Using sensory activities to improve dementia care

In this article...

- What the Namaste Care programme involves
- How it can benefit residents, relatives and staff
- Introducing it across three nursing homes

Keywords: Dementia/End-of-life care/ Person-centred care/Nursing homes/ Quality of life

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Namaste Care is a structured programme of sensory activities that aims to improve end-of-life care for people in nursing homes who have advanced dementia by giving them pleasure and helping them connect with others. This article describes how the programme works and details studies showing benefits for residents, relatives and staff. It describes the introduction of Namaste Care across three nursing homes by one London trust, and the challenges and rewards encountered.

Research shows many people with advanced dementia living in care homes have little contact with staff other than for personal care or help with eating and drinking (Alzheimer’s Society, 2007). This article demonstrates how a structured programme of sensory activities that are focused on pleasure rather than physical need can benefit residents with advanced dementia nearing the end of life.

Central London Community Healthcare Trust manages three continuing care nursing homes in Westminster and Kensington and Chelsea, with a total of 111 beds. Although most are for older people who are physically frail, 24 beds in the Princess Louise Nursing Home are for older people with advanced dementia.

At a conference organised in 2013 by St Christopher’s Hospice in London, some of our care home staff heard a talk on Namaste Care, presented by its founder, US social worker and dementia care specialist, Joyce Simard. Namaste Care is an end-of-life programme for people with advanced dementia; it centres on the structured delivery of sensory activities to help residents enjoy the best possible quality of life before they die. Our team was inspired by what we heard, and felt the programme fitted well with our aims, as well as building on two of our work streams.

Person-centred care

We had been working to provide person-centred care in our three nursing homes for more than three years. This involves treating each resident as deserving respect, understanding, empathy and kindness, and focusing on the person behind the task, rather than the task for its own sake. It also involves recognising care as a partnership, rather than treating residents as passive recipients of care (Commission on Dignity in Care for Older People, 2012). To this end, we had embarked on two strands of work:

- Assessing all residents with cognitive impairment, using the Pool Activity Level (PAL) tool, to find out what kind of activities they can engage with and benefit from (Pool, 2011);
- Following a national best-practice programme, the Gold Standards Framework (GSF) for End-of-life Care in Care Homes, to help ensure we provide the best possible end-of-life care and support to residents and their relatives, tailored to individual wishes and needs. Two of our care homes are GSF accredited – one with a pass and the other with a commendation – while the Princess Louise Nursing Home (PLNH) is working towards accreditation. The trust had also introduced
an organisation-wide work stream on compassion in care, based on Cummings and Bennett’s (2012) 6Cs. It was decided that Namaste Care could be the nursing homes’ contribution to this, along with building on the person-centred approach.

Namaste Care

“Namaste” is a Hindu greeting meaning “to honour the spirit within”, reflecting the person-centred care at the heart of the scheme. Namaste Care seeks to engage people via their senses, especially through the power of “loving touch”, to improve quality of life. It should run twice daily, seven days a week, in a designated space.

The room is calming, with few distractions, the lights are low, the scent of essential oils fills the air and soft, relaxing music is played. The Namaste Care worker welcomes residents into the room by name and gently touches each of their hands. Each session includes activities tailored to individual preferences, including:

- Hand/foot massage;
- Reminiscence;
- Food and drink treats;
- Personal care including hair brushing or face washing.

These activities focus on the pleasure they invoke, not meeting physical need.

Research shows Namaste Care can help calm people with dementia, and may even reduce the need for medication (Simard and Volicer, 2010). It can also increase staff satisfaction, helping them connect and communicate with residents even when verbal communication is difficult (Stacpoole et al., 2014a). Residents’ families say how improved the quality of their visits by offering a viable, helpful, enjoyable way to interact with their relatives (Baldwin, 2012).

Implementing Namaste Care

In July 2013, before introducing Namaste Care, the dementia unit at PLNH won a bid to the Department of Health to create a more therapeutic environment for people with dementia. This included creating a sensory garden and staging posts in the corridor to give residents attractive places to sit and enjoy music, pictures, fragrances, or textures and a multisensory room. The trust also won a grant from the Burdett Trust for Nursing under its Delivering Dignity Through Empowered Leadership award, which funded a part-time project lead to implement Namaste Care across the three care homes.

Training

In April 2014, a group of managers, occupational therapists, activity coordinators and other key care home staff attended a one-day workshop on Namaste Care hosted by St Christopher’s Hospice, which developed a Namaste Care training programme and toolkit. The study leader, nurse researcher Min Stacpoole, followed up the workshop with a visit to each of our homes.

The aim was to inform all staff about Namaste Care and inspire them with the vision behind it, as expressed by Dame Cicely Saunders: “You matter because you are you and you matter to the end of your life, and we will help you not only to die peacefully but to live until you die” (Stacpoole et al., 2014a).

