible to staff and residents, with involvement in hands-on caregiving, will inevitably enhance managers’ standing with staff more than being remote and office-bound. Other attributes include having a thorough knowledge of residents’ care needs, wants and potential for improvement and a commitment to staff (and own) training and maintaining competencies.

**Involving staff**

In preparing for change, all staff levels need to be involved from the outset in developing a vision of what a remedial care home could be like. This should be followed by
Discussion

**BOX 1. RESEARCH FINDINGS ON INHIBITORS TO UPSKILLING SOCIAL CARE STAFF**

**Resistant attitudes**
- Some staff did not want to change ways of working or learn new skills as they thought these were already adequate
- Some believed they were too old to change
- Only when staff could see the result of improved care did change become positively accepted

**Lack of focus in education**
- The content of formal courses was insufficiently related to hands-on practice
- The system of assessment and supervision of competencies was weak

**Lack of professional standing**
- Lack of understanding of accountability and liability
- Sense of being a professional inside the home but less so in the eyes of those external to it
- Social support care staff lack a professional framework, body and registration

**Ineffective management**
- Some home managers subscribed rhetorically to change but did not have the experience or knowledge to lead implementation with staff
- An office-bound, remote management style tended to leave staff feeling unsupported
- Although a vision and strategy for quality improvement for the home, staff and residents was written by management, only in one in four of the homes was this fully shared with and understood by staff
- Few reciprocal links between homes and wider NHS or other providers’ networks were established to support or sustain change
- The value of audit as evidence was not fully recognised by managers


Preparation a mission statement of what would need to be done to turn the vision into a reality. Finally, a values statement of the conduct to be adhered to by those involved in achieving the vision should be defined, as it will help to maintain group harmony by setting the tone and context for their future behaviour (Gottlieb, 2007). Through this type of inclusive process, staff are more likely to commit to both the vision and mission with a sense of ownership before starting the process of developing the strategy for change.

For managers and staff, knowing what happens now and why is both the springboard for change and the basis on which its success can be gauged. By mapping residents’ assessed level, range and type of needs against staff caregiving responses to meet them, and against the profile of staff skills and learning (given collectively in Fig 1 at A as “scope”), the level of demand on caregiving activity and the adequacy of staff skills to meet these can be gauged. Review of past audit and regulatory outcomes is a further addition to homes’ care history.

By taking time to understand staff’s current interactions between themselves and with residents and within their ways of working (including their use of material resources and the physical environment), future interventions become more transparent (Scott et al, 2008). Dialogues with staff could involve simple questions such as: “What do we need to learn and do to change X aspect of caregiving to achieve the quality-improvement goal Y?” This could then progress to the more complex and probing questions of: “If we change X, what else could be positively or negatively affected during the course of progress towards the achievement of Y?” and “How can we reduce the potential for harmful effects?” A simple SWOT analysis (strengths, weaknesses, opportunities and threats) by all or a representative group of staff is a useful exercise to provide and explore general perceptions of current and future caregiving approaches in practice.

Through such techniques, managers and staff will be able to identify the first change and go some way to second-guessing some of the common inhibitors towards it at the outset and during its progress. Examples of inhibitors found in recent studies are shown in Box 1 to illustrate some of the issues that could emerge.

**Managing organisational change**

**Changing staff roles and ways of working**

Changing ways of thinking will open minds to new ideas but is also likely to raise the question of resources. Given the current financial climate, it is likely that changes will largely be confined to using the same resources but in a different way. Remedial care depends on establishing strong one-to-one carer and resident inter-related relationships, with a continuity of dedicated time provided from one caregiver to another across shifts over the 24-hour day (Wild et al, 2012a).

The crucial change will move away from horizontal working, where staff work together to complete a series of tasks across a number of residents, towards vertical working with individual staff members being responsible for a small caseload of residents jointly involved in the process of achieving remedial goals (Wild et al, 2012b).

