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- What person-centred care means for care home residents living with dementia
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Enhancing wellbeing of residents with dementia in care homes



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Key points

People with dementia living in care homes need person-centred care

To provide person-centred care, we need to recognise personhood and all it brings with it

The seven domains of wellbeing for people living with dementia are identity, connectedness, security, autonomy, meaning, growth and joy

Reminiscence activities help people with dementia make sense of what is happening to them

Making the care home environment more interesting and easier to navigate supports the wellbeing of residents living with dementia

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Abstract In the past few years, care home provider Barchester Healthcare has implemented a new programme designed to reduce distress and improve wellbeing in residents living with dementia. Developed by the company's specialist dementia care team, the programme has achieved remarkable outcomes in the initial eight homes that were piloted and evaluated. It is now being rolled out to all care homes in the company. This article describes the programme, its rationale and outcomes.

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One in six people aged 85 or over in the UK are living permanently in a care home (Alzheimer's Society 2017). Barchester Healthcare has over 200 care homes across the UK, and over 160 of them provide specific communities for people living with dementia known as our 'memory lane communities'.

Providing person-centred care

The phrase 'person-centred care' often 'trips off the tongue' and appears in mission statements, government publications and advisory leaflets, where it seems to have replaced 'individualised care' as a strapline (Baker, 2015). However, how do we provide person-centred care?

One of the first adopters of the term was Kitwood (1997), who advocated that, to truly provide person-centred care, we needed to recognise personhood and all it brings with it. As well as creating wellbeing, we needed to remove ill-being or malignant social psychology – those things that sometimes we do or say without malicious intent, but that could psychologically harm a person living with dementia. Examples include, talking over somebody rather than including them or

not giving the person a choice because it is easier (or quicker) to make it for them.

Brooker (2007) created the VIPS model of care – VIPS standing for 'valuing people, individualising care' – which encourages staff to look at the personal perspectives and social environment of those living with dementia in care settings. Powers (2014) helped us by determining seven domains of wellbeing for the person living with dementia: identity, connectedness, security, autonomy, meaning, growth and joy.

However, the recipients of our care are often the best teachers and, as we read more from people living with dementia and talk to our residents living with dementia in our homes, we internalise their thoughts and accommodate their wishes in our practice (Swaffer, 2016; Whitman, 2016; Bryden, 2007).

In his inquiry into care homes, Kennedy (2015) purports that, in an increasingly diverse and individualised society, we still have a care home system akin to a 'Henry Ford model'; that is, an undifferentiated production line. In a study in care homes in Wales, Rochira (2015) states that, too often, there is an acceptance of an overall level of care that is not good enough, as care delivered without neglect or abuse is

Box 1. New dementia care mission statement

People living with dementia are admitted to our care homes at various stages of their journey, but whichever path they are on in the complex map of cognitive impairment, we need to prioritise the reduction of any distress and the promotion of their wellbeing.

The idea underpinning our 'memory lane communities' is to help residents to continue living their lives as independently as possible by working alongside them rather than for them, and by promoting positive memories wherever we can.

The person is our focus rather than the diagnosis, and this allows us to work with residents in a natural way without preconceptions.

Our staff will be skilled in dementia care interventions and will be chosen for their empathic approach towards people living with dementia.

Our environments will reduce confusion and promote orientation, as well as offering evidence- and research-based interventions to assist our residents to achieve fulfilment.

considered to be good care. A harsh statement that many of our nurses and carers would disagree with, but how can we evidence good care? As a company, we have the opportunity to disprove this by providing a dementia care programme that reduces our residents' levels of distress and improves their wellbeing.

Introducing change

Shortly after my arrival at Barchester Healthcare in April 2015, our dementia care specialist team increased from three to eight staff. With five new members joining the organisation, including me, there was an opportunity for us to sit down together and bring all our ideas to the table. The team works across all of the company's homes and comprises six dementia care specialists, a deputy and a director of dementia care.