The training discussed advanced dementia and end-of-life care, then showed how person-centred care and Namaste Care fit together. We used the toolkit to prepare teaching sessions and handouts for our care homes, and made Namaste Care a standing agenda item at all staff meetings. It was taught in staff’s weekly afternoon training slots and in bitesize sessions of 20-30 minutes after afternoon shift handovers.

Each home set up its own working group. Initially these met weekly and were most successful when they included a wide range of staff, including recognised Namaste Care champions, senior nurses and those who had volunteered or shown an interest. As Namaste Care became established the meetings occurred three times a week or once a month.

Environment

Each home created a designated Namaste Care area, where residents can feel they are entering a special space. Key factors are:

- Having a space big enough to accommodate residents and their comfortable chairs;
- Ensuring the space is distinct from other parts of the communal areas;
- Avoiding distractions or disturbances.

PLNH’s dementia unit was able to use its new multisensory room, another home chose an existing activity room and the third chose a section of the residents’ sitting room. Donations were used to help purchase additional equipment such as soft flannels and towels, aromatherapy diffusers and essential oils, toilet bags and a selection of relaxing music.

Delivering Namaste Care

Each home adopted a phased approach to the introduction of Namaste care: two starting in April 2014 and one in August 2014, with three to five sessions in each nursing home per week. The standard set by Professor Simard is that Namaste Care should be offered in two sessions for at least four hours a day, seven days a week (Simard, 2013). Some homes offered sessions of 90 minutes, others managed two hours.

We used a combination of factors to decide which residents might be suitable for Namaste Care. In line with the GSF, staff in each home meet regularly to review residents and identify those nearing the end of life. For Namaste Care we focus on those coded yellow (weeks to live) or red (days to live); we look at residents with dementia who have been assessed using the PAL tool as likely to benefit from sensory activity. Clinical judgement is also needed to account for individual likes and needs.

Outcomes

We measured a number of factors before and after Namaste Care to evaluate its effectiveness on challenging behaviour scores. We measured a number of factors before and after Namaste Care to evaluate its effectiveness on challenging behaviour scores.
Residents in PLNH’s dementia unit were observed for a period of five minutes, with the nature and type of their interactions with staff, other residents and relatives noted every five minutes. QUIS scores five sorts of interactions:

- Positive social interactions; 
- Positive personal care; 
- Neutral care; 
- Negative controlling care; 
- Negative subtle abuse.

In the QUIS observations carried out after the introduction of Namaste Care we observed a marked improvement in the quality of interactions – there were virtually no negative interactions and an increase in positive interactions across the board. In PLNH’s dementia unit, for example, a series of observations were carried out in January 2014 (before Namaste care) and at the end of August (after Namaste care); Table 1 summarises the results.

A retrospective audit of nursing records of regular attenders of the Namaste Care groups showed improved sleeping patterns in just over half of residents receiving Namaste Care across the homes. The records for a week before the resident started attending Namaste Care were compared with the latest records available. However, in some of the homes the number of residents concerned and whose records were available was small. Existing records were used and on occasion some of the data was missing (for example, charts had not always been fully or correctly completed).

Similarly, audits of weight records showed that more than half of those attending sessions maintained or gained weight, suggesting improved appetite/eating. For each regular attender of Namaste Care, the weight in the month before joining the groups was compared with the latest data available, which was usually after a period of 4-6 months.

**Satisfaction levels**
Staff satisfaction was assessed in all the homes using the Gold Standards Framework for End-of-life care Team Working Questionnaire, outlined in Borrill and West’s (2001) guide for managers; respondents rate 16 statements on how accurate/inaccurate they think they are. This covers four areas of team working:

- Clarity and commitment to team objectives;
- Focus on quality;
- Decision making;
- Support for innovation.

Not all the data is available across the homes yet, but in PLNH’s dementia unit 12 out of 27 questionnaires were returned in December 2013 before Namaste Care, giving a response rate of 44%. Twelve questionnaires were also returned in August 2014 after the introduction of Namaste care. All the average scores increased slightly, with the largest increase (from 3.37 to 3.77) being in the quality section. It will be interesting to compare the results of subsequent questionnaires in the unit as well as post-Namaste Care questionnaires in the other homes.

Resident and relative satisfaction has been more difficult to demonstrate due to a lack of data. However, informal feedback from staff and relatives in the three homes suggests benefits for residents (Box 1).

**Challenges**
We were unable to appoint a full-time project lead, which delayed our proposed timetable. This was perhaps due to the post being fixed term or as a result of the nursing homes undergoing a process of major organisational change.

The biggest challenge, however, was creating the necessary cultural change. For example, at first, staff found it strange to take off their gloves to give hand massages, but they are now starting to understand the importance of skin-on-skin contact when attempting to connect with residents, and that gloves should only be worn when attempting to connect with residents.