Essential to organising work in this more person-centred way is the manager’s role in matching caregivers’ skills to support residents’ own efforts towards QI goal attainment. However, if one-to-one care cannot be consistently provided across shifts to meet a remedial care goal, a skills learning cascade system should be activated to ensure that enough staff are adequately upskilled before embarking on remedial change. When changing practice from an excessively protective “caring for” approach towards a more hands-off but therapeutic “caring about” approach, it is important to retain the key quality of empathy. Since this cannot be taught, it is crucial that there is tangible evidence of this in both new and existing staff.

**Staff motivation and incentives**

A further important aspect relevant to workforce development is managers’ understanding of what motivates staff and which incentives they are most likely to appreciate. Haslam et al (2009) found that most care workers’ self-identity and motivation stemmed from their close identification with other colleagues. Furthermore, because carers demonstrated a sense of altruism towards their care work, they responded to work-related issues from a perspective of what was good for the group rather than for themselves as individual care workers. Monetary reward was not seen as a high priority. Some have suggested that managers should commit to developing a culture that encourages staff productivity and high morale based on staff’s personal sense of meaning and purpose given to their work rather than by externally imposed motivators (Morrison et al, 2007).

Upskilling and changing ways of working may destabilise some staff
members’ sense of comfort and morale due to the loss of familiar routines and part-nerships. This can result in initial resist-ance to change (Bozak, 2003). However, upskilling the carer workforce can lead to benefits for residents such as: improved quality of life; increased activity and stim-ulation; positive interactions and relation-ships with other residents and staff; and more appropriate and directed care (Fleming and Taylor, 2006; Smith et al, 2005; Proctor et al, 1998).

Keeping the vision and strategy alive, by managers leading from the front with hands-on visible support and adhering to values, will do much to bridge “what was” towards “what could be”, in terms of changing the approach to caregiving. By adopting a constructive management style such as “appreciative inquiry” (Cooper-ruider et al, 2008), managers can seek and build on the best in staff, their homes and wider systems rather than focusing on what is wrong with them. By doing so, staff resistance to change and negative “groupthink” (Janis, 1972) could be reduced.

Most of all, managers should not under-estimate the time needed to support and understand staff as people as well as workers when they are undergoing change, even when enhanced by new remedial role titles (such as social care support therapist) and with mutually agreed job descriptions.

Developing the home

Transforming the home’s culture

Manthey (2002) suggested that changing practice alone will not change culture if unsupported by a climate in which innova-tion is encouraged and those innovating feel empowered. This echoes work by Banks (2006), who argued that day-to-day care in care homes must have a focus on applying moral philosophy in practice sit-uations – that is the value bases that inform decisions in practice (see Wild et al, 2012b). Nolan et al (2008) noted that in transforming a home’s culture, education appears to be desirable but not pivotal to changing it. Other influential factors were: raising the home’s role and status; adopting a person-centred approach to care; and acknowledging the importance of all those who live, visit or work in the home.

Jost and Rich (2010) found that inspira-tional and credible leaders who communi-cated with staff and listened to the story of change as it unfolded and recognised new opportunity, had the most influence in changing culture. Thus, managers act as guardians of their homes’ past and future. On the one hand by capturing and reflecting the achievement of change over time and on the other, by translating this into a representation of the home’s car-giving culture as one of aspiration to improve residents’ health, sense of well-being and autonomy.

As Fig 2 shows, the two CFCA models represent mechanisms to support a learning culture that embraces:

» Remedial caregiving practice;

» Remedial care management.

Both are presented as separate but com-plementary journeys.

New enterprise opportunities

Care homes in the independent sector are run as businesses where surplus income must be made. Seeking new enterprise opportunities is therefore important for viability but this has to be cost-effective. Encouraging a remedial care approach is likely to require selected key staff to acquire an appropriate level of remedial knowledge and expertise in practice. How-ever, care home staff can be isolated from other homes, and are largely excluded from mainstream care systems (the NHS) by different conditions of employment (Davies, 2001).

To overcome these constraints, devel-oping a local network of like-minded care homes working towards remedial care could provide economies of scale through shared development costs and joint delivery of formal courses supported by hands-on learning provided by local NHS sources of expertise (Wild et al, 2005). Also, once key staff have been assessed as competent, they could take on the role of cascading their learning not only to in-house novice staff but also as “visiting remedial skills disseminators” for staff in other networked homes.