During a four-day workshop in June 2015, we worked on a programme of change that included refreshing staff training and looked at how to implement and evaluate the programme. By the end of the workshop, we were able to present a draft to members of the board, who agreed to provide funding to carry out a pilot in 12 care homes across the company.

Box 2. 10 key things

1. Staff have received training in person-centred approaches and understanding dementia (level 1)
2. Staff have a thorough understanding of things that may constitute abuse and know how to follow safeguarding procedures
3. Staff communicate well with residents both verbally and non-verbally, and do not use disempowering language at any time
4. Staff are able to demonstrate an empathic approach to residents
5. Staff use any intervention or activity with residents as an opportunity to increase their wellbeing and meet their psychosocial needs
6. Staff work together as a real team and support each other
7. Residents are enabled to continue with their own wishes, preferences, routines and abilities wherever possible
8. Senior staff fully support their team and facilitate opportunities for creative ideas and changes that help residents
9. Privacy and dignity is afforded to residents at all times
10. Relatives and friends of residents are supported at all times

The next three months were spent finalising the programme, collecting the evidence and research for our criteria and training, and developing standard operating procedures to accompany each criterion. By September 2015, we were ready to roll out the pilot.

Box 3. CAREFUL tool

The CAREFUL observational tool was developed by the team at Barchester Healthcare to enable staff to discreetly observe residents and categorise their observations into seven main activity areas; for example, being involved in activity, resting or socialising with others. This activity area is then graded to establish whether residents are perceived as experiencing wellbeing, ill-being or a neutral state.

Alongside this, the observer also records the interactions with staff, aligning them to the seven domains of wellbeing; for example, if a resident is carrying out an activity with a member of staff and they are chatting and laughing, the interaction would be recorded under the domain of 'joy' as a positive interaction (emotional gain); if a member of staff had removed an activity because lunch was coming without consulting the person, this would be recorded under the domain of 'meaning' as a negative interaction (emotional loss).

After observation and analysis, the observer sits with the team and talks through their observations, and staff and observer discuss how they might continue to improve resident wellbeing.

The 10-60-06 programme

The programme, called 10-60-06, is a blend of interventions and training designed to improve dementia care. It is based on what we believe to be the latest or most reliable evidence- and research-based practice. The focus of this new dementia care programme is to help to reduce residents' distress and increase their wellbeing, as stressed in our new dementia care mission statement (Box 1).

To begin with, the homes are expected to meet '10 key things' (Box 2) across the whole of the home, not just the 'memory lane community'. These are the absolute essentials of care and include person-centred approaches, the use of life story work, and ensuring that a high percentage of staff across all disciplines attend the first level of dementia care training. These 'essentials of care' need to be in place before any further specialisation can ensue.

The '10 key things' are complemented by 60 criteria broken down into 10 themes – each theme containing six criteria. The criteria apply to all residents regardless of diagnosis. Each criterion is accompanied by a standard operating procedure to guide staff. At the introductory presentation, staff are encouraged to volunteer to lead one of the themes.

Table 1 details the 10 key themes as they are today.

Four levels of training

The dementia care team has developed four levels of training to ensure that staff have an empathic and person-centred approach to dementia care.

The first two levels run over three days and cover the different types of dementia and how different approaches can help or hinder residents. We draw heavily on the

work of Power (2014) on the seven domains of wellbeing, as we have found that they help staff to self-reflect and think about their approaches in more depth.

The third level takes staff through the experience of care, not particularly how it might feel to have dementia, but how it might feel to receive positive care and how it might feel to receive poor care. When we carry out the evaluation session, we ask staff to imagine how much worse it might feel if they were confused or disorientated. Staff have evaluated this training level highly throughout the pilot.

The fourth level introduces staff to a new observational tool developed by the team, called CAREFUL (Box 3). We wanted to come up with a tool that staff could use to observe not only the main activities of residents in the home but also their wellbeing. The emotional losses and gains that staff might observe with the tool are categorised into the seven domains of wellbeing. The tool has not been widely introduced yet, as we are still testing it.

