Some other observations in Care Homes

When a Glasgow resident is transferred to a care home outside, Glasgow continues to be the local authority responsible for the resident. However Glasgow occupational therapists (for example) are unwilling or refuse to visit clients outside the Glasgow boundary. This creates obvious difficulties.

Younger adults are on a regular basis transferred from specialist rehabilitation (eg at the Brain Injury Rehabilitation Centre in Wishaw or at the Southern General Hospital) to care homes, but without any arrangements made for their ongoing rehabilitation.

Younger adult residents of care homes have very limited access to specialist health services (eg therapies provided by AHP's; specialist brain injury assessment and rehabilitation services; nurse specialists in multiple sclerosis, epilepsy, palliative care etc). Care home staff need much clearer information about specialist services and how to initiate referrals on behalf of residents; and the health service should respond more effectively and sympathetically to requests from care home staff. Ref:

We identified a number of courses at local colleges that we thought might incorporate experience of working in care homes in their training programmes: for example aromatherapy, other 'complementary' therapies, hairdressing, beauty treatment, social care. The idea was that residents and students would both benefit. However our first experience - with aromatherapy - in one of the more 'challenging' homes was unfortunate. Staff regarded the small team of students of something of an oddity, providing them with the opportunity for an extra break rather than helping to escort residents to, from and during treatments. We still feel, however, that there is considerable potential for the engagement of students from a wide variety of courses and professions – to the benefit of the students, residents and care homes themselves.

In many care homes the nurse manager spends a great deal of time attending to paperwork, to the serious detriment of her ability to lead, teach and inspire staff. Ref:

Much time is wasted in care homes in obtaining simple remedies (even Vaseline and dressings) on an individual resident basis – rather than having a small 'pool' of these available for emergency use. Ref:

Input of only 3 – 4 hours per week from a physiotherapist or occupational therapist can greatly improve physical and psychosocial function and the quality of life for individual residents, and make a marked difference to the knowledge, skills and attitudes of the staff.

Inspections by the Care Commission tend to focus on what is measurable, and fail to notice (or record) some of the issues that are important to residents: eg access to gardens, meaningful activity, needs for rehabilitation, encouraging independence, poor staff morale.

In many care homes care-workers are not treated with respect and are not encouraged to make use of the many learning opportunities available or to contribute their observations and thoughts. Ref:

Care homes would provide valuable learning opportunities for students and recently qualified professionals such as AHP’s, nurses, social workers and medical students. This would also be of considerable benefit to care homes and residents. Ref:

Singing, music and dancing in care homes is often extremely morale-boosting and life-enhancing for residents. There are also residents who would like to paint, do needlework or to take up a past interest (eg some woodwork or making things) these opportunities are seldom made available.

Nothing will improve a service if the staff are demotivated: methods of motivating staff and organisations must be explored and developed (Jennifer Dixon). Decentralisation and incentives are needed (Iain Enthoven).

More will be achieved by promoting a culture of learning and enquiring rather than one of judgement. Emphasising learning over regulations is the linchpin strategy for improving care. Use measurement for learning rather for solution, reward or punishment. (Donald Berwick).