When the vision for the home becomes established practice, fresh enterprise opportunities could arise as the home’s reputation grows. For example, if a home is aspiring towards becoming a centre of remedial care excellence, it could partici-pate in a “hospital to home” scheme. In this, hospitals discharge older patients earlier to remedial care homes than to their own homes, thus relieving pressure on acute hospital beds while increasing occupancy in care homes. These tempo-rary residents would receive more inten-sive remedial goal-oriented care supported by NHS community therapists, with the objective of handover to community care support in their own homes within 2-10 weeks. Remedial day and short-stay care schemes with specialist care, such as dementia and stroke, could also be options.

In these ways, delays in permanent admission to care homes would enable many older people to remain longer with community support in their own homes with associated savings for social and health budgets. The added value in terms of enterprise-building for these care homes could lie in their recognition as a respected major resource through closer partnership working with NHS commu-nity and acute care staff.

However, close partnerships between care homes and local NHS community health professionals will not arise by chance but need joint vision, mission and values to be engineered and nurtured by influential managers of both sectors. In taking this further into developing strategy, “cross sector” (NHS commis-sioner and provider managers with inde-pendent-sector counterparts) reciprocity would become accepted as a logical “whole-system” partnership approach. For example, access to high-quality remedial homes could provide the NHS, local uni-versities and colleges with inspirational placements for students from many health and social care disciplines. In return,
lectures and dissemination of best practice by the educational institution’s staff could be open not only to their students, but also to able care home staff. Furthermore, if NHS managers can change the ways of working of visiting community therapists and community and specialist nurses to include mandatory skills dissemination to and supervision of care staff, then high-quality continuity in remedial practice could become a reality.

Conclusion

This series has highlighted care homes as a major long-term resource for the NHS but one that has perhaps been underestimated in terms of its value and potential.

Currently, once placed in a care home, older residents seem to suffer from a prevailing ageist assumption that they are on the fringe of entitlement to NHS services. However, in reality, as residents they still have the same rights to these services as they would have if they were in their own homes. Home managers are crucial in ensuring not only that these residents’ rights are exercised but also in encouraging continuity for remedial care initiatives.

The CFCA organisational change model offers a conceptual guide to the dynamic process of moving from a culture of “caring for” to one of “caring about” and is underpinned by shared decision-making between managers with staff. In addition, the model contains a useful by-product in its emphasis on evidence-based practice informed by scoping exercises, and the ongoing use of audit and assessment. The cumulative outcomes from these information sources can be used to provide a reliable picture of the home’s performance against national standards for registration and ongoing compliance with the Care Quality Commission.

In making the change towards a remedial care culture, new business opportunities for care homes could arise with minimal investment. However, this relies on the sector taking the initiative by looking outwards for more support and expertise as well as inwards in terms of embracing change towards a new vision. By putting into place the quality improvement attributes, given as a checklist in Box 2, care home managers and staff could build the culture that older residents need and deserve. NT

References

Quetiapine was the antipsychotic most often prescribed, in an unlicensed use.
we need practical and sustainable models of care to address concerns regarding antipsychotic prescribing. Government plans for community pharmacies include greater involvement in the management of long-term conditions (Department of Health, 2008). In addition to care and nursing staff and GPs, community pharmacists in primary care are ideally located to review monthly prescriptions for residents in care homes.

The national audit of care homes
Our national pharmacy chain services a large number of care homes across the UK. Care home leadership teams had expressed a need for support in better managing the medicines of their residents, with antipsychotic prescribing identified as a priority area.

It is an NHS contract requirement for community pharmacists to undertake at least two audits per year (Pharmacy Services Negotiating Committee, 2013). We therefore carried out an audit of antipsychotic medication between July 2010 and June 2012 with homes that were customers of our company and that had requested the service. The homes were run by national chains of care homes and were located in England, Scotland and Wales.

Preparation for the audit
Community pharmacists were trained to provide the audit-based service using online training packages and attendance at an Alzheimer’s train the trainer session. This session increased their knowledge and enabled them to deliver a two-hour dementia awareness session to care staff in the care homes.