The pilot process

The 12 homes chosen for the pilot by the regional and divisional directors were sent the criteria along with an explanation of the programme, and asked to score their home as either 'excellent', 'good' or 'needs action plan'. This was followed by a visit from their dementia care specialist, who conducted their own assessment of the 'memory lane communities' before sitting down with the home managers and teams to agree baseline scores. In most cases, the scores given by the homes themselves did not need to be changed. The aim is that at least 80% of the scores achieved are 'good' or 'excellent' by the end of the programme.

Throughout the process, each home was visited at least every four weeks by their dementia care specialist and additional visits were made to provide the training. Some homes received additional bespoke training (for example, on pain assessment tools or the mealtime experience) if it was felt this would be beneficial.

Making improvements to the homes' environments delayed the pilot by approximately four months, as we wanted to design new signage helping residents find their way around the homes. The pilot was originally planned to last six months, but in most cases it took 10 months for the homes to be ready for accreditation.

Homes were not told their accreditation date to ensure that what we saw on the day reflected a 'typical day' at the home. Homes were accredited during a process of

Table 1. The 10 themes of the 10-60-06 programme

Staff training and knowledge	It is essential that staff working in a 'memory lane community' have a good working knowledge of person-centred approaches to dementia care. Memory lane teams will be provided with support, guidance and leadership by the dementia care team to empower them to implement and cascade their knowledge and skills
Meaningful activity	Residents living with dementia must be provided with meaningful activities and stimulation to ensure a sense of wellbeing and purpose. The provision of meaningful occupation and connectedness staves off boredom, social isolation and ill-being. For residents who wish to spend their time alone, this must be respected by staff and evidenced in their care plans
Involving resident and family	Working in partnership with residents and families is crucial to provide holistic care and promote a sense of inclusion and respect for each other's roles (resident, relative and staff role)
Interesting and orientating environment	The environment should be designed and adapted to help residents locate key areas in the home while maintaining a sense of homeliness and relaxation. For residents who wish to walk around the home, colour, signage and themed areas in corridors should be used to help them orientate and engage. Strategically placed rest stops should be used where possible for residents to rest or spend time away from communal areas
Reducing distress	It is imperative that residents are assessed when distress occurs to ensure that potential causes are highlighted and addressed and to promote wellbeing. Distress is reduced and wellbeing enhanced when the seven domains of wellbeing (Power, 2014) are present
Improving wellbeing	A holistic approach to meeting physical, psychological, social and spiritual needs will ensure that residents' wellbeing is observed and enhanced whenever possible
Providing help with the diagnosis	Although many live positively with a diagnosis of dementia, that diagnosis can have a negative impact on a person's wellbeing. It is therefore vital that we understand what impact it can have and how we can work with residents to alleviate any fear or anxiety and provide further support if needed
Medication	Residents living with dementia are likely to be taking several medications for a range of age-associated conditions (polypharmacy). The Department of Health recommends six-monthly medication reviews to determine whether each medication is necessary and effective. Antipsychotics should not be seen as a first-line approach to reduce distress
Nutrition	This section focuses on enabling a good mealtime experience along with putting strategies in place to help residents who may be at risk of losing weight to maintain or improve their weight
Legislation	Provide documentary evidence that homes meet all government, regulatory and company legislation and standards
Six additional criteria	The Additional Six criteria focus on introducing innovative projects into the home to enhance either activity, community inclusion or existing areas of good practice that have not previously been tried within the home, for example, Namaste Care

observation (using CAREFUL), speaking to residents and relatives where able, speaking to staff (to establish their understanding and approach to dementia care) and reviewing some of the documentation before scoring the home against the criteria.

