

THE MAIN ISSUES IN CARE HOMES AT PRESENT

1. *Lack of health service input to Care Homes* (in comparison with services to people living in their own homes). Input from physiotherapists, OTs, Speech & Language therapists, specialist nurses, and specialists in acquired brain injury - both alcohol-related and due to other causes) is particularly poor. And when services are provided they usually
 - are intermittent rather than continuing
 - focus on acute rather than long-term problems
 - rarely involve residents themselves or families; residents and their families need to be involved, educated, enabled and empowered.
 - do not involve Care Home staff in establishing or implementing care plans. If staff are not involved, they cannot be expected to continue with treatments and other interventions between visits from specialists.
2. *Loss of independence: poor quality of life; preventable impairment (eg contractures)*. These, at least in part, are due to minimal availability of rehabilitation services for Care Home residents. These problems are particularly marked amongst younger residents - many of whom may have 40 years or more of institutional 'care' ahead.
3. *Low staff morale* (particularly amongst care assistants), *excessive time spent in bureaucratic processes* (often by the only registered nurse available) and *poor communication between staff*. These result in failure to recognise problems and unmet needs (eg inappropriate PEG feeding, development of contractures, end-of-life care); also in failure to respond to medication needs and requests from GPs and others.
4. *Focus on attempting to improve practice by issuing ever more guidelines and protocols*, rather than encouraging staff to identify and resolve problems using their own initiative and common-sense - supported by the provision of effective learning experiences.
5. *Neglect of what matters most to residents once their need for food, warmth and adequate health care have been met*: meaningful things to do, people to talk to, things to see, good relationships with staff, contributing something (eg planting a plant, preparing vegetables), getting out, exercising choice (eg in making a purchase), engaging in communal activities (singing, dancing etc, exercise, creative activity (eg artwork, music).
6. *Lack of influence of training in terms of changing practice*. This is mainly due to
 - ineffectiveness of formal teaching compared with learning and personal development which is integrated with clinical practice
 - poor attendance for formal training; training not available for staff who work only during evenings or weekends
 - no formal reflective practice to enable staff to learn from 'significant events'.

Key recommendations

1. Access to services and opportunities should be the same as for people living in their own homes

Eg physiotherapy, wheelchairs, other equipment/supplies, daytime activity, hearing aid repair/maintenance, podiatry, care of eyes and teeth, and specialist medical services (eg for acquired brain injury, palliative care, continence advice/support, learning difficulty services, physiotherapy, speech and language therapy); also access to chronic disease management programmes and community physical disability teams.

2. Address the particular needs of younger people in care homes

- Physiotherapy and other therapies to maintain/improve physical function; goal planning.
- Improved assessment procedures (for health and social support)
- Meaningful activity; holidays.
- Explore the possibility of transfer of each resident to more suitable accommodation; avoid future inappropriate placements
- Establish more suitable and appropriately staffed facilities for those residents who need continuing care.

3. Address the particular needs of residents with Alcohol Related Brain Damage (ARBD)

- Ensure no admissions of newly identified patients unless rehabilitation attempted.
- Establish *specialist* rehabilitation and continuing care facilities.
- No younger people with ARBD should be resident in a 'mainstream' (non- specialist) Care Home.

Staff

4. Maximise physical, mental and social function by encouraging residents to:

- Do things for themselves wherever possible.
- Participate in activities within and outwith the Home.
- Engage in physical activity.
- Be involved in the running of the Home

And encourage all staff, social workers and other professionals to focus on what residents can rather than cannot do for themselves.

5. Improve the knowledge-base, skills and status of care assistants and others who work in Care Homes

- All those involved to be familiar with the considerable body of evidence relating to the effectiveness of different training methods – some of which

relates specifically to care homes.

- Recognise that teaching programmes and courses usually have little or no influence on practice, and therefore benefit neither residents or staff.
 - Adopt a variety of more innovative approaches to improving practice, eg
 - a. Workplace learning (identification and resolution of problems)
 - b. Reflective practice/critical event analysis.
 - c. Experience of good practice in other settings.
 - d. Self-instructional material.
 - e. Expansion of nursing competencies.
 - f. Clinical supervision processes.
 - Bring about involvement and commitment of care home-owners; and promote a culture of enquiry, learning and proactivity.
- 6. Train and support all staff in Care Homes** to identify and deal with problems that arise (relating to individual residents or to the Home and to react appropriately to changes observed in residents. Staff should be proactive rather than reactive. Also to try to forestall problems – eg by suggesting or persuading residents who have continence problems to go to the toilet – without them necessarily having to ask; or on the other hand helping and encouraging residents who need help to eat and drink.

Procedural matters

- 7. Identify and explore possibilities for reducing the amount of paperwork,** duplicative activities and other apparently unnecessary bureaucratic processes in Care Homes. Make much better use of administrative staff already employed.
- 8. Explore the potential for influencing the Care Commission** to adopt a more evidence-based approach to the standards set, and to focus much more on issues which are important for the achievement of a good quality of life for residents rather than physical and procedural considerations.
- 9. Improve communication within Care Homes and between Care Homes and other agencies** - particularly with acute hospitals, hospices and community nursing services. In particular expedite procedures for the transfer of patients from acute hospitals and hospices to Care Homes and vice-versa.
- 10. Ensure effective joint (ie team) working of all nursing services which relate to Care Homes:** District Nursing, Community Palliative Care nurse facilitators, hospice-based palliative care specialist nurses for Care Homes, nurses in Care Homes and Care Home nurse facilitators. At present these nurses are accountable to a diverse range of individuals and agencies with lack of understanding of each others' responsibilities – giving rise to much misunderstanding, inconsistency and inefficiency. There is need for vision and leadership in Care Home nursing, and realisation that this is a specialty in its own right: neither acute nor primary care, but requiring quite different skills and competencies.

11. **Streamline the procedures for periodic review/assessment of residents** – particularly for younger residents (who may have several or many years still to live) – requires to be streamlined: in terms of purpose; adequacy, frequency and outcome.
12. **Facilitate the employment of volunteers** to work in a range of capacities within Care Homes. This will require action both at a practical and political level. People who themselves have a (physical) disability would be particularly likely to benefit, and their experience makes them well-suited to this work.

Residents

13. **Empower residents/advocates.** Ensure that in all Care Homes residents (or their representatives/advocates) have real influence in the way that Homes operate. All Homes should have an effective Residents' Committee and probably also have advocacy arrangements with an independent agency.
14. **Put into effect the recommendations of the report 'Care in the Balance' (Audit Scotland,1999):** promoting autonomy, encouraging independence, linking with the outside world, meaningful activity, use of gardens and communal areas, control of the environment etc. For bigger Homes offer holidays to other Homes for those who would like a change of scene.

Homes

15. **Encourage and facilitate all Care Homes to engage with outside organisations, professionals and others** as is the practice already in some Homes: for example with providers of art, music, creative and other providers, with complementary therapists, and with volunteers (both organisations and individuals).
16. **Ensure that all residents have sufficient funds** each week to enable them to make small purchases and to ensure that they are able to participate in any activities, outside or inside the home, for which there is a charge. It is unacceptable that some residents are unable to join in an outing because they cannot pay. It is also unacceptable for any Care Home to require residents to pay for items such as a light bulb. All residents should be able *to choose* from a selection of toiletries and other small items – preferably as part of an outing to shops and other places.
17. **Care Homes should be opened up to the services and opportunities available to people living in their own homes.** These should include health, social work, leisure and recreation, community education, volunteers, voluntary organisations and schoolchildren (participating for example in intergenerational activities).
18. **Identify and promote the particular needs of care assistants and nurses from overseas.**