Using patient medication records held nationally by the community pharmacy company, pharmacists undertook a clinical assessment of antipsychotic prescriptions for individual residents to establish possible reasons for starting the medication, the duration of the prescription and any interactions.

A blank audit form, GP information letter, consent letter and explanation of the process were sent to home managers. They were asked to identify residents who were prescribed at least one antipsychotic medication, and who were either diagnosed with dementia or suspected of having dementia. If there was no suspected or confirmed diagnosis of dementia, and the resident was taking the medication for other medical conditions such as schizophrenia or bipolar disorder, they were not included in the audit.

The homes sent consent letters to the relatives of those residents identified as potentially suitable for the audit as well as an introductory letter to their GPs.

The audit process

Pre-audit joint strategy
Before discussing individual residents, the audit-trained community pharmacists worked with the professionals responsible for patient care at each home to create an joint strategy for the use of antipsychotic medication in line with national guidance (National Institute for Health and Care Excellence, 2006).

Pre-visit work
Before the audit visit, care home managers were asked to collate the following information for all relevant residents: Date of admission; Date of medication started; Medical conditions; Recent changes; Monitoring; History of falls and fractures.

Individual assessments to determine the presence of symptoms that required treatment with an antipsychotic were undertaken.

Audit visit
During the audit visit, pharmacists recommended antipsychotic medication reviews for residents who had not received a review within the last three to six months, or where there was evidence of side-effects or no current symptoms of behavioural and psychological symptoms of dementia (BPSD).

Pharmacists and home staff discussed guidelines from NICE (2006). Then, for each resident, a risk versus benefits discussion took place, with a particular focus on falls and cardiovascular accidents.

Where it was deemed necessary, the pharmacists recommended that staff should discuss titrated withdrawal of antipsychotic medication during the review. The audit pharmacist also discussed with the home staff the information that would be provided and discussed with the GP or psychiatrist during the review. This could include a description of other ways of managing BPSD, and how the resident’s needs were being met after admission to the care home, including how the need for medication may have changed.

The audit visit was seen as helpful in facilitating a conversation between home staff and their GP to challenge prescriptions. A document was provided to the home to enable them to request an anti-psychotic medication review from the GP. Homes decided whether to use the form or to make more informal direct requests.

Follow-up
Pharmacists telephoned or revisited the homes twice, two to four months after the audit visit, to ascertain the impact of their recommendations.

Data governance and ethics
No resident-identifiable data was removed from any care home. All databases contained unique reference numbers, which could be identified only within care homes or community pharmacies providing the service and were stored on password-protected computers.

As this was a service evaluation, which falls under the remit of clinical audit, ethical approval was not sought. All homes provided written consent to participate. The community pharmacists providing the service were employed by the company responsible for the regular provision of medicines to the residents so the review of prescribing was within their remit.

Results of the audit
Data was analysed from 463 homes, which received a service from four audit-trained community pharmacists on behalf of 350 company stores.

A total of 3,165 residents receiving antipsychotic medication were reviewed, of whom 1,300 (41.1%) had a recorded diagnosis of dementia; 1,180 reviews were started in 2010, 1,078 in 2011 and 901 in 2012. For six reviews, the year of initiation was not recorded.

Of the 3,165 residents reviewed, 2,341...
(74%) demonstrated symptoms that may necessitate antipsychotic treatment. In 236 (7.5%) residents, antipsychotic medication was prescribed for BPSD, while a further 250 (7.9%) residents had been prescribed antipsychotic medication for another condition and had subsequently developed dementia.

By the first visit 147 (4.6%) of residents were deceased and a further 119 (3.8%) had died by the end of the follow-up visit.

Types of antipsychotic medication prescribed

Table 1 provides a summary of the antipsychotic drugs prescribed for the residents reviewed. In 87 instances, a resident was prescribed more than one antipsychotic concurrently and, in two cases, the name of the antipsychotic drug reviewed was not recorded. Quetiapine represented 42% of prescriptions, risperidone 16.8%, and haloperidol 12.2%.