Additional interventions

As well as implementing the 10-60-06 programme, each home conducted one additional activity that the company had not tried or evaluated. In one home, Namaste Care (Simard, 2007) was introduced; in

Fig 1. The *Getting to know me...* booklet



Fig 2. The *Getting to know me...* board game



that home, over half the residents experienced an average weight increase of 2.4kg. Three homes tried physical intervention and activity programmes; two homes signed up for an intergenerational croquet programme; and the remaining homes proposed different types of reminiscence activities through digital platforms.

Three new interventions were produced by members of our own team – for which they have been nominated for the Dementia Care Awards 2016.

David Owen a dementia care specialist created the *Getting to Know Me...* life story book (Fig 1), which beautifully captures peoples' interests, stories, celebrations and photographs. People make sense of what is happening to them in the 'here and now' by reference to experiences they have had in the past (Brooker, 2007). Not only

can the book be used for that purpose while residents live in the home, but it also provides a lovely memory for families to take home after their relative's death.

The board game of the same name (Fig 2), developed by Ann Marie Harmer, a dementia care specialist, enables residents and staff (or residents and relatives/friends) to have fun together while also capturing information for residents' life story books.

The third intervention was put together by our Dementia Care specialist Claire Peart; it consists of slide shows of images from the 1950s and 1960s, with accompanying music and text, projected in a rest area on wall-mounted plasma television screens. This has been highly rated by residents, relatives and staff. One lady who was not known to communicate with anybody was observed by her relative to be singing along to the slides. All three interventions proved so successful that they were adopted across all of the pilot homes and introduced into each new home coming onto the programme.

Outcomes

All the pilot homes were accredited by the end of 2016 and there are now a further 23 homes accredited, with 20 homes due for accreditation in December 2017. Eight of the accredited homes were evaluated in June 2016. In these homes, we found that, since September 2015, there had been:

- An 11% overall reduction in falls;
- An average 22% reduction in distress reactions;
- An average 17% reduction in the use of antipsychotics;

- An average 79% reduction in the use of anxiolytics;
- An average 29% reduction in the use of night-time sedation;
- An average 38% increase in the number of residents who had gained weight since being on the programme;
- An average 43% increase in the number of residents who had improved their wellbeing scores.

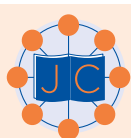
These are incredible outcomes for residents in the pilot care homes, but what the figures do not demonstrate is how calm the communities now feel, how easier the orientation is in the homes, and how happy residents and staff generally are.

Enhancing dementia care in the future

The pilot has been such a success that the company has agreed to roll out the programme across all its 162 'memory lane communities' over the next two years. This has been the result of a vast team effort, not only with the specialists who produced the programme but also with staff, who have wholeheartedly adopted and implemented it. It has engendered a sense of pride and accomplishment, and the certainty that we can continue to enhance dementia care for our residents. **NT**

References

- Baker C** (2015) *Developing Excellent Care for People Living with Dementia in Care Homes*. London: Jessica Kingsley Publishers.
- Brooker D** (2007) *Person-centred Dementia Care: Making Services Better*. London: Jessica Kingsley Publishers.
- Bryden C** (2007) *Dancing with Dementia: My Story of Living Positively with Dementia*. London: Jessica Kingsley Publishers.
- Kennedy J** (2015) *John Kennedy's Care Home Inquiry*. London: Joseph Rowntree Foundation.
- Kitwood T** (1997) *Dementia Reconsidered: The Person Comes First*. Maidenhead: Open University Press.
- Power GA** (2014) *Dementia Beyond Disease: Enhancing Well-Being*. Baltimore, MD: Health Professions Press.
- Rochira S** (2015) A place to call home? *Nursing Older People*; 27: 2, 12.
- Simard J (2007) *The End of Life Namaste Care Program for People with Dementia*. Baltimore, MD: Health Professions Press.
- Swaffer K** (2016) *What the Hell Happened to my Brain? Living Beyond Dementia*. London: Jessica Kingsley Publishers.
- Whitman L** (2016) *People with Dementia Speak Out*. London: Jessica Kingsley Publishers.



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