**Table 1. Quality of Interactions**

<table>
<thead>
<tr>
<th>Interactions (%)</th>
<th>Positive</th>
<th>Neutral</th>
<th>Negative</th>
</tr>
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<tbody>
<tr>
<td>Before Namaste Care</td>
<td>35</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>After Namaste Care</td>
<td>64</td>
<td>32</td>
<td>3</td>
</tr>
</tbody>
</table>

**FIG 2. Depression Scale Scores Before and After Namaste Care**

<table>
<thead>
<tr>
<th>Jan-14 Before Namaste Care</th>
<th>Aug-14 After Namaste Care</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
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<tr>
<td>0</td>
<td>2</td>
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Residents in PLNH’s dementia unit were assessed using the Challenging Behaviour Scale, which measures the number of difficult behaviours, their frequency and how challenging they are to deal with. Assessments took place in December 2013 and again at the end of August 2014, after residents had received Namaste Care; 10 of 14 (71%) showed reduced challenging behaviour scores (Fig 1).

We also used the Cornell Scale for Depression in Dementia to assess residents’ mood. A score of six or above indicates depression, with lower scores generally associated with no significant depressive symptoms. Ten out of 11 (91%) residents in the dementia unit who had symptoms of depression in January 2014, before Namaste Care was introduced, no longer had these symptoms in August 2014 after receiving Namaste Care (Fig 2).

**Quality of life, sleep and appetite**
We used the Quality of Interactions Schedule (QUIS) to measure quality of life. Residents are observed for a period of time, among staff, along with residents’ and relatives’ satisfaction levels.

- Aggressive or “challenging” behaviour;
- Mood;
- Quality of life;
- Sleeping patterns;
- Appetite.

We also looked at job satisfaction among staff, along with residents’ and their relatives’ satisfaction levels.
aggressive during personal care, crying out, pinching and spitting at staff, which made tasks such as brushing his teeth and washing him extremely difficult. Following Namaste Care, staff and his wife have said he is much calmer, no longer pinches or spits and is much more cooperative during personal care. He now even allows staff to brush his teeth.

Mike Jones: On first attending Namaste Care, Mr Jones did not engage. He did not open his eyes even when awake, and was silent, not speaking or making any noise at all. Now he opens his eyes, makes eye contact, nods his head as if acknowledging a greeting or comment from staff, and smiles. Previously silent, Mr Jones will now speak briefly or say hello in response, and make choices verbally between two options of flavoured dessert or music. On one occasion he responded to the activity coordinator’s comments about the cat that visits, continued in a low dialogue of tonal inflexion with occasional words. Several of these words were clear and understandable, including “cat”. ‘Residents’ names have been changed

Bob Carter: Before starting Namaste Care, Mr Carter, was often physically

when there in a risk of contamination or transmitting infection.

There was also resistance from some staff who felt this sort of care was not their job. It is important that all staff understand that Namaste Care requires a team effort. For example, the housekeeper has to fetch and prepare the fruit, while other staff need to prepare residents and take them to the designated space so the Namaste Care worker can be ready to greet them and begin the session.

Another challenge is ensuring Namaste Care is treated as a core activity, and not as an optional extra. It is easy for staff to say “We can’t do Namaste because of the staff shortage”, but nobody would suggest not providing lunch or giving out medication due to staff shortages. When shortages do occur, it is crucial that everyone knows what to do and feels confident in supporting the Namaste Care worker.

Motivating factors

Staff are encouraged and motivated by the positive changes they see in residents, including surprising moments of communication and connection. Other motivational factors include:

- Having a shared vision;
- The training, toolkit and support offered by St Christopher’s Hospice;
- Finding champions at all levels to help implement the programme, whether senior colleagues, housekeepers or healthcare assistants;
- Using a variety of ways to communicate the project to staff (including leaflets, training and pocket cards), delivered at various times such as shift handovers and team and nursing home meetings;
- Having the support of senior managers and staff (for example, in assigning Namaste Care carers for each day, dealing with staffing crises, dispelling the myths and supporting and encouraging staff).

Future developments

We are still at the early stages of our journey and now need to embed and sustain the programme. Our current objectives are to:

- Continue embedding Namaste Care in our homes, increasing sessions to twice daily;
- Keep spreading ownership of Namaste Care to all staff, and arrange visits to other homes implementing it;
- Continue gathering outcome data and share our experience and outcomes with others;
- Arrange for Joyce Simard, founder of Namaste Care, to visit our nursing homes this summer.

Conclusion

Although Namaste Care is only one part of our person-centred approach, there have been clear improvements in residents’ behaviour, mood and quality of life since providing it three to five times a week. There are also signs of improved satisfaction among staff and residents’ families. We look forward to increasing the frequency of sessions and providing increasingly meaningful activity, comfort and pleasurable experiences for residents with advanced dementia to realise the full benefits and help residents enjoy the best possible quality of life before they die. NT

References


For more on this topic go online...
- How a time machine concept aids dementia care
- Bit.ly/NTTimeMachine