Reviews of medication

A total of 1,772 (56.0%) residents had had a recorded review of their antipsychotic medication within the previous three months, 465 (14.7%) within the previous six months and 228 (7.2%) in the previous 12 months.

Residents’ antipsychotic prescriptions were reviewed when:

- They were currently receiving another antipsychotic;
- They were demonstrating side-effects from their medication;
- The risks of antipsychotic medication were deemed to outweigh the benefits;
- There was no evidence of symptoms;
- There was no evidence of review.

Fig 1 shows the numbers of prescriptions in which these criteria for questioning were found. Risks were deemed to outweigh benefits for 1,840 (58%) of prescriptions, while there was no evidence of symptoms for 824 prescriptions (26%).

Actions resulting from the audit

Table 2 shows the actions taken as a result of the audit process. A total of 653 patients out of 3,165 (20%) had their dose reduced while 548 (17%) had their prescription discontinued.

Just over half of dose reductions were made before the audit visit, while the majority of discontinuations resulted from the audit visit. There were a large number of anecdotal stories of significant success as a result of this audit.

Discussion

This large-scale audit found that in care home residents receiving antipsychotic medication, 26% did not have any symptoms that necessitated regular antipsychotic medication, and in 58% of cases the risk of the medication was deemed to outweigh the benefit. This relatively simple audit-based service resulted in over 20% of residents having their antipsychotic dose reduced and more than 17% having antipsychotic medication discontinued.

With the known side-effects of antipsychotic medication, including sedation, and an increased risk of falls and cardiovascular events, this service is likely to have improved the quality of life of a large number of care home residents.

The results suggest that nurses working in care homes should regularly question prescriptions for antipsychotic medication. This would ideally be done in partnership with the GP and community pharmacist.

It is not possible to determine what would have happened without this service. It is reasonable to assume that the regular reviews recorded as being undertaken would have led to some antipsychotics being reduced or stopped. However, it is unlikely that the large reduction seen in such a relatively short period of time would have happened without this service. It is perhaps surprising that so many medicines were still considered suitable for stopping or reducing as part of the audit process. This may, however, demonstrate the value of using a third party to instigate such reviews, as in the US model (US...
Federal Government, 1987) since this provides a fresh perspective that is not clouded by historical practice. It may also provide support for less frequent independent reviews rather than regular in-house reviews. It would, however, also seem sensible for nurses in care homes for older people to review local practice to ensure that antipsychotic medication review is undertaken effectively.

The changes to prescribing at different time points of the project demonstrates the value of developing a care home strategy jointly, collecting information on each resident and holding interprofessional meetings to discuss individual prescriptions. The development of a joint strategy for antipsychotic prescribing was effective in reducing antipsychotic use, while the visits to discuss individual residents’ prescriptions had a greater impact on therapy discontinuation.

Although in 58% of cases, the risk of antipsychotic medication was deemed to outweigh the prescription, it would be unreasonable to expect all these prescriptions to be discontinued, as such decisions must be taken with care and all factors require consideration.

The reductions in antipsychotic prescribing seen in this audit are similar to those found in other studies (Westbury et al, 2012; Patterson et al, 2010).

Quetiapine was found to be the most commonly prescribed antipsychotic for BPSD, which is an unlicensed use. Risperidone, the only licensed therapy, was used in fewer than one in six residents. The preference for quetiapine requires further exploration, as national guidance states that unlicensed use of medicines should only become necessary if the clinical need cannot be met by licensed medicines (Joint Formulary Committee, 2013). It would therefore be appropriate for prescriptions for quetiapine to be questioned.

While this audit-based service focused on strategies to manage the use of antipsychotic medication once prescribed, an additional emphasis by nurses, carers and GPs at the initiation of antipsychotic medication in patients with dementia in care homes on risk scoring, drug selection, effectiveness monitoring and review is perhaps also required.

The audit was designed to encourage conversations between nurses, care home staff and GPs about antipsychotic medication. The pharmacists reported that it appeared to empower the nursing and care staff to feel more confident with GPs. It also made nursing and care staff reflect on current practice, taking time out of the “day job” to review patient care and prescribing.

The audit team also reported, perhaps unsurprisingly, that engagement of the care homes involved was the key to success. Where the leadership team focused on positive outcomes for patients, we had more engagement and enthusiasm throughout the audit process. Furthermore, in homes with more stable employee populations, more of the actions seemed to be followed through, which ultimately influenced patient outcomes.

**Conclusion**

This is a simple audit in an important area of practice that has potential for providing significant improvements in patient care.

A large number of medicines were discontinued or stopped as a result of this service, which will in many cases have immediately improved quality of life.

The results suggest that nurses and carers in care homes for older people should question, at the point of initiation, whether antipsychotic therapy is required and ensure the most appropriate drug is selected. At antipsychotic medication reviews, they should be aware that this should always be undertaken from the perspective of discontinuing or reducing therapy, rather than simply confirming that the therapy is working and not causing any harm. Working with suitably trained pharmacists provides the opportunity for an independent perspective on the appropriateness of and need for therapy. NT

● Declaration of interest: corresponding author Aileen Prentice is employed by Boots UK, which funded this work.

![Prescriptions Queried](https://www.nursingtimes.net/prescribing)

**Fig 1. Prescriptions Queried**

- Another antipsychotic currently prescribed (n=88)
- Demonstrating side-effects from antipsychotic medication (n=345)
- Risk deemed to outweigh benefits (n=1,840)
- No evidence of symptoms (n=824)
- No evidence of review (n=614)

**References**


Tackling infection in care homes

In this article...

▶ Taking a multifaceted approach to infection control
▶ The effect of audit, screening and staff education on MRSA
▶ Advice on replicating this model of infection control

Authors Jodie Winfield is infection prevention and control nurse; Carolyn Wiley is operational nurse manager infection prevention; both at Royal Wolverhampton Hospitals Trust. Abstract Winfield J, Wiley C (2012) Tackling infection in care homes. Nursing Times; 108: 7, 18-20. Care home residents have a higher risk of contracting a healthcare-associated infection than the general population. This article describes a three-dimensional strategy that reduced MRSA colonisation among this group. This project won a Nursing Times/Health Service Journal Patient Safety Award in the primary care category in 2011.

Introduction Preventing healthcare-associated infections (HCAI) is a priority in delivering clean, safe care to patients. Wolverhampton City PCT has taken a care economy approach to infection prevention and control, working with the local acute hospital, local authority, independent contractors and care homes to deliver a joined-up vision to prevent HCAIs and improve patient safety. This strategy has enabled us to take a city-wide approach by working with partners and stakeholders.

The vision was devised and approved via a care economy committee and developed, planned, delivered and evaluated by nurses in the community infection prevention and control team (CIPCT).

The Wolverhampton model, entitled PREVENT, incorporates an audit, a “seek and destroy” MRSA screening programme, and education and training for care home staff across the city (Fig 1).

Background HCAIs cause unnecessary pain and suffering for patients and are costly to treat. In 2008, the Wolverhampton care economy committee recognised that care homes were a potential source of infection and that support would be needed to reduce the risk of acquiring an HCAI while living or working in these settings.

In colonisation, a microbe establishes itself on part of the body but does not produce an active infection. Coia et al (2006) identified that patients at high risk of MRSA colonisation include those living in residential care who have a known or likely high prevalence of MRSA carriage. Locally, MRSA carriage in care home residents was unknown but data collected after admission to the local acute trust indicated that a disproportionately high percentage of MRSA colonisation occurred in care home residents.

*Staphylococcus aureus* is part of the skin’s normal flora, especially in the axilla, groin, perineum and nose. Some people are heavily colonised with *S aureus* and areas of damaged skin are especially prone to colonisation. MRSA may replace sensitive strains of *S aureus* on the skin, which it will colonise to provide a reservoir from which it may spread to other patients and staff.

The project We felt a three-pronged approach was the best way to achieve the desired outcomes, as MRSA screening alone may not reduce colonisation (Fraise et al, 1997). The CIPCT launched the PREVENT initiative, consisting of audit, a surveillance programme for care homes and staff education and training, in January 2008 (Fig 1).

Audit To encourage compliance and commitment to improving clinical practice and the environment in which nursing and residential social care are delivered, the PREVENT charter was instigated in 2008 (Box 1).

Managers and staff were asked to sign a pledge of commitment to improve infection prevention standards year on year.

The charter aims to recognise their efforts by awarding a certificate of achievement, ranging from an 80% standard of compliance for bronze to silver and gold certificates for higher achievers (Table 1).

Initially, the audit tool was devised using guidance from the Infection Control Nurses Association (2005) and the Department of Health (2006). It has since been strengthened to include aspects of the Health and Social Care Act (DH, 2008, revised 2010). Developing and using an infection control audit tool should ensure that appropriate policies and standards are in place in care homes and that these standards continue to be met (Tunney et al, 2006).

Staff ownership of infection prevention and control is crucial; care home managers are encouraged to embrace the advice and recommendations given at their annual audit, and the PCT chief executive presents compliance certificates at an annual awards ceremony. This shows the PCT’s “board to ward” approach (DH, 2007), and is an excellent opportunity to showcase best practice and highlight the year’s successes.

Keywords: Healthcare-associated infection/MRSA/Care homes

● This article has been double-blind peer reviewed
Patients colonised with MRSA have an increased risk of developing serious infection.

MRSA screening alone may not reduce colonisation.

Staff ownership of infection prevention and control strategies is crucial.

Practitioners’ knowledge and formal training is vital in preventing the spread of HCAIs.

Nurses wishing to replicate this model need a clear vision, board level support, effective leadership, supportive management and funding.

Audit results

In the past three years, the number of awards presented to care homes has increased, with 74 out of 79 homes in the borough now meeting the minimum standard of 80% compliance, achieving at least a bronze award (Table 2).

Environmental standards have improved dramatically since the project started, along with noticeable improvements in staff attitudes. This is demonstrated by the increase in silver and gold awards.

During 2010-11, the Wolverhampton borough had 79 care homes; 77 were audited and two declined to participate; however, this did not cause concern as both are small learning disability units that are classified locally as low risk. One took part in the 2011-12 audit and received a silver award. The other will be invited to participate in PREVENT in 2012-13.

The implications of declining to take part are explained to managers; they receive neither an action plan for progression towards best practice nor a portfolio of information to support their Care Quality Commission registration process.

A change in manager/owner can tip the balance from a successfully run home with excellent infection prevention awareness and compliance to one that does not meet the required standards.

Three homes did not achieve at least the minimum of 80% (bronze) during the 2010-11 audit. Although this was disappointing, remedial action was taken immediately via an action plan and an improvement letter from the PCT’s director of infection prevention and control.

Furthermore, liaison with the CQC by the CIHPT is standard practice for a home about which there are concerns. If patient safety concerns are noted during the audit, the commissioner at the PCT is contacted about action. Homes are supported to make improvements and an infection prevention nurse carries out further support visits to monitor progress.

MRSA screening

All care home residents are offered six-monthly MRSA screening as part of the PREVENT initiative. Swabs are obtained from the nose, axilla and groin to analyse for colonisation. Any resident found to be colonised is offered a course of decolonisation treatment, which is funded by the PCT and delivered using a patient group directive. GPs are not asked to prescribe unless the patient is unsuitable for standard treatment or the strain of MRSA is resistant to the standard treatment.

At the start of this project, the MRSA colonisation rate was 9%; three years later, this has dropped to below 3%; this may be as low as we may be able to achieve using existing methods. The risk of acquiring an MRSA bacteraemia has reduced significantly (by 67%) since the start. Fig 2 shows the numbers of residents screened every six months, those who were MRSA positive and those who were colonised.

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As part of a wider MRSA screening strategy across the city, this “seek-and-destroy” risk reduction programme has seen MRSA bacteraemia rates reduce city-wide to just two cases during 2010-11, compared with 82 in 2005-06. Neither of the two cases were in care home residents.

Education and training

It is widely accepted that staff knowledge and formal training and experience in infection prevention and control plays a crucial role in preventing the spread of HCAIs. Koch et al (2009) argued that implementing an infection control programme incorporating staff education is vital in reducing the number of infections in nursing homes.

Wilson (2003) recognised that, although...
MRSA can be spread by patient-to-patient and airborne transmission, it is usually transferred via the hands of healthcare workers. It is therefore important that staff are updated annually on standard infection control measures and that hand hygiene remains a high priority.

Education and training for care home staff was recognised locally as a priority as there is generally a high turnover of employees. Although infection prevention and control training is mandatory, it tends to be during induction using a “train the trainer” approach and the trainer’s knowledge cannot be guaranteed.

The PCT recognised this approach was haphazard and provided funding to produce a training DVD covering every aspect of basic infection prevention principles that can be applied to different work environments. Given the rapid staff turnover in care homes, the 30-minute DVD offers an introduction to the topic in a format that can be easily absorbed. New staff can watch it as part of their induction programme.

The DVD was supplied free of charge to every care home in the Wolverhampton area, including independent, local authority and PCT-commissioned services. Care home managers were asked to return a training log, so access to training could be monitored and reported on. A resource folder was also produced and provided free of charge to each care home, as a source of basic information that may help to answer any queries.

DH (2006) guidance recommends that each care home should appoint a staff member with specific responsibility for infection control. Homes are encouraged to nominate infection prevention champions and, to support this, the CIPCT devised a care home link practitioner group in April 2010. This holds quarterly meetings that act as a forum for sharing best practice.

Nationally, care homes generally do not receive the kind of support that Wolverhampton City PCT provides. As they are independent organisations, the NHS has no statutory obligation to offer this level of input. Tunney et al (2006) highlighted that only 23% of care homes in Northern Ireland had ever received a visit from community infection control nurses.

Main outcomes

Randle and Bellamy (2011) acknowledged Wolverhampton City PCT as being the first in the UK to work with staff in residential and nursing homes to improve infection control standards and reduce MRSA cases. PREVENT has resulted in measurable improvements in environmental standards, clinical practice and awareness of infection prevention, and has reduced MRSA colonisation rates by more than 50% in this care home residents. It has achieved the following so far:

- MRSA colonisation rates in care home residents reduced from 9% to below 3%;
- No MRSA bacteraemia recorded in a care home resident since May 2008;
- A significant reduction in cases of C difficile;
- Improved practices – piloting a dehydration clinical care pathway in care homes during outbreaks of diarrhoea and vomiting;
- Improved management of diarrhoea and vomiting outbreaks;
- Effective working relationships;
- Sustainable, measurable improvements;

A pilot of MRSA screening on admission to care homes began in October 2011. Since then, 343 screens have been taken, just one of which (0.3%) identified MRSA colonisation. A statistician has said that we have reached the sample size required to have statistical significance, although it is recognised that it is still a small sample size.

The 2011-12 care home audit tool has been strengthened, using the Health and Social Care Act (2008) as its evidence base. This will allow a platinum award to be given should homes achieve 98% compliance or above. Homes that received a gold award in previous years had commented that they aspired to do better and this positive feedback enabled the CIPCT to review the project and strengthen the tool.

Replicating PREVENT

Infection control nurses wishing to replicate the Wolverhampton model in their area need a clear vision, board-level support, effective leadership, supportive management and funding. They also need to communicate the vision to stakeholders, engage care home staff, and have good operational support including a robust project plan that can be measured.

Knowledge of change management in theory and practice is essential. Marquis and Huston (2009) recognised that for staff to be receptive to change and for it to be effective, it must be systematic and planned. To encourage the effectiveness and success of the PREVENT model, the CIPCT used Lewin’s (1951) model of change to support implementation.

Conclusion

Delivering a structured programme of audit, MRSA screening and education for care home staff across Wolverhampton reduced HCAIs in these settings.

Communication was pivotal to the project’s success, and infection prevention nurses regularly liaised with care home staff and other stakeholders by telephone and letter and by carrying out visits.

The Nursing Times/Health Service Journal Patient Safety Award 2011 is the reward for all those who shared the vision: patients, directors, managers, GPs and the infection prevention and care home teams.

We feel that the work in Wolverhampton demonstrates innovation and vision and has shown what can be done when teamwork is fully implemented